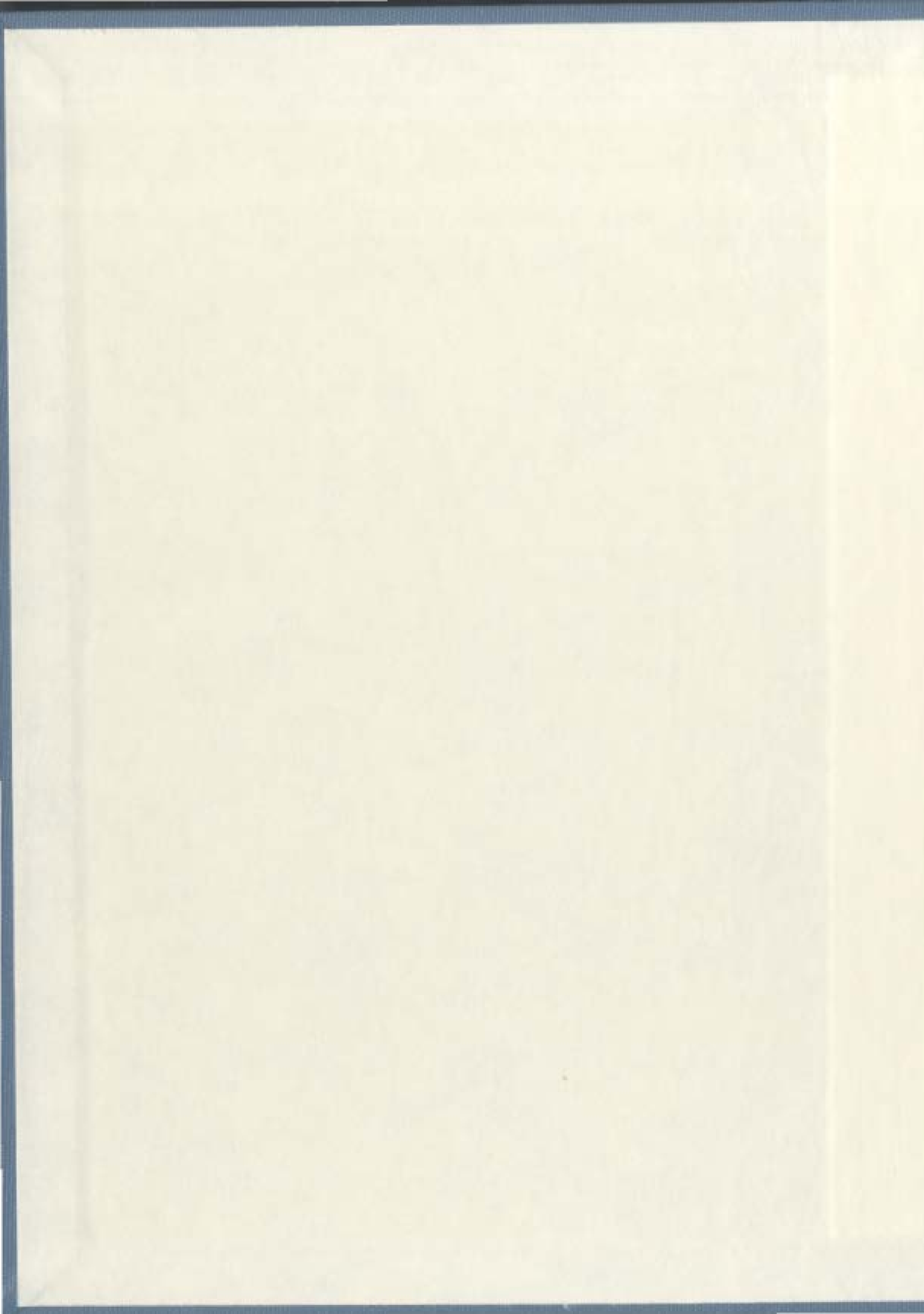
WOMEN'S EXPERIENCE OF TREATMENT FOR DEPRESSION: A PHENOMENOLOGICAL STUDY

JILL CUMBY



Women's Experience of Treatment for Depression: A Phenomenological Study

by

© Jill Cumby R.N., B.Sc.N.

A thesis submitted to the

School of Graduate Studies

in partial fulfillment of the

requirements for the degree of

Master of Nursing

School of Nursing

Memorial University of Newfoundland

October 2006

St. John's Newfoundland and Labrador

Library and Archives Canada

Published Heritage Branch

395 Wellington Street
Ottawa ON K1A 0N4
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Direction du Patrimoine de l'édition

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence
ISBN: 978-0-494-30458-7
Our file Notre référence
ISBN: 978-0-494-30458-7

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Abstract

Treatment programs for persons with severe depression have eased the suffering that this condition causes and have allowed many women to have an increased quality of life. However, little research has been published on how women experience their treatment. The purpose of this study is to describe women's experience of treatment in programs for depression (inpatient treatment, mental health day treatment, and mental health outpatient treatment) and to gain a greater understanding of this experience. Six women who participated in these programs were recruited for the study. Data were generated through one-on-one unstructured interviews.

The methodology for this study was phenomenology as outlined by Colaizzi (1978). Phenomenology seeks to describe a phenomenon as perceived by the individual. Therefore, the women's experience is presented using their own words as much as possible, while maintaining confidentiality of the women.

Data were clustered under six themes; (a) feeling a sense of safety and relief, (b) frustration of learning to navigate the system, (c) making connections with others in a similar situation, (d) finding therapeutic staff members, (e) learning new insights and skills, and (f) gaining some control over your illness. These interrelated themes illustrate what it is like for women to take part in treatment programs for their depression.

Findings from the study will contribute to the knowledge and understanding of how women who have depression experience treatment in selected programs. A number of practice, education, and research implications for nurses and other health professionals come from this research.

Acknowledgements

I wish to acknowledge the following people who have contributed to this study. To my thesis supervisors, Dr. Shirley Solberg and Dr. Alice Gaudine – your expert guidance throughout the planning, implementing, and writing of this thesis is truly appreciated. To the six participants of this study – I sincerely thank you for your generosity in sharing your experience of treatment with me. To Ms. Marie Kavanaugh, coordinator of the mental health day treatment program in Halifax, – thank-you for your assistance in the recruitment of the participants for this study. To my family and friends who have supported me throughout this process – many thanks.

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CHAPTER I

Introduction

Depression is the most commonly diagnosed mental illness in women (Steen, 1991; WHO, 2001). The World Health Organization reported that 3.2% of women are suffering from unipolar depression at any point in time and that 9.5% of women will experience some type of a depressive episode in any one-year time frame. The incidence of lifetime depression in women is approximately 25% (Peden, 1994; Starkes, Poulin, & Kisely, 2005). In Canada it is estimated that approximately 8% of adults at some point in their lives will have a major depression (Health Canada, 2002). Women in Canada, as in other countries, have approximately twice the risk of developing depression as men (Health Canada; WHO). Episodes of depression last longer in women than in men and spontaneously remit at a lower rate (Endicott, Weissman, & Yonkers, 1996; Hagerty, 1995; Jambunathan, 1996). Women also have higher hospitalization rates for depression than men (Health Canada).

Depression creates a significant burden for the person affected and his or her family, the workplace, and the health care system (Health Canada, 2002). Using the *Global Burden of Disease* as measured by disability-adjusted life year (DALY), unipolar depressive disorders were estimated to rank second highest for women aged between 15-44 years in 2000 in terms of burden for a disease (WHO, 2001). DALYS are used to estimate years of life lost to premature mortality and disability from selected conditions in a population.

Given the prevalence and burden of depression, research into effective treatment for this condition has assumed some importance (Pettit & Joiner, 2006). Much of the research on treatment for depression reported in the literature has focused on the effects and/or outcomes of pharmacological treatment with few, if any, studies focusing on what it is like for women to participate in treatment programs for depression. As Olfson and colleagues (2002) observed, "In comparison to the extensive literature on the efficacy of psychotherapy and pharmacologic treatments, remarkably little is known about access to treatment for depression and the treatment experiences of those who gain access" (p. 203). Some research has been done on women's experience with electroconvulsive therapy (ECT) for depression (Koopowitz, Chur-Hansen, Reed, & Blashki, 2003; Orr & O'Connor, 2005) and interpersonal psychotherapy (Crowe & Luty, 2005), but there are few studies that looked at the experience of treatment for depression. The focus of this study therefore is to explore the experience of participation in treatment for depression within commonly offered programs. This study explored the experiences of women who had participated in the following treatment programs: inpatient programs, mental health day treatment programs, and mental health outpatient programs. This qualitative study used a phenomenological approach to guide the exploration of women's experiences of treatment for depression.

Background

There are a number of treatment options available for women diagnosed with depression (Health Canada, 2002). These include but are not limited to the use of pharmacological agents (such as anti-depressants), psychotherapy, and education.

Psychosocial rehabilitation is another approach offered to those who are unable to manage living with their disability in the community and partaking in this process allows them to learn to cope with their condition (WHO, 2001). Many times these treatments are used in combination. However, because the experience of depression is unique to each individual, treatments need to be tailored to the individual. In addition other factors, such as level of acuity, can influence the treatment needs.

The acuity of depression can range from mild to severe; therefore treatment must meet the needs of women at a particular moment in time. For example, if a woman is severely depressed and perhaps suicidal, treatment goals should focus on providing physical safety and measures to help lift the severity of the depression. During this stage of depression, women may benefit from hospitalization where the focus of treatment would include different types of treatment for severe depression. Typically the treatment during this time involves medications, possibly ECT, and the introduction of some psychotherapy and psychoeducation (Hughes & McCormack, 2000).

Following an inpatient treatment program, some women participate in treatment in other programs designed to address the underlying psychological and social aspects of depression. Mental health day treatment programs are both a follow-up and an alternative to inpatient psychiatric treatment (Ogrodniczuk & Piper, 2001). Day treatment programs may vary quite widely with respect to the services offered through them (Briscoe, McCabe, Priebe, & Kallert, 2004). Often such programs offer people diagnosed with depression and other mental health conditions, such as bipolar illness, personality disorders, and psychosis the support and therapy they need in areas such as

life skills and psychotherapy (Howes, Haworth, Reynolds, & Kavanaugh, 1997). The broad focus of day treatment programs has been effective in improving functioning and in decreasing symptoms of depression (Howes et al.; Prior, 1998).

Like day treatment programs, mental health outpatient programs are quite variable in structure and focus of treatment (Thornicroft & Tansella, 2004). At times they involve individual psychotherapy with clinicians from various backgrounds who use a variety of therapeutic approaches. Treatment may also continue to include medications. There is usually a range of group programs offered through these outpatient programs. These generally include some type of psycoeducational and/or group psychotherapy programs. There has been a trend towards providing more treatment to patients with depression in the past few decades through outpatient settings (Olfson et al., 2002).

Treatment through day treatment programs and outpatient programs is suitable for women who need longer term, structured treatment that focuses on psychotherapy and psychoeducation (Ogrodniczuk & Piper, 2001). Women may be particularly emotionally vulnerable during this stage of treatment as often it follows a hospitalization for an acute episode or the threat of suicide. Having the treatment offered within a structured environment can be helpful. Effective treatment requires, in part, that women are motivated to participate in therapy, have identified therapeutic goals, feel the timing and nature of treatment is appropriate for their needs at that time, have a good therapeutic alliance formed with staff members, and have supportive relationships formed with co-patients in group settings (WHO, 2001).

This current study was designed to discover how women experience treatment within programs designed to treat depression at various stages of their illness. Regardless of the acuity of the illness or the nature of the treatment program, it is important that women feel they are in control and fully-informed of their treatment process during any stage and setting of treatment (Moyle, 2003). Given the importance of women feeling they have control over their treatment, I wondered whether or not women felt supported and empowered during their treatment and did these feelings vary throughout and across treatment settings? Reflecting on this question led to the development of this study.

In seeking to learn about the experience of treatment, one must consider the experiencing of accessing treatment (Starkes et al., 2005). There has been a reduction in inpatient treatment services, thus making it challenging for a woman with severe depression to access treatment within an inpatient setting. Similarly, accessing treatment through day treatment programs and outpatient programs can be challenging as there are lengthy wait times for these programs (Howes et al., 1997). There is also limited availability of treatment options for women living in rural areas (Starkes et al.). Those in need of treatment for depression often have questions around how to access treatment, including how referrals are to be made and how long people have to wait for treatment. Currently, wait times for these treatment programs may vary from six months to one year. Waiting for treatment for such long periods of time can be extremely difficult for a woman with depression. Overcoming these challenges is a significant aspect of the overall experience of treatment.

Finally, women may have different hopes and expectations for their treatment, regardless of the setting (Peden, 1996). These expectations may include the length of treatment, the nature of the therapeutic relationships with staff, and the availability of future treatment. For example, following treatment in day treatment settings or outpatient settings, women may benefit from various other services including vocational services. These alternative services may or may not be recommended or available to a woman. The variability of treatment experiences highlights the importance of learning and investigating how women have experienced treatment for depression.

Rationale

The most common form of treatment for depression is pharmacological agents (Starkes et al., 2005). Despite appropriate pharmacological treatment, many people continue to suffer from depression. When medications do not resolve women's symptoms of depression, women may be treated within a variety of treatment programs that offer a combination of treatment. Treatment programs include inpatient treatment, mental health day treatment, and mental health outpatient treatment. The experience of women attending these programs has been virtually unexplored. I was interested in learning how women experienced different treatment modalities within these programs. Specifically I wanted to learn about aspects of their treatment that they deemed significant, either as positive or negative experiences.

My current role in a day treatment program involves psychotherapy and psychoeducation with women who have depression. My former role on an inpatient unit focused on administering, assessing response to, and providing education around

medications. It also included some supportive interventions to address the issues leading to women's depression and culminated in discharge planning. In both settings, I have consulted with and referred to other treatment programs. Some of the women I worked with on an inpatient unit later entered day treatment and outpatient programs. Therefore I began to consider how might the women I work with experience their treatment?

I felt that it was important to explore the experience of treatment within programs for depression in order to increase the understanding of this experience. My interest is in the group of women who have depression that does not respond to treatment in a primary care setting, where most of the treatment for depression usually occurs (Olfson et al., 2002). This study will explore how women diagnosed with depression experience treatment in institutional settings. The results of the study may provide insight into how nurses and other therapists may assist women during their treatment for depression.

Purpose and Research Question

After identifying my phenomena of interest, women's experience of treatment for depression, I selected a phenomenological approach to guide my study. This approach most closely matched with my intent to learn from women who were clinically depressed how they experienced their treatment for this condition within the various programs. This led to developing the research question that I aimed to answer as a result of my research - what is the experience of women who have received treatment for depression? By addressing this research question, I hope to meet the dual purposes of my study, that of describing women's experience of treatment for depression and of gaining greater understanding of this phenomenon.

CHAPTER II

Literature Review

The history of the development of modern psychiatry illustrates how important this development has been in the improvement of the quality of life for those who suffer from a mental illness (Shorter, 1997). Developments in treatment options have been a critical factor in improvements in psychiatric care, including major depression (Thornicroft & Tansella, 2004). In an effort to learn more about what research has been conducted on the experience of treatment for depression, a review of the research literature was conducted on the topic. The following databases for all available years were searched: Cumulative Index of Nursing and Allied Health (CINAHL), Pubmed, Medline, and PsycINFO. Key terms used in the search included women and depression, experiences with depression and treatment, and treatment for depression. Research articles were limited to those that were printed in English. When pertinent research articles were identified, I checked the database for related articles and expanded my search. I also checked the references in published articles to help expand my search.

There is a great deal of research on clinical trials of drugs used for depression. However, research that dealt solely with pharmacological treatment for depression was omitted unless it dealt with women's experience with that particular treatment modality, as pharmacological treatment per se was not the focus of the current study. The following review of the literature on experience with treatment for depression is organized around inpatient treatment, mental health day treatment, and mental health outpatient treatment.

A small section in the chapter is on specific treatment modalities that may occur in either of these settings.

The Experience of Treatment for Depression

A number of research studies were located that addressed experiences in treatment programs or with particular treatment modalities. While I tried to limit the search to treatment for depression, this was too limiting. Most of the studies included depression among a variety of psychiatric conditions or did not identify the particular patient population, and these studies were included.

Inpatient Treatment

Inpatient psychiatric treatment for depression aims to reduce any potential for self-harm that may be associated with major depression, to stabilize patients' mood, and to help patients restore previous level of functioning (Health Canada, 2002). Treatment modalities for major depression on inpatient units include medications and/ or electroconvulsive therapy (ECT). Psychotherapy and psychoeducation may be introduced but they are not the focus of treatment during an acute stage of depression. A major reason for admission is if people pose a risk of harm to themselves. There is also increased surveillance of the patient if suicide is a threat. Patients may also be admitted if the nature of their illness is unclear and they require a psychiatric assessment and diagnosis. The function and nature of inpatient psychiatric treatment has not been explicitly stated but can be inferred from the reasons why patients are admitted to hospital (Bowers, 2005).

Recent changes in psychiatric treatment, such as a reduction in the number of inpatient beds available, have resulted in fewer patients with depression being admitted to hospital and patients who are admitted to hospital for treatment of depression are acutely ill. The decrease in rates of hospitalization for women and men with major depression was 33% between 1987 and 1999 (Health Canada, 2002). Most of the research located for the literature review focused on inpatient treatment. By far most of the studies found focused on patient satisfaction with inpatient psychiatric treatment and these will be discussed. This section of the literature review also includes specific experiences of treatment on an inpatient unit.

Patient satisfaction with treatment on an inpatient unit.

Patient satisfaction studies on treatment in an inpatient unit dealt with patient and/ or staff satisfaction of some aspects of treatment and/or of the environment. These studies generally did not explore people's experience with treatment. However, the results from satisfaction studies hold important implications for this current study as the quality of healthcare is indicated by patients' satisfaction (Woodring et al., 2004). Measures of quality of health care tell us something of what patients find helpful or not in their treatment environments.

The quality of nursing care may influence patient care and patient satisfaction and it is therefore important to study how patients view this care. Beech and Norman (1995) took such an approach and interviewed twenty-one patients with mixed psychiatric diagnoses in two inpatient wards in the United Kingdom in order to determine what indicated high and low quality of nursing care. Patients rated active listening by nurses

as an indicator of high quality care. Poorer nursing care was identified when nurses failed to explain their actions, were perceived to have a lack of knowledge relevant to patient treatment, and did not consider the negative effects on patients when there are staffing shortages.

More commonly, the studies on satisfaction dealt with broader aspects of patient care. Lovell (1995) examined how satisfied users of in-patient mental health services were with various aspects of their hospitalization in England. The aspects she focused on were admission, treatment, ward environment, and safety. Generally, the participants of this study expressed high levels of overall satisfaction, however specific areas where satisfaction with care were lower, centered on information related to treatment. Further, both men and women expressed concerns about safety. This study used a combination of qualitative and quantitative methodologies. Of the sixty-six people who were asked to complete questionnaires, twenty-five returned the surveys, and only seven individuals completed the interviews, thus there was a low response rate.

Along the same lines of looking more broadly at satisfaction, Ricketts (1996) conducted a quantitative study to determine general satisfaction and satisfaction with nursing communication. The research was conducted on an adult psychiatric ward in England. Although satisfaction with nursing communication correlated highly with general satisfaction, satisfaction scores in both domains were generally low. In particular some comments by patients illustrated the reasons for their dissatisfaction. These included a perception of staff not having time for patients on the ward, poor attitude towards patients, or staff not being well prepared.

Greenwood, Key, Burns, Bristow, and Sedgwick (1999) also studied how satisfied mental health inpatients were with their hospital experiences in England. They interviewed four-hundred-and-thirty-three patients in psychiatric units in mental and general hospitals in an attempt to understand how personal characteristics of the patients and experiences on the unit were related to satisfaction. A high percentage of patients were satisfied with care despite a number of them reporting some untoward happening on their unit. Some of the untoward happenings included incidents of patient aggression towards other patients. Gender and age differences were found with women and younger patients having lower satisfaction levels. Where the unit was located (psychiatric or general hospital) did not make a difference.

Like some of the other research cited above, Berghofer et al. (2001) studied patient satisfaction. They compared those experiencing a first admission to psychiatric care with longer-term patients in the inpatient area (i.e., at least two admissions) and outpatient (i.e., treatment for more than three months) in psychiatric settings located in Austria. However, a main difference from some of the research reported above was that along with the usual measures relating to staff and the unit environment, they also included patient satisfaction with other patients. Longer-term patients generally viewed other patients in a more positive manner than those admitted for the first time. The authors suggested first time patients may be more fearful of other patients and this might negatively affect their treatment. This was the only study located that explicitly examined how patients may affect each other. Gender representation was fairly equal but

diagnoses varied a great deal with only thirteen percent having a diagnosis of mood disorder.

Other studies on satisfaction focused on the ward environment. Middelboe, Schjodt, Byrsting, and Gjerris (2001) attempted to measure the relationship between satisfaction with psychiatric care and the patients' perception of the inpatient psychiatric unit in a Danish hospital. They found a positive correlation between the two measures in that the higher the patients' ratings on the ward atmosphere scale (WAS), the greater was the patient's satisfaction. The WAS is a one hundred item questionnaire consisting of true-false statements. There are ten subscales of the WAS that attempt to measure patient's satisfaction with specific aspects of the ward environment, including relationships on the ward, personal progress while on the ward, and the structure of the ward. The researchers found that ratings on the WAS were independent of patient characteristics. They did note though that patients perceived more anger and aggression if they were on a locked unit compared to being on an unlocked unit. Patients who perceived that they were subjected to coercive measures perceived less autonomy. Patients completed two versions of the WAS. The real version was how they rated the atmosphere they actually experienced. The ideal version was how they would rate the atmosphere they would like to have experienced. There was a gap between ratings on the ideal and the real WAS which accounted for forty-five percent of the variance in satisfaction. The scores on the ideal version of the WAS were higher than the scores on the real version of the WAS. The sample included two locked and two unlocked

psychiatric units. All four units were reported to be at over one hundred percent patient capacity, a factor that may have influenced satisfaction ratings.

Rossberg and Friis (2004) also used the WAS when they studied patients' and staff 's perceptions of how the psychiatric ward environment and the working conditions of staff influence patient and staff satisfaction. This study included six-hundred-and-forty staff and four-hundred-and- twenty-four patients from forty-two wards in Norway. The results indicated that staff had significantly higher scores than did the patients on nine of the eleven subscales of the WAS. There was a moderate correlation between patients' and staff's scores on the WAS. Patient satisfaction was strongly correlated with patients' WAS scores, moderately correlated with staff's WAS scores, but was not significantly correlated with staff's scores on the working environment scale-10 (WES-10). The WES-10 is a ten-item questionnaire that measures staff's self-rating of their workload and working conditions. The data were collected over a five-day period. Therefore, patient acuity may have varied during the data collection process and this may have influenced the results.

In addition to examining patient satisfaction, Langle et al. (2003) included the importance to the patient of selected aspects of psychiatric in-patient care in Germany. Areas that were both important and with which patients were satisfied included therapeutic relationships with physicians, psychologists, nursing staff, social workers, and cooperation of hospital staff with each other. Other findings of high importance but not related to satisfaction included medical and psychiatric examinations and individual psychotherapy. Relationships with physiotherapists and occupational therapists were

given high satisfaction ratings but these ratings were not related as important to the patient. A strength of this study was that the researchers controlled for age and time of treatment.

Remnik, Melamed, Swartz, Elizir, and Barak (2004) limited their research to the satisfaction of psychiatric patients with personnel, nursing staff, treatment, and ward conditions. Levels of satisfaction were similar for all four categories with treatment slightly higher (3.5 out of 5) than the other categories. All were around the mid-range score. Satisfaction was not related to socio-demographic characteristics or the hospital environment. A weakness of this study is that it involved a mixed sample in that the authors mentioned that some of the patients who were being prepared for discharge were attending as "day care patients"; however we do not know who fell in that latter category. The researchers included patients with different psychiatric diagnoses. The survey was conducted with current patients and the authors admitted that this could have influenced the patients' responses. The study took place in Israel. The type of treatment received may differ from one country to another. People in certain countries may not feel as free to express their opinions about the satisfaction of their treatment. Therefore, the satisfaction of treatment may also vary if the same survey was conducted in another country.

Eytan, Bovet, Gex-Fabry, Alberque, and Ferrero (2004) limited their study on patient satisfaction with care to a single unit in a hospital in Switzerland, but included patients who had both physical and mental health problems. As with the studies reported on above, they found high levels of satisfaction with care. Those individuals who had

experienced previous hospitalizations had higher satisfaction ratings suggesting that previous experiences may influence ratings. Of the sixty patients included in the study, sixty-three percent were women and fifty-two percent had been diagnosed with a depressive illness. These authors attributed the high satisfaction levels they found to the fact that it was a mixed treatment unit, however it is difficult to discern if the satisfaction scores were related to treatment for psychiatric versus physical health problems.

Woodring et al. (2004) developed and tested a patient satisfaction measure for inpatient psychiatric care. Satisfaction was measured with respect to patient perceptions of staff attributes, the therapeutic environment, and treatment gains during hospitalization. This study was conducted in the United States and included six-hundred-and-seventy-three patients. The results indicated that the most helpful aspects of inpatient care included staff perceived as friendly and attentive to patients' needs and participating in activities on the unit with other patients. The least helpful aspects of inpatient care included the process of admission that was seen as inefficient and an inadequate orientation to the unit. The research included men and women, however the psychiatric diagnosis(es) was/were not reported. There were a wide range of ages among the participants and twenty-three percent of the respondents were between ages thirteen and eighteen. Data were collected on the day of discharge and this may have influenced the results as patients may have been distracted by thoughts of discharge. This study developed and utilized an original questionnaire. Therefore, reliability and validity of the study measurements have not been determined.

Experience of inpatient psychiatric treatment.

The environment in which treatment occurs is a significant aspect of the treatment experience. A therapeutic milieu, or environment, can enhance or inhibit recovery from mental illnesses. Thomas, Shattell and Martin (2002) conducted a phenomenological study of eight inpatients regarding their experience of the inpatient environment in the United States. The participants felt that the hospital setting provided them with a break from daily challenges and stresses. This break also helped to reduce impulses towards self-harm behavior. The findings also indicated that the most beneficial aspect of hospitalization was peer interactions. Participants reported that they wanted to have a stronger alliance with staff and they wanted treatment that was more intensive and which led to greater insights. The participants reported that they had not gained greater understanding into their dysfunctional patterns of behavior. It was important to these participants that their needs for safety, structure, and medication administration were met.

In order to learn about women's experiences of treatment, Cutting and Henderson (2002) conducted a grounded theory study on women's experiences of a psychiatric hospital admission in the United Kingdom. The findings indicated that women's rights and needs were disregarded in treatment, and they did not feel respected as individuals. While they were on the inpatient unit, these women described high levels of male violence against them and violations of their privacy and dignity. They expressed dissatisfaction with their perception of over-reliance on biological treatments. They likewise expressed dissatisfaction that they did not feel heard in what they needed as patients. Neither patient diagnoses nor number of participants were included.

A qualitative study, conducted in Sweden, was done in order to determine what patients defined as good psychiatric treatment (Johansson & Eklund, 2004). They included sixteen men and women, representing various psychiatric diagnoses and different treatment experiences (inpatient and outpatient). The experience on the inpatient unit was generally positive. Those who experienced inpatient treatment to be positive cited being understood by staff as the most helpful aspect of treatment. Inpatients also viewed this unit as providing stability and structure. Specifically they felt that the building, the rooms and the relationships with staff provided stability. The structured environment also provided relief from the pressures of illness and daily demands. The researchers wanted to have as heterogeneous a sample as possible. As a result, the experience of women with depression was not specifically identified.

Koivisto, Janhonen and Vaisanen (2004) studied the experience of inpatient psychiatric treatment in Finland. These researchers conducted a phenomenological study involving nine voluntary patients recovering from psychosis in Finland. The purpose of the study was to learn how patients experienced being treated as an inpatient. Participants in this study reported that inpatient treatment protected them from vulnerability. This meant that they felt safe, understood, respected, and trusted. They became conscious of what was happening to them and the changes they were experiencing as a result of their illness. They felt that throughout their treatment their sense of integrity was maintained. As participants recovered, they restructured their sense of self and began to cope with daily life. A number of aspects of treatment promoted their recovery. They liked the homelike and peaceful aspects of the

environment on the unit. They appreciated being informed of their treatment, medications, and unit activities. They were satisfied with their relationships with nurses when they knew what the role of the nurse was. The patients felt they had frequent contact with nurses and they knew the focus of the conversations with nurses. Aspects that were identified as hindering their treatment included an unsafe environment, information regarding treatment and medications that was not adequate, unsatisfactory relationships with nurses, and the perception that they were not well monitored. Some participants described aspects of treatment as positive while other participants described the same aspects of treatment as negative. This confirms the subjective nature of the experience of treatment.

Schroder, Ahlstrom, and Larsson (2006) also studied the experience of both inpatients and outpatients in Sweden. The focus of their study was on how patients perceived quality care. The phenomenographic study included twenty patients' perceptions of the concept of the quality of care in the psychiatric setting in Sweden. Overall, the participants described the quality of care they received as good. The participants experienced their treatment as respectful and as promoting security. They saw themselves as active participants in their treatment and that they felt they moved towards recovery. Patients described their treatment as calming and as providing the space they needed to recover. This study included persons who had participated in inpatient treatment and outpatient treatment, yet the findings were not specific to either treatment experience.

One specific aspect of inpatient treatment experience is the experience of interdisciplinary rounds. Rounds are an opportunity for staff to review patients' care, evaluate treatment, and plan for discharge. In an effort to discover how patients on an acute care unit experience ward rounds, Wagstaff and Solts (2003) interviewed eight patients from the same psychiatric unit regarding their experience of ward rounds in a hospital in the United Kingdom. Participants experienced both negative feelings (intimidation, fear) and positive feelings (relaxed, challenged, interested) regarding ward rounds. The participants reported that they felt excluded from the process of decision-making inherent in ward rounds, dissatisfied with the number of people present during rounds, and had a lack of understanding of the role of each of the staff members involved in ward rounds. The experience of ward rounds perpetuated the feeling of powerlessness experienced during depression.

In response to the current changes in psychiatric care, Quirk and Lelliott (2001) reviewed the literature up until the 1990's on psychiatric inpatient treatment in the United Kingdom. They focused their review on research related to the experience of patients in acute care settings. They believed that the pressures for changes in treatment have negatively affected the quality of care. The research literature showed that the nurse-patient relationship is an important aspect of care but contact between nurses and patients has declined. Patients are critical of inpatient treatment and they have expressed boredom and a lack of safety in this environment. The current atmosphere of change in services in psychiatry is an appropriate time for research to explore the meaning of inpatient treatment, to determine what happens on inpatient units, and to determine what

hinders or facilitates patients' access to quality care. These researchers suggested further qualitative research in the area of inpatient psychiatric treatment.

Mental Health Day Treatment

Mental health day treatment programs offer various daily treatment services for people experiencing mental health problems (Dufton & Siddique, 1994). Mental health day treatment programs are sometimes considered as an alternative to inpatient treatment where patients are offered the care they need while they live at home (Piper, Rosie, Azim, & Joyce, 1993). The general and common objective of such programs is to help patients reduce psychiatric symptoms, develop coping skills, improve communication skills necessary to build healthy relationships, and improve overall functioning (Howes et al., 1997). These programs vary in length from six weeks to eighteen weeks (Piper et al.). A multidisciplinary approach tends to be used to provide patient care, consisting of psychiatry, nursing, social work, occupational therapy, psychology, recreation therapy, and spiritual care (Howes et al.; Piper et al.). Generally, each patient is assigned a clinician as his/ her case coordinator.

Treatment in day treatment programs are likely to include intensive, group psychotherapy and psychoeducation to men and women with different psychiatric diagnoses, including depression and personality disorders. While the format of these programs may vary, patients also usually meet individually with case coordinators throughout their program for individual psychotherapy. A priority of day treatment programs is to ensure an atmosphere of mutual respect, trust, and confidentiality where

all patients feel safe to explore and express their thoughts and feelings as a means of recovery (Howes et al., 1997).

The emphasis on research into day treatment programs for depression seems to focus on a comparison of treatment effectiveness between acute inpatient care versus day treatment for psychiatric disorders (Marshall et al., 2001; Thornicroft & Tansella, 2004). There were no studies located that examined women's experiences of treatment for depression within day treatment programs. There were a few studies found that described the structure and outcomes of such programs and these will be discussed in this section.

Previous research indicated that mental health day treatment programs offer several benefits (Howes et al., 1997). Some of these benefits are provider focused. As they are a form of partial hospitalization, they are much less costly than inpatient psychiatric services. A growing trend in healthcare is to reduce the length of inpatient stays. Therefore, patients are being discharged while still in need of services. Such programs offer group psychotherapy to patients with various mental illnesses, including depression. In the particular program Howes et al. described, there were approximately seventeen group members during any given six-week period, the majority of these being women. Approximately fifty women with depression attended this program on an annual basis.

Similar to many of the studies measuring satisfaction with inpatient care, Russell and Busby (1991) found high levels of satisfaction with patients attending a day treatment program in Canada. These researchers were interested in examining how well patients in the program rated specific treatments. While most of the study's findings did

not suggest much difference among treatment modalities, one of the treatments, group psychotherapy, resulted in the most variation on the rating scale. The authors suggested this finding implied the need for a better matching of patients with treatment, as some patients were very satisfied with group psychotherapy and others were not.

Several studies have evaluated outcomes of various mental health day treatment programs. A number of these studies used randomized clinical trials to evaluate these outcomes. In a Canadian study Piper et al. (1993) compared a number of outcome variables for patients diagnosed primarily with affective and personality disorders who attended an eighteen week dynamic, group focused day treatment program with those who did not. An important finding concluded was that the patients who attended the day treatment program functioned better in family and other social situations, scored higher on life satisfaction and self-esteem, and had higher mood levels than control patients. Improvement was noted up to eight months when the last follow-up was done.

Russell et al. (1996) in another Canadian study compared outcomes for one-hundred-and-sixty patients admitted to an acute day hospital (ADH) with one hundred inpatients. In this study patients acted as their own controls. These researchers also noted significant improvements in the ADH patients on social functioning scores. In addition the ADH patients had less psychological distress, anxiety, and depression than on admission. The ADH patients felt that quality of the services they were offered were very good and they had received the help needed.

Other studies were more evaluative in that they examined outcomes for patients who attended day treatment programs to determine the effectiveness of these programs.

Howes et al. (1997) evaluated outcomes related to a six-week day treatment program in Eastern Canada. Their study included patients with a variety of disorders, but mainly those diagnosed with major depression and adjustment disorders. From the admission to the discharge period, all patients had a significant improvement related to symptoms and patient functioning in social situations was improved for all but those with a bipolar disorder.

A more recent study by Mazza, Barbarino, Capilani, Sarchiaponei, and DeRiso (2004) also evaluated how effective a day treatment program was in an Italian hospital. They too had an intensive treatment program and the participants were more homogeneous in that they all had mood disorders. There were one-hundred-and-two women and eighty-five men who took part in the study. At discharge their study participants had a significant decrease in symptoms and an increase in their ability to adapt socially and in their general functioning.

Mental Health Outpatient Treatment

Outpatient treatment for depression has increased markedly because of pharmacological development and a move to more community-based treatment (Health Canada, 2002; Olfson et al., 2002). Treatment for depression in outpatient settings may involve individual or group treatment that utilizes different theoretical approaches to treatment. Psychotherapy, psychoediucation, medications and/ or ECT are some of the treatment modalities used in outpatient settings. The frequency and duration of outpatient treatment varies considerably on patients' needs and on availability of services.

Patient satisfaction with outpatient treatment.

The research literature on outpatient treatment, as with inpatient treatment, contains many studies of patient satisfaction with treatment. Siponen and Valimaki (2003) included one-hundred-and-seventy-one men and women in their quantitative study conducted in Finland. The aim of their study was to describe what patients identified as satisfactory with respect to their outpatient treatment. Patients rated highly their interactions and communications with staff. They rated lowest the information they received as part of their treatment. Patients reported that wait time affected their satisfaction with treatment. In comparison with patients who thought that they waited a reasonable time period for treatment, those who believed that they waited too long for treatment were generally more dissatisfied with staff, their belief in their ability to influence their own care, and with the help they received. Results are not specific to patients with any one psychiatric diagnosis. The researchers did make one solid recommendation based on their findings and that is to increase the emphasis placed on developing innovative teaching methods for patients.

In the study by Johansson and Eklund (2003) previously mentioned within the section above on inpatient experience, patients reported the quality of the helping relationship as the most significant determinant of quality of psychiatric outpatient care. In contrast, a negative experience of receiving psychiatric care occurred when patients felt that their therapists did not understand by them.

Rather than patient satisfaction, the construct many researchers used to evaluate psychiatric care, Sheeran (2003) studied what constitutes quality care in this setting. This

study included one-hundred-and-ten psychiatric patients (two-thirds women and one-third men) with different diagnoses from outpatient services in an American state. The patients indicated that quality of care is dependent upon the particular practitioner one has in this setting. One area most patients felt lacking was the amount of information they were given regarding clinicians. The age range of participants was large – eighteen to seventy-five. A narrower age range may have yielded different results.

Another important aspect of patient care in psychiatric outpatient treatment is continuity of care. Hautala-Jylha, Nikkonen, and Jylha (2005) studied patients' and staff's perspectives of continuity of care in light of the growing focus of psychiatric treatment in outpatient settings. This phenomenological study was conducted in Finland and included five outpatients, eighteen personnel from inpatients and outpatients, and five administrative personnel in psychiatric units. Outpatient treatment occurred within the inpatient unit where patients had previously been hospitalized. The findings included seven categories of the factors improving the continuity of care. These were a collaborative therapeutic relationship, maintaining quality of the care environment, treatment that is flexible and individualized, continuity of contact in the treatment environment, constant access to the inpatient treatment unit, information that is delivered in a timely manner, and collaboration among service providers.

In a study that focused on a more homogenous population, Horvitz-Lennon, Normand, Frank, and Goldman (2003) reviewed outpatient care of people suffering from major depression in the United States. They noted that the two most common treatments for depression, on an outpatient basis, included psychotherapy and antidepressant

medications. They concluded that the most effective treatment for depression is either a short involvement in psychotherapy combined with antidepressant medications, or a prolonged involvement (ten to twenty-four sessions) in psychotherapy without medications. They noted that more research is needed in this field.

Johansson and Eklund (2006) conducted another study in order to determine which patient factors were relevant in forming a therapeutic relationship with a clinician and in predicting dropout from outpatient treatment. This quantitative study included one-hundred-and twenty-two staff and patients and was conducted in Sweden. The factors strongly correlated with establishing a helping alliance were staff being perceived as cold or distant (negative correlation), the extent to which patients were motivated to engage in treatment, and interpersonal sensitivity. The most essential variable was the perceived alliance with staff by patients. Early dropout from outpatient treatment was predicted by low helping alliance, lower age of patients, and staff being perceived as cold or distant. Patients with depression were included in this study that also included other psychiatric diagnoses.

Information plays an important role in treatment of mental illness. Perreault, Katerelos, Tardif, and Pawliuk (2006) studied patients' perspectives of information they received in outpatient psychiatric treatment. This quantitative study, conducted in Canada, included eighty-six men and women with various psychiatric diagnoses attending outpatient clinics. The areas on which patients received information that were rated highly included education on the side effects of medications, assurance of confidentiality, and access to their medical charts. Information on treatment received

high ratings. Patients were dissatisfied with the information they received on service modality and service organization. The data were collected from patients attending two outpatient clinics.

Blenkiron and Hammill (2003) attempted to identify some of the factors that might be related to both satisfaction with mental health care and quality of life among one-hundred-and-twenty patients receiving outpatient care in England. While gender and length of psychiatric illness were unrelated to satisfaction with care, age and satisfaction with financial and social situations were related. Older patients and those satisfied with other areas of their lives had higher satisfaction scores. Quality of life and satisfaction with services thus appear to be related. A limitation of the study is that the research did not identify aspects of care that were important to the patient. A strength of this study is that the satisfaction results of each diagnostic category (i.e. depression) were identified.

Barak et al. (2001) also studied satisfaction with outpatient psychiatric services in Israel. They found that among the two-hundred-and-three patients (fifty-nine percent women) in this setting who were surveyed that general satisfaction was high. One of the treatment modalities that demonstrated a good correlation with satisfaction was whether or not the patient had received psychoeducation. Those taking part in this treatment had higher levels of general satisfaction. Since psychoeducation helps patients with aspects of their lives that cause or contribute to psychiatric illness, the results suggested that helping patients solve some of their problems influences how they view psychiatric care or services.

Jones and Lodge (1991) measured the satisfaction of patients attending an outpatient clinic in a hospital in Scotland. In particular these researchers wanted to have patients' views on how they accessed treatment, and their general satisfaction with treatment. They were interested in how satisfied the patients were with what are described as "consumer" aspects of treatment, rather than the quality of the treatment itself. The satisfaction ratings were generally high and these were positively correlated with good communication and how long the patient had to wait for an initial appointment.

Other Treatment Modalities

A number of research studies were located that looked at women's experiences with particular treatment modalities for depression. These treatment modalities were not linked with a particular health service delivery setting. These included antidepressant medications, ECT, and education for depression.

Antidepressant medications.

Antidepressant medications are the most common treatment modality for depression. Knudsen, Hansen, and Eskildsen (2003) conducted a qualitative (grounded theory) study in Denmark involving interviews with twelve women between ages twenty-one and thirty-four in order to determine perceptions concerning the use of antidepressants and how these medications affected their lives. The women attributed a number of improvements in their lives to the use of the medications such as feeling less isolated and having more energy. They also described that coping with daily demands was a challenge when depressed and before initiating medication. Most of the women

surveyed indicated that taking anti-depressant medication was beneficial in that they gained control over their emotional problems, viewed themselves more positively, and now felt that they had the ability to move on with their lives. They were relieved of their symptoms of depression, could engage in psychotherapy, and more importantly, had a renewed sense of normalcy to their lives. The experiences of older women may be different than those reported from these participants, given that they may have had more experience with depression and treatment of depression, and are at a different stage of their life.

Experience with ECT.

ECT is a common treatment modality for depression, both within the inpatient and outpatient treatment settings. The experience of participating in ECT has not been well documented in the literature. Orr and O'Connor (2005) conducted a qualitative study in Canada to explore the experiences of six older women who were being treated for depression with ECT. The participants in this study indicated that the experience of receiving ECT must be understood within the broader context of the experience of depression. They indicated that the experience of ECT, as well as with depression, involves a shift in power from self to others. As women loose control over depression and the need for ECT arises, women establish therapeutic relationships with health care professionals. This study sampled a limited age range of older women (age seventy-one to eighty-nine). The experience of other age groups may be different as treatment needs and potentially satisfaction with treatment vary among age groups. The researchers

reported on the experience as relayed by the participants and this experience was broader than their original research focus.

Koopowitz et al. (2003) also conducted a qualitative study of eight patients' opinions and experiences with ECT in Australia. The findings from this study included that patients experienced fear of ECT. The women felt that cognitive decline and memory loss had occurred as a result of having had ECT. There were some positive experiences of ECT reported, such as experiencing pleasant emotions, including calmness, following ECT. ECT had a generalized positive impact on their sense of self and this treatment was viewed as both a life-saving and a proactive procedure. Patients also made several suggestions for future ECT procedures, such as a reduction in the wait time prior to the procedure and improvement in staff communication with patients. They also felt that a dedicated space needed to be given to the treatment area to help reduce the stress associated with discomfort before the procedure. A final suggestion from the participants was to conduct further research into patients' experience of ECT. This study was conducted in South Australia with younger women (age twenty-five to fifty). The results may vary in future research studies conducted in other settings or with other populations.

Experience of education for depression.

Education about the causes, symptoms and treatment options for depression is increasingly being recognized as an important aspect of treatment. Education helps give patients insight into this illness and into the symptoms they are experiencing. However, few research studies have addressed how people with depression experience the

education they receive about their illness. The literature search conducted for this study resulted in one study to explore this phenomenon. Chou, Lin, Wang, and Hu (2004) conducted qualitative interviews with participants who had depression regarding their self-learning experiences using interactive multimedia education programs. This study took place in Taiwan. In total, eight participants successfully completed all learning activities within the prescribed two-week timeframe. All participants had a diagnosis of depression without psychotic features and they completed the learning exercises after their first episode of depression. Aspects of successful self-learning were the triggering of learning motivation, enjoyment of self-paced learning, support for the effects of learning materials, and gaining self-awareness and changes. Factors that influenced learning performance were environmental impact (i.e., busy lives), degree of familiarity with traditional learning, possession or non- possession of necessary computer skills, and availability of computer support. The setting of the study was not specified.

The significance of patient education specific to psychiatric nursing has been relatively unstudied. The limited data in this area led Freed (1998) to conduct a phenomenological study of twelve American nurses in order to learn about the significance they placed on patient education. The pattern described in this study was a pattern of perseverance – nurses persevered to promote patient education despite any challenges and resistance against doing so. Perseverance involved nurses' identity as being patient educators. Nurses reported internal conflict experienced when their value of patient education conflicted with those of physicians who were seen as having a role of authority over nurses. As nurses identified themselves as patient educators, they engaged

in self-reflection regarding their values and their role as nurses. The experience of patients was not explored in this study.

Summary

Most of the literature found for this study addressed satisfaction of psychiatric treatment. The majority of these studies addressed satisfaction in one treatment setting, either inpatient or outpatient. There were a few studies that explored the experience of inpatient psychiatric treatment. The literature on mental health day treatment programs did not include the experience of this treatment program and therefore only a couple of studies could be included in order to describe treatment in this program.

A common finding among all the studies, the satisfaction studies, and the experience of treatment studies, was the importance of the therapeutic relationship with the patients and staff members. The results of the satisfaction studies showed that patients rated highly their satisfaction and importance of the therapeutic relationships. In the studies that explored patients' experience of treatment, patients reported that a therapeutic relationship with staff involved being available, listening, respecting, and understanding. Patients indicated that they were dissatisfied when they perceived staff to be not listening or not available. These finding held consistent across treatment settings, study settings, gender, psychiatric diagnoses, and across the health disciplines represented by staff (including nursing).

A second finding that was identified in several of the studies was the issue of patient security or safety. Although these studies did not explore the nature of depression or other psychiatric illnesses, it is worth considering why safety is identified in studies

rating patient satisfaction or experience with treatment. Patients in psychiatric treatment need to feel that they are in a safe environment while they recover. Ensuring safety needs of patients in any treatment setting is an essential role of nurses and other staff working in these settings.

Some of the critiques of the literature on treatment for depression are conceptual and others are methodological. On the conceptual level, most research was related to patient satisfaction. While patient satisfaction is an important construct that contributes to the literature on consumerism in health care, it does not address how patients view their experiences with treatment. Nor does it provide an understanding of what patients believe is important for their treatment.

Methodological weaknesses included studying a variety of mental illnesses or conditions, not reporting on the gender of participants, or how findings related to a particular gender. As a result, we have limited research in the area of women and treatment for depression. The results of these studies have limited applicability to my study as I am focusing on women's experience of treatment for depression. The results of this literature review indicate that more research is needed in the area of women's experience of treatment for depression.

CHAPTER III

Methodology and Methods

The methodology and methods of the study are outlined in this chapter, which is divided into two main sections. The first section contains a description of the methodology for the research. The second section contains a description of the methods used throughout this study. The methods section contains the inclusion criteria for participants, recruitment of participants, setting and context, data collection, data analysis, credibility of findings, and ethical considerations.

Methodology

Phenomenology was the methodology used to guide this study. In particular I used the phenomenological methodology as described by Colaizzi (1978). In this section, I will provide a brief overview of Colaizzi's description of phenomenology as a research methodology. Phenomenology as described by Colaizzi (1973) has its roots in humanistic psychology, which developed as psychologists began to consider how human behavior was influenced by experience. These psychologists held that the means of accessing information on the relationship between behavior and experience was to discover how people perceived their lived experiences.

Although the methodology has intellectual roots in psychology, Colaizzi's approach to phenomenology has had widespread use in nursing research to study such phenomenon as nurses' experiences with practice or education (Hass, Cover, & Theobald, 2005; Waite, 2006) and patients' and families' experiences with disease and treatment (Rinaldi Carpenter & Narsavage, 2004; Namasivayam, Orb, & O'Connor, 2005).

Description of human experience is important to nursing as we attempt to understand what nurses as caregivers experience as a result of their work and what patients and families experience in their interactions with nurses and other health care workers or as a result of health and illness.

According to Colaizzi (1978), phenomenology relies on the descriptive method of investigation, a method of investigation identified with Husserl (Ray, 1994). Within this type of methodology, the purpose is to obtain a description of a selected phenomenon as it is experienced or lived by the participants in the study. Colaizzi (1973) viewed experience as, "the source of all human significance without which there would be no meaning. Since experience is intentional, since it is not a set of facts caused by other things, since it is cannot be explained, it must be investigated descriptively" (p.5).

This lived experience is influenced by many factors and those who live an experience interpret it in a uniquely subjective manner, therefore it is the function of the phenomenologist as researcher to assist the participants to bring these factors to the participant's consciousness so he or she may share them. Thus, phenomenology according to Colaizzi (1978) allows the researcher to identify selected phenomena and to understand and describe the phenomena as experienced by those living the experience. Perceptions of experiences obtained from those who have had the experience are transformed into essential meanings or essences. Phenomenology of essences involves searching for common themes within the data. The patterns of relationship that phenomenologists identify from the data are known as essences (Speziale & Carpenter, 2003). Essences of experiences are what of are of interest in the final analysis.

To further phenomenology as a methodology, it was necessary to develop rigorous techniques to guide the collection and analysis of lived experiences. These techniques have been identified as procedural steps (Speziale & Carpenter, 2003). These steps as outlined by Colaizzi (1978) consist of:

1. Describe selected phenomenon - what is it that is of interest?
2. Obtain a description of this phenomenon from participants who have experienced the phenomenon.
3. Become familiar with participants' descriptions of the phenomenon - reading transcripts or listening to recordings (depends on data source).
4. Identify significant statements that are related to the phenomenon of interest.
5. Identify the meaning of each significant statement selected from the data.
6. Organize the identified meanings into themes.
7. Write a full description of each of the themes.
8. Obtain validation of the description of the themes from participants; and
9. Include any new data obtained from participants into the full descriptions.

In summary, the result of exploring a person's lived experience through phenomenology is a wealth of rich and detailed data. More importantly to my study, phenomenology is an appropriate method for investigating phenomena or experiences that previously have been unexplored. The experience of treatment for depression has been relatively unexplored. The goal of this study was to learn, in depth, how women with depression experienced their treatment. Therefore, phenomenology was the method used to identify and explore women's unique experience of treatment for depression.

Colaizzi's (1978) suggested method of analysis was used to identify the "themes" that were contained within the actual words each participant used in telling about her experience of treatment. The identified themes capture the essence of the experience (Colaizzi). The data will help increase an understanding of the participants' experiences of treatment within programs designed to alleviate depression, and will add to the current knowledge of the phenomenon under investigation.

Methods

Using the procedural steps of Colaizzi (1973) for a phenomenological research study, the following section of this chapter describes how I carried out my research.

Inclusion Criteria for Participants

I chose to study women's lived experience of treatment for depression, my phenomena of interest. To do this study, I required women who met selected inclusion criteria. The inclusion criteria meant that a woman was eligible to participate in the study if she had participated in each of the following treatment programs for depression : hospitalization on a mental health unit, participation in a mental health day treatment program, and follow-up treatment through a mental health outpatient program. I was interested in the experience of treatment that patients receive within all treatment programs. I believe that the experience of treatment, which spans separate programs occurring during various stages of depression, is meaningful to the women involved. I also believe that it is important for nurses to learn about the experience of treatment in order to understand how women with depression perceive their treatment.

I wanted to recruit women who had attended the mental health day treatment program for any six-week period between January 2002 and January 2003. This time frame was close enough to the time of data collection (fall 2004) that I believed the women would be able to recall their treatment experience in this program as well as their inpatient experience just prior to day treatment. I also believed that it created enough of a time lapse before the interviews that they would have had time to reflect on their experience in outpatient treatment.

Another inclusion criterion was each woman has the diagnosis of unipolar depression. Other diagnoses, including bipolar disorder and psychotic disorder, involve a different experience of illness and require different treatment options than those under study. In addition, I limited my potential participants to those who were between the ages of thirty and fifty years regardless of ethnicity. I believe that younger and older women who are treated for depression have different issues and experiences than the age group I selected.

I wanted to recruit women not currently hospitalized or attending the mental health day treatment program at the time of the study. This was necessary to ensure that the women were not acutely depressed and in hospital as participation in this study at this stage of illness would potentially induce unnecessary distress for women. As I am a staff member at the mental health day treatment program from which patients were being recruited, I needed to avoid a conflict that could be created by being a clinician and researcher to the same women at the same time.

Participants were asked to voluntarily agree to take part in my study. This was to ensure free consent - an ethical consideration - as well as to foster a willingness to freely share experiences. The final inclusion criteria was that the participants be able to read, speak and write English, the language used in the programs under study and by me as the researcher. In phenomenology, data analysis is very much dependent on an understanding of the language used, therefore it is important that the researcher and participants speak the same language.

Recruitment of Participants

In order to obtain women as participants, I first approached the program coordinator of a mental health day treatment program to discuss my study with her and to seek her cooperation with recruiting suitable participants. She agreed to assist me and I then provided her with a brief written description of the study. The program coordinator assessed previous program participants to see if they met the inclusion criteria, contacted women to determine their interest, provided them with information about the study, and if they were interested in the study and available to take part in the research, obtained their permission to release their name and contact information to me. In total six women consented to my contacting them.

When the women gave their consent to be contacted, their names and phone numbers were forwarded to me. I telephoned all six women who expressed interest, gave them further information, and set up a time and place for a written consent and first interview. The six women I contacted all agreed to participate in this study. Recruitment of participants occurred during the summer of 2004.

Setting and Context

This study took place in Halifax, Nova Scotia. The interviews were held at a time and place agreed upon with the women. In selecting the setting for my data collection, I tried to ensure privacy and freedom from interruptions during the interview as well as a setting that provided for the emotional and psychological comfort of the women. I offered to meet the women in their location of choice, including their homes, my office, or some other location, which they were free to select. Five of the women elected to come to my office for the interviews and one woman requested that I travel outside the city to her hometown where she arranged for a private meeting room at her local hospital.

All six women had attended three treatment programs within various institutions within Halifax that are each administered by one health care system and one research ethics board. These programs occurred within a variety of inpatient units in two psychiatric hospitals. Following inpatient treatment, all women attended the same mental health day treatment program located within a local hospital. After the mental health day treatment program, the women attended mental health outpatient treatment programs. Five women attended outpatient programs at one of two local hospitals and one woman attended an outpatient program that was located in the community.

Data Collection

Data were collected using unstructured interviews. Each woman was asked if she might agree to two interviews. The first interview was to gain an account of the women's experience of treatment within the same treatment programs for depression. A second interview was conducted in order to clarify the accuracy and interpretation of the first

interview and to obtain any additional information about her treatment programs. These steps are in keeping with the procedural steps as outlined for Colaizzi's methodology (1973).

I extended a general invitation to the woman to describe her experience of treatment in any way she would like to, in her own words. I encouraged each woman to begin describing her experience wherever she was comfortable. I would begin with an open-ended statement such as, *" I would like to hear about your experience of treatment in your own words."* However, each of the women described her experience chronologically, beginning with in hospital treatment, next in day treatment, and finally with outpatient treatment. To ensure that I captured the best and most complete experience of the woman, I repeatedly asked, *"Is there anything else that you recall about your treatment experience?"* This often generated further data until the response was "*No, that is all.*" Each of these interviews was approximately sixty minutes. The interviews were audio recorded.

During the second interview, the women were asked to read the transcripts of the first interview. I addressed any questions they had while reading the transcripts. Four of the six women met with me for a second interview. The other two women elected not to meet with me for a second interview. The four women who reviewed the transcripts from their initial interviews indicated that the transcripts accurately reflected the content of the first interview as well as their treatment experience. Each of these four women indicated that it had been important to them to recount their experience of treatment during the first

interview. Little in the way of new data was revealed during the second interviews. These second interviews lasted approximately thirty to forty-five minutes.

Data Analysis

For me data analysis began as I interviewed the women. Throughout the interviews, I listened to the experiences of the women as they recounted them and I began to form impressions of what they shared. Following the interviews, I transcribed each interview as soon as possible. This process provided written texts to analyze and the process also helped me become familiar with the data and to begin to think about the lived experience as reported by the women.

Transcripts of the interviews were systematically analyzed following the steps outlined by Colaizzi (1978) in order to identify themes. The first step was to read all participants' descriptions of the phenomenon. As I read each transcript and reflected on the data, I searched for any common experiences of treatment as reported by the participants. Any common experiences noted at that time might suggest themes that could describe the experience of participants.

The second step of data analysis involved extracting significant statements from the transcripts (Colaizzi, 1978). I began this process by reviewing each transcript separately and examining the data, line-by-line, and making notations on the transcript of statements I believed described the experience of treatment. Through rereading and examining the data, I was able to determine which data did or did not reflect the lived experience of treatment for depression.

Next, I began to reflect upon the meaning of each statement I had selected (Colaizzi, 1978). Paramount to this stage of data analysis was to continually ask of the statements that I thought to be important, what they told me about the experience of treatment for depression. It was at this stage that I began to identify and to name themes from the data.

After I identified the meaning of the certain statements, the next step was to organize and aggregate these statements into clusters of themes (Colaizzi, 1978). This process involved organizing and reorganizing the themes so that there was a good description of the experience of treatment. The process also involved renaming themes until an appropriate description was found, combining themes when appropriate and assigning data to a different theme when it was a better fit than my previous designation.

Once the themes were identified, clustered, and named, I began to write an exhaustive description (Colaizzi, 1978). This involved writing narrative descriptions of the themes that explained the data as fully as possible. These descriptions were written in a manner that attempted to capture the essence of the experience of women in treatment programs for depression.

Credibility of Findings

In qualitative research, credibility refers to the trustworthiness of the data or findings (Speziale & Carpenter, 2003). Credibility of the findings is achieved when participants identify the data as reflecting their lived experience. To determine if credibility had been achieved, the participants in this study were asked to read a transcript of their initial interview. Credibility was achieved when the participants indicated that

the transcripts accurately reflected what they reported and what they reported reflected their experience of treatment.

Credibility of the findings was enhanced through the process of submitting a copy of the transcripts to my thesis co-supervisors. One supervisor has a background in mental health nursing and has experience in working with people who have depression. The other supervisor has expertise in the phenomenological methodology. Both supervisors read the transcript from the first interview conducted with the first participant before I proceeded with any further interviews. This was to ensure that my interviewing technique was appropriate for capturing the participants' experience of treatment for depression. My supervisors added to the credibility of my data by discussing with me the thematic analysis as it progressed. This helped to shape my descriptions of the experience of treatment as reported by the women in this study.

Ethical Considerations

Ethical considerations are an important part of any research that involves human beings. The process of obtaining ethical approval was conducted through two research ethics boards at two different institutions – Memorial University of Newfoundland and Capital District Health Authority. This occurred throughout the winter and spring of 2004. Upon completion of my research proposal, I submitted the necessary documentation to the Human Investigations Committee (HIC) at Memorial University of Newfoundland where I was a student and was granted approval to proceed with the study (see Appendix A). Since my intent was to recruit participants through the Queen Elizabeth II Health Sciences Centre in Halifax, I was also required to submit the

necessary documentation to the Research Ethics Board (REB) at that institution, including the approval from the HIC. Following approval from the REB (see Appendix B), I proceeded with recruitment of participants for the study.

The ethical considerations of confidentiality, informed consent, and risk were addressed. In any communication with participants, either verbally or through their written consent, I assured them confidentiality. I kept all tapes and transcriptions under lock and key at my home and these data are accessible only to myself as the researcher and to my thesis committee members. No identifying information was associated with these data. Neither the names nor any other identifying information were used in reporting findings. I am the only one who knows the identity of the participants. Each woman was informed that her identity would not be revealed. Interview tapes will be returned to participants (if desired) or destroyed when the study is completed. I will telephone each woman after the study is completed to determine if she would like me return her tape. Transcripts will be kept securely and until five years after publication of research findings to ensure the integrity of the research.

The second ethical consideration addressed was that of informed consent. During the initial meeting with a potential participant, I discussed the purpose of the study, how her confidentiality was to be protected, and her right to refuse to answer any question and to withdraw from the study at any time without any implications for current or future health care. This information was on the consent form. Prior to beginning data collection, I asked each participant if she had any questions regarding the study and if she did, I addressed these questions. Each participant was then asked to read an informed

consent form. I gave participants a copy of the signed consent form, which contained my contact information and contact information for the REB of the local Capital District Health Authority.

For any research to be ethical it is important to balance the risks and benefits of the research. The risk of experiencing emotional distress during and following the interview was identified in the consent form. I contacted each participant the day following the interview in order to identify if she was experiencing emotional distress and to determine if emotional support would be beneficial. If the participant experienced distress as a result of the research I was prepared to supply her with a name and telephone number of a support person, and to assist the participant in contacting the support person, if necessary. This support person was arranged in consultation with the program coordinator of the mental health day treatment program. None of the participants indicated experiencing distress as a result of taking part in the study. Therefore, it was unnecessary to make any referrals because of emotional distress.

CHAPTER IV

Findings

This chapter contains the findings from the study. The first section of this chapter includes a description of the study participants, the women who took part in this study. The themes that were identified from the data are presented in the second section of this chapter.

Study Participants

A total of six women were interviewed. Their ages ranged from thirty-six to fifty years old. All women had been diagnosed with depression three to twenty years previously and had been admitted to an inpatient treatment program two to three years previously. Following hospitalization, all of the women attended a mental health day treatment program before receiving follow-up treatment at a mental health outpatient program. At the time of the interviews, none of the women were inpatients at the hospital, attending a mental health day treatment program, or receiving follow-up at a mental health outpatient program.

The number of hospitalizations for depression ranged from one to three. The length of hospitalization ranged from seventy-two hours to four months. The length of time in follow-up in mental health outpatient programs ranged from two meetings to several months. Only one woman reported seeing any mental health professional at the time of the interviews and she indicated this was a private psychiatrist. All had received various treatments for depression.

At the time of the interviews, all six of the women were living at home. Three of the participants were living alone; three of the participants were living with their husbands and children. Four of the participants were employed outside of the home. One woman is unable to return to her previous career and uncertain if she will ever be able to do so.

Themes

During the interviews, the six women shared their experiences of treatment for depression. In total, six themes were identified which taken together reflect the experience of treatment for these women. The themes that were identified were (a) seeking a sense of safety and relief, (b) frustration of learning to navigate the system, (c) making connections with others in a similar situation, (d) finding therapeutic staff members, (e) learning new insights and skills, and (f) gaining some control over your illness. Each of the themes will be presented using the women's own wording to provide a rich description of the women's lived experience of treatment in programs for depression.

Seeking a Sense of Safety and Relief

In her book *Depression and Women: An Integrative Treatment Approach*, clinical psychologist, Susan Simonds (2001) outlined four areas where women suffering from depression require safety and security. These areas encompass a therapeutic environment, suicide prevention, time away from the demands of everyday life, and security in life circumstances. All of the women identified these four areas in relation to their experiences with treatment. Safe, safety, and relief were words used frequently by

these women as they recalled their experience with treatment across the various programs.

Early in their depressive episodes, the need for physical safety was increased because of the real threat of self-harm of some sort. The women had a need to feel physically safe and to know that others would help ensure their safety by carefully monitoring the actions of women with depression. During this phase of their treatment, they talked about this need for safety and how important this was, particularly during acute episodes of depression involving suicidal ideations. Suicidal thoughts were extremely frightening and were often the catalyst for the women to actively seek treatment at a time when she had little energy to look after activities of daily living. One of the main worries was actually acting on the suicidal thoughts because the women did not have any help to deal with these thoughts. Those who had made a suicide attempt reflected on how helpless and hopeless they felt at that time and how frightened they were to have felt that powerless:

> *As soon as I started mentioning about that problem I started crying and crying and crying and then I guess I knew then myself what the problem was. I was really drained from trying to help them and then I was tired tired tired and then I was alone alone alone alone and then I didn't want to go out and I didn't want to do nothing. So that's when I ended up in the hospital.*

Seeking this sense of safety and relief in the early stages of depression was accompanied by a great deal of anxiety for some of the women because they did not know if they would get the treatment they felt they needed at that time. One woman in particular described how she worried that the doctor in the emergency department would not admit her to the hospital and she was very concerned that she would then act on her

suicidal thoughts. She viewed her hospital admission as a means of providing for her physical safety, "I knew that my depression was beyond family help, that I needed professionals [help]".

The women repeatedly described their episodes of depression as frightening experiences and this was the main reason why they were looking for some kind of safety and relief. For most, the worst aspect of depression at this stage was experiencing changes in mood and thoughts. These feelings were described as being emotionally distressed, hopeless, quite low, and devoid of emotions. Changes in their mood resulted in changes in their thought processes. Their low mood led to thoughts of despair and hopelessness. It seemed as if they were unable to solve the problems that led to their depression and this led them to a fear that they would not recover. The women recalled that these thoughts led to further feelings of hopelessness, which led to thoughts of self-harm or suicidal thoughts and attempts of suicide. The women described their awareness of changes in mood and thoughts and that they knew that there was something happening with them (i.e., that they were ill). It was the awareness of these changes, of not "being myself" and a resulting lack of safety that caused distress for the women.

These changes in mood and thoughts resulted in the women being frightened because they believed that they needed treatment, yet at the same time they felt more vulnerable and less able to advocate for themselves in seeking treatment for depression. They were also frightened that they would not recover from depression without professional treatment and recalled their unsuccessful struggle to overcome their depression on their own. The women perceived the need for treatment and believed this

required being hospitalized. They also perceived that treatment was not available to them or that they had to struggle to access treatment. They constantly encountered barriers in trying to explain their needs, having doctors listen to them, and being admitted to hospital.

Other aspects of safety were important to these women as they continued in treatment programs for their depression. Seeking a safe therapeutic environment as they progressed through day treatment and outpatient programs were important as well. They emphasized the importance of feeling safe to share their thoughts and feelings within the different treatment programs. This need for safety was met when the women felt supported and accepted without judgment by staff or other persons within the programs.

Safety was seen as important and essential to therapy aimed at addressing the issues related to depression. Safe treatment settings provided confidentiality, acceptance, and respect. Safety implied that someone listened to them and helped support them through the process of self-discovery and healing. According to the women, it also meant that the environment in which they participated in therapy included a sense of confidentiality and acceptance of the issues being shared as well as respect for the individual sharing the issues. The need for a safe therapeutic environment was described as one woman reflected on her experience in the day treatment program:

> *And I guess the other thing was there was something safe about the program, it was safe for me to come and do that kind of work here, not because it was in the hospital. It was more than just my needs being met. There's something safe that what was said here would stay here. I knew in order to help myself I had to tell the truth and say things about myself. The safety may come from the non-judgment.*

As they progressed though the various treatment programs, there was an increased sense of relief. The day treatment program was an important transition experience following a hospital admission. The mental health day treatment program provided a bridge between hospital and community living and therefore met physical safety needs while it fostered emotional safety needs necessary for women to engage in psychotherapy and psychoeducation. As such, the women grew in their sense of safety and in their ability to increase their functioning:

> *I thought it must have been helpful because by the time the six weeks were over, I was ready to leave whereas when I started the program I was not ready to leave. I think it was absolutely essential. I could not have gone from the hospital to the outside world without it. The day treatment program allowed me to be here during the day and to go home at night. It was an easing back into the real world that was really essential.*

When their safety needs were met within their treatment programs, they felt a sense of relief. It was a relief just to be in an environment where they could take a break from daily responsibilities while they sought treatment for depression. Simonds (2001) has described this as a "zone of safety" that allows for those who are very depressed and functioning at a low level to find relief from the usual demands of living. Hospitalization for depression was a means for the women to separate from their daily life events and stressors. This separation then allowed them to focus on themselves and their need for treatment. It seemed to be the reason why the women viewed their hospital treatment as important and essential to recovery:

> *At that point I was very relieved just to put my whole life down – that was the happiest part of my depression, which has been going on for about four years. It was a very strange place for me to find myself, given my university education and my career and so on, but that was o.k., because when I landed there it was either that or nothing.*

The initial hospitalization during the acute stage of depression gave almost immediate relief. This relief often followed a struggle to access treatment for depression. For example, the following quote illustrates one such attempt and how the woman felt when access was achieved:

> *Then after that I was sent to psychiatry, to the short stay unit and that's when things finally started. The relief of going to the short stay unit was unbelievable. You didn't feel like you were being kind of brushed off, or having someone say 'deal with it'. They dealt with me right then and there and made me feel like finally someone's listening to me, I'm going to get help. It's just a relief to know that you're being taken seriously and that they're trying to help you. It's just knowing that maybe there's a light at the end of that tunnel. Somebody's actually going to treat you and not say 'let's just wait'.*

Having safety needs met and beginning treatment were important milestones for the women because it enabled them to see changes in their longstanding symptoms of depression. Engaging in treatment not only provided an opportunity to address these symptoms, but a chance to address the issues underlying depression. This improvement in symptoms led to a further sense of safety and relief as described in this quote:

> *It's just [pause] I remember talking to another lady in the short-stay unit and saying you see such a change in yourself once you're in the hospital. Suddenly you get your appetite back, a lot of anxiety is gone. You know you're going to get the help. It's such a relief. It's so instant. Suddenly you feel like eating again where the thought of food would turn me right off. Suddenly as soon as I'm in the hospital I have this appetite and wanted to eat. It's just a relief to actually know you're going to get the help.*

Frustration of Learning to Navigate the System

In his classic study on mental institutions almost half a century ago, Goffman (1961) outlined some of the characteristics of total institutions that make them a special

environment and create a special "culture" for patients and health care professionals alike. This special environment and culture makes it very difficult for the uninitiated to understand how the institution works. While much has changed within these institutions since Goffman's work, mental health units even in general hospitals still present a challenge for people upon admission (Quirk & Lelliott, 2001). The women described their experiences and feelings with accessing treatment, understanding the health system, and being a part of a treatment program. One of these feelings was related to the uncertainty experienced while encountering an unfamiliar mental health care system and how they needed to learn to get through, "to navigate this system".

The challenge began with gaining access to the system. There was great uncertainty regarding how to access treatment for depression as well as protocols and procedures for assessments in the emergency departments, admissions to inpatient treatment programs and referrals to other treatment programs (mental health day treatment and outpatient treatment). The uncertainty experienced within the mental health system led the women to feel frightened, frustrated, overwhelmed, uncertain, confused, and helpless. The paramount feeling described by the women, however, was frustration. Based on the women's descriptions of their experiences and feelings while seeking treatment, I have interpreted this theme as the frustration of learning to navigate the system.

The first encounter with the mental health system was in many ways the most challenging because it occurred at a time when the women had fewer personal resources for coping with the challenge than they did later in their treatment regimes. Many

described this encounter as "frightening". The fear was associated with the unfamiliarity and complexity of the health care environment as well as what they were experiencing as a result of their depression. The women recalled that fear led to vulnerability when they advocated for their own need for treatment. Seeking an assessment through the emergency department was quite intimidating. The women were frustrated, frightened, and confused because they did not know the procedure around assessment that involved several health care professionals:

> *My frustration was with repeating the story over and over again because it seemed like there were so many people coming for the case history. By the time I got to see the psychiatrist, I had told the story so many times. I got tired of repeating the same thing over and over and over again. There's probably a reason for that which I don't understand. I found that tiring and stressful.*

The women also described the frustration they experienced as they made the transition from one treatment program to another. They had expected a smoother transition and felt the interruptions to treatment were not helpful for them. The process of referral to day treatment programs and outpatient programs and the wait times associated with being admitted to these programs was difficult to understand. They were also frustrated by the lack of information conveyed with respect to what they could expect of themselves and the treatment programs involved:

> *I finished the day treatment program in July and I got in to see the occupational therapist in the outpatient program maybe not until September. Although I coped, and just thinking back, it would have been just like when I left a hospital, it would have been better for me if I had had contact and if that was available I didn't know that. If that was a support I could have used, I wasn't aware of that.*

Women were critical of what they saw as a lack of response from the health care system when they tried to access care at a time of great need. This perceived lack of response led to feelings of dissatisfaction. One of the greatest sources of dissatisfaction was not being heard by health care professionals and hence not having their needs taken seriously. They exemplified their frustration with examples where they were denied access to treatment:

> *In the emergency department - it was quite an ordeal because although I had not attempted suicide, for me I had to fight to get in to the hospital because I was in the state where I could not look after myself and it wasn't that I was trying to be preventative, my fear was if I did not do something about this now I was going to do something I was sorry about. I hadn't taken any action to move towards suicide so initially they weren't going to admit me and that's when I had to argue with him saying 'so I will walk away and make a [suicide] plan". So coming here that day and feeling depressed, I found I had to fight to get in, which although I have the verbal skills, it was still a challenge for me to convince someone that I just couldn't look after myself any more.*

Not all the experiences with hospitalization and hospital staff were seen as positive. There were some differences between how the woman felt and how she was perceived to be feeling, based on her interactions with others. The rules of behavior or how a depressed person should act were not transparent to the women as patients. Nevertheless health professionals seemed to make assessments of the woman based on certain rules of behavior for depressed patients. Or at least this is how some of the women perceived they were being judged, as the following situation illustrates:

> *I don't feel I had any treatment in the hospital. The first time I went in, they told me all this stuff. I don't even know how they would have the nerve to say anything about my personality or anything because they were never at any time in the room with us. One night I was trying to think if I*

> *had the courage [to kill myself]. They take everything away from you that you could hurt yourself with, but I still had my shoelaces, and I was trying to think if I had the courage to swallow them or use them to hurt myself. I was still suicidal, not to the point where I actually went through with it but I was thinking it. And then I go in, right after that, having a night of not sleeping, and having all these thoughts. She [Dr. A.] said "We don't think you're all that depressed because you're friendly with the other patients, you're interacting with the other patient". I thought "Well, who the hell was that in my bed last night"? How could they come to that conclusion when they weren't there?*

The women in learning to navigate the system also had to learn how to get access to the treatment they felt was important to their situation. Some second-guessing took place around the women giving the doctor and other health care professionals the "best" response so that they could have access to treatment versus how they really felt or thought:

> *They asked me, [be]cause I had a newborn, if I had any thoughts of hurting my son, and I thought maybe if I tell them yes, they'd take me seriously. This is really serious. And that's when I said, yes, I've had thoughts where I sometimes find myself wishing he wouldn't wake up. Actually my anxiety was that I was worried about him not waking up. I just thought, I had to turn it around, so maybe then they'd take me seriously.*

Making Connections with Others in a Similar Situation

Depression is a socially isolating experience and people with this condition have feelings of loneliness and marginality (Karp, 1996). Jack (1991) described how women with depression are silenced in different ways and how important interpersonal relations are to overcoming depression. One of the important aspects of treatment for depression, as described by the women, was making connections with others in a similar situation. The women cited several benefits they experienced when they connected with other people in the treatment environment. These benefits included a reduced sense of

isolation (social and emotional), the discovery that the issues underlying depression are not unique to the individual but rather shared by others, and a sense of mutual support within treatment programs.

All of the women in this study experienced the isolation of depression. They felt socially isolated as a result of their decreased interest, motivation, and activity level when ill. This isolation was difficult and it marked a change from their functioning when they were not depressed. The connections formed with others in treatment programs were significant in decreasing the isolation they experienced when depressed. They also stated that these connections were important to their recovery. The women defined their experiences with treatment programs as an opportunity to form connections with others as they were all struggling with depression:

> *I thought the social aspects of it were very positive. I enjoyed the luncheons, the bonding that went on there, because I was desperately in need for friendship and at that point I couldn't find it outside the hospital. I think it was more the association with the other members of the group that was the key to my getting out of here.*

Emotional isolation was another feature of their depression. Often the woman had not shared their emotions with others prior to treatment. The women explained that by not expressing their emotions, they felt alone with their feelings and that they believed that no one else experienced the same feelings they experienced while they were depressed. Gradually during therapy they began to share their emotional experiences. Sharing these experiences was helpful in reducing the sense of being alone with their feelings:

> *To be around other patients who also knew exactly what you were talking about with your experiences. It is comforting to be around people who*

> *can relate to everything you're saying and know exactly what you're talking about with this illness. It was great to get in there and meet with people. It was just – you meet people you can really get along with.*

Sharing their feelings served another function for the women in that it validated these feelings. These women reported that while depressed, they believed that no one else had experienced the events and situations that led to their depression. They felt quite alone in their experiences that led to their depression, including abuse and abandonment (emotional, physical, and sexual), and loss (broken relationships, and grief):

> *We got into a group and we started talking and you find out that a lot of people were dealing with the same issues, low self-esteem or problems with family, problems coping with day-to-day life, problems making decisions, facing confrontations, things I had been struggling with for years and then I came here and realized hey you're not the only one.*

The women recalled that once they formed connections and shared similar experiences and feelings with others receiving treatment, they experienced a sense of mutual support within their treatment programs. The mutual support experienced among members of treatment in the treatment programs was meaningful to their overall experience and assisted in their healing from depression. This mutual support was a significant aspect of their group treatment program experience:

> *It always seemed that wherever one of us was weak, the other one was strong. There was always someone you could look at and say they overcame it so maybe I can overcome it. You had the opportunity to say that this is something that worked for me and share that and to have that good feeling, to know you could help someone else. It was like a family atmosphere in way, it was a very sharing thing, which I don't think depressed people do very often. We tend to keep things internal.*

The mutual support inherent in treatment programs also allowed them to meet their individual goals for treatment. They noted that the mutual support they experienced

in treatment programs was important as it provided the challenge and expectation that each person would set her own goals for treatment:

> *So I guess I came to like being part of a group. Even though we were moving through things individually and even though we may have had lots of similar issues, there was a feeling that we were moving through this as a group as well.*

According to the women, the support they experienced in treatment programs was based on an understanding that each program member shared similar needs and experiences with others and that each person had individual needs for treatment.

Finding Therapeutic Staff Members

As the women reflected on their experience of treatment, they talked about the importance of finding and connecting with staff members who were therapeutic. They reflected on the meaning they attached to their relationships with staff in each program. Their relationship with individual staff members varied according to the acuity of their depression as well as the treatment program, and with attributes they felt were important for staff members to have at the various stages of their depression. Despite these different experiences, the women described common aspects of their relationships with staff. For these participants, therapeutic staff members were perceived to be those who were nonjudgmental, understanding, and supportive.

The women placed great importance on staff members who were nonjudgmental. This characteristic cannot be overemphasized, as often women suffering from depression feel negatively judged by others as well as by themselves (Jack, 1991). As a result, women with depression struggle to accept themselves. The women in my study fit this description. It was only when they found staff members to be nonjudgmental, that the

women began to be open and honest with respect to their thoughts, feelings, and experiences. They believed that this openness and honesty was significant to their treatment and recovery:

> *I would say the non-judgment of the staff and in general the participants, I mean we all come with our own judgments, but in general all the staff and most of the people in the group were accepting and supportive.*

In addition to the nonjudgmental attitude and acceptance of staff, it was important to feel understood by staff. Being understood by staff meant that staff identified their needs for treatment. For these women, being understood further enhanced their ability to be honest and open with themselves and staff. The women defined being understood as requiring that staff took the women's issues and struggles seriously and that staff recognized the significance of women's feelings. The importance of being understood is reflected in this comment:

> *Just feeling understood, they could really relate to you, that they understood your illness. They took it very seriously too, I think that's the thing – they really took it seriously and didn't say like 'It's just a mental illness – get over it' – they really understood how serious it was. It's just feeling they understood you – you could be very open about it and not have to say the right things. That was definitely good.*

In addition to finding staff members who were nonjudgmental, accepting and understanding, the women looked for staff members who were supportive. The support they received from staff members changed throughout their treatment experience and as recovery progressed. For example, the women described staff members who were available to talk, listen, and encourage as essential to their treatment. One woman recounted, *"I liked that at the hospital you could talk to any of the staff at any time"*.

The women could see the critical role that education played in their recovery and looked for staff to help them learn more about depression. When initially hospitalized for depression, it was beneficial for the women to have staff members teach them about depression, for example the causes and symptoms of depression as well as treatment options for depression (including medications, ECT, and psychotherapy). As treatment progressed, women found it helpful when staff in day treatment programs and outpatient programs provided education around specific skills to help deal with depression, causes of depression specific to the individual, and additional treatment options:

> *Dr. [B.] was really supportive of that cognitive therapy. He was great. So was the nurse I saw. They really know their stuff, that's the thing. They give you really good feedback. The nurse was really helpful in terms of giving me different options, programs, checking things out for me.*

Their need for education varied according to the acuity of their depression. The participants also noted that it was helpful for them when staff met their needs for daily living, such as assistance with completion of insurance application forms, securing housing, organizing household tasks, and connecting them with community resources. This support or assistance helped women meet their basic needs for shelter and finances. The participants explained that once these needs were met, they were able to engage in further treatment for depression that helped them address the reasons behind their depression. Further, the women explained that once their reasons for depression were addressed, they benefited from staff support in assisting them to meet their social and recreational needs:

> *Well, when I went to the outpatient department there was an occupational therapist. She was so lovely to me. She was really great about it. And then I told her that I loved music and I how I loved to listen to music and*

> *how I love to sing myself but was still quite shy. So she even said about joining those senior places and going to one of the manors. She showed me a lot of programs that go on there so she was even willing to take me and she said she'd go with me until I get used to the going there and I joined. She said she'd even help me with a place where I could get my guitar lessons – I've had a guitar all my life and never learned to play yet.*

In contrast to the staff members who were therapeutic and whom the women sought out, others were not perceived to be as helpful. When a woman encountered a less helpful health professional, she felt this led to a negative experience in treatment. In these negative experiences the woman was not able to establish a therapeutic relationship with the staff member. Therefore, their recovery was negatively impacted. They recalled that when they perceived staff as non-therapeutic, it was difficult to repair the relationship. Women who did not establish a therapeutic relationship with staff noted that their recovery from depression was negatively impacted. When this happened, women made decisions regarding changes in their treatment. In some instances, women explained that they terminated their relationship with staff. In some instances, the sought a therapeutic relationship with a different staff member:

> *I went to Dr. [J.] first. I thought he was impossible. I went in there, he seemed so cold, and uncaring and blunt. I told him I should leave. Dr. [J.] was just a cold fish. It was his whole approach I guess. Maybe that works for some people, it didn't work for me. I just cried so hard when I was with Dr. J. in the first meeting. I saw him a few times and then I decided I didn't need to see him anymore. He did want me to go to his group. I did go a time or two but I couldn't do it. Dr. [J.] is a man of few words, I would say. It was the coldness. I was so beside myself when I first met him. In fact that was probably the biggest cry I had since leaving home to go to the hospital. I couldn't really understand why he was like that and I think that is wrong, I really do.*

Learning New Insights and Skills

Gaining new insights and skills is an important aspect of engaging in treatment programs for depression (Simonds, 2001). The women recognized the importance of gaining new insights and skills and talked about how they were able to develop these from their treatment. They associated these insights as essential to their recovery. Some of the insights gained as a result of their treatment included: exploring the connection between their thoughts and feelings, learning how childhood experiences led to depression, developing an improved sense of self-esteem, and gaining insights into their anger.

In addition to the insights gained, the women reflected on how the skills they learned during treatment helped them cope with their condition. They recalled a variety of skills they acquired during treatment and they defined these skills as essential to their learning how to cope with life situations differently. The coping strategies they learned in treatment helped them to feel less overwhelmed by life situations. These new coping strategies provided them with alternative ways to manage things in their lives and this led to increased self-confidence. The women identified improved self-confidence as integral to their recovery. The women identified the following skills learned in treatment as important: establishing structure in one's life, developing writing skills as a means of exploring feelings, gaining assertiveness skills, practicing relaxation techniques, and learning goal setting skills.

One insight that the women deemed critical to recovery was the discovery and understanding of the relationship between their thoughts and feelings. They learned how

thoughts and feelings influence each other and this insight was helpful to them in managing their depression. They were aware of feeling depressed, however prior to treatment they were unaware of the thoughts that were associated with these depressed feelings. The thoughts they experienced during times of depressed feelings were generally negative. Once they identified their negative thoughts, they were able to think about things differently, consider alternative views and begin to think more positively. They noted that by thinking more positively, they began to feel less depressed:

> *I think the thing I actually got most out of that, was learning how to question what I was thinking when things happened. I worked more there with the cognitive distortions that we have and that was so helpful to me when things come up. I dealt a lot in absolutes and I think that what I got most out of that was just learning to question my own thinking. When a situation would come up, to stop and think is that really true.*

In addition to discovering how thoughts and feelings influence one another, the women felt that their treatment experiences allowed them to explore painful events from childhood. Although not all the women revealed any history of abuse, some women recounted how powerful it was during treatment to discover that they were not to blame for the neglect and abuse they experienced as children. They cited that it was an important component of their treatment to accept that, as children, they were not responsible for the actions of the adults who hurt them:

> *I was able to say yes I understand how early childhood and adolescent experiences and issues can lead to a pinnacle where one cannot do anything except collapse. I came to understand that my depression was not a short-term onset; it was a culmination of many years of abuse and suffering.*

For those women who had experienced abuse, during their treatment they learned that the abuse they experienced in childhood and adulthood had a negative impact on

their self-esteem. Through their treatment they discovered the connection between abuse and low self-esteem and that this connection helped them to address low self-esteem in treatment. Their treatment provided an opportunity to explore how they thought and felt about themselves and an opportunity to work on improving these thoughts and feelings. Developing an improved sense of self-esteem was pivotal to their treatment.

During their treatment the women explored some of the reasons why they experienced low self-esteem. Their self-esteem had been damaged as a result of difficult life experiences, such as being neglected or abused as a child or as an adult. Some women indicated that their self-esteem had suffered as a result of setting high expectations for themselves or trying to live up to the expectations of others. They also described how they had defined their sense of self by their accomplishments, including caring for others at the expense of their own needs:

> *One of the problems I had was that I needed everyone to like me so I had to take care of everyone else's problems. Learning that I have rights and that I don't have to take care of everyone else, I can take care of me. That was a big help.*

Treatment enabled them to change how they defined themselves. They began to associate their self-esteem with who they were versus what they did. Through the process of exploring the relationship between thoughts and feelings, the link between childhood experiences and depression and self-esteem issues, some women discovered that they had unresolved anger. They understood that their depression was related to this anger and that their unresolved anger had contributed to their depressed feelings. For these women, it was important to acknowledge their anger, to understand what caused it, and to realize that unresolved anger can continue to manifest as depression. The women

who made the connection between unresolved anger and depression stated that they benefited from treatment that specifically addressed these issues:

> *When I actually got into the anger management program I realized that I actually did have issues with anger. Not so much that I was angry all the time, but that I would keep the anger inside and that I would have these explosions from time-to-time. It was interesting to learn how much of that anger was feeding my depression. What was happening was that I was getting angry about things in my life that weren't the way I wanted them to be, and instead of dealing with it I was keeping it to myself.*

The women emphasized the importance of gaining new insights into their depression. They believed that the insights gained during treatment allowed them to consider their depression from a new perspective. This new perspective provided the readiness for women to develop new skills to manage their depression. One skill recalled by the women as significant to their experience of treatment was developing structure in their lives. These women stated that having depression meant a disruption in their regular routines such as family activities, work, and community activities. At the peak of their depression, they had little routine or structure in their daily lives. They noted that their treatment experiences provided structure and that this was fundamental to their ability to reestablish structure in their lives:

> *It got me going in terms of the schedule. I knew I had some somewhere to go to, that I was doing something for myself. It was a place to come to really get in touch with myself in a focused way. What I really liked about the program, I liked the structure - it was flexible. I guess to me it's a bit like going to school - it helps me to stay organized and focused in a way that I might not otherwise do on my own, or to also keep it [my life] in a balanced perspective.*

The significance of the structure of a day treatment program was also reflected in this comment, *"It was just a chance to being committed to going somewhere everyday, to*

deal with the stress of that commitment and the commitments at home, and getting more structured in my life".

Once the structure of treatment was established, the women were able to develop other skills to manage their depression. A skill that was new to many of the women was developing writing skills as a means of exploring and expressing feelings. The women described this as helpful to them as it allowed them to connect with their thoughts and feelings in a way that they had not done before:

> *I find writing is a really good tool for me. I guess it's out of my head and then I don't dwell on it anymore. So that type of expression was supportive for me because I probably would have said it verbally, but it's much easier and probably more efficient to write it down.*

Some of the women described letter writing as an effective and meaningful component of their treatment. The letter writing was a means of dealing with their painful feelings. Letter writing allowed them to focus on specific situations and people that had caused them painful feelings. The process of letter writing enabled them to share their letters and feelings with other members of their treatment programs. The feedback they received on their letters from group members was an important part of their treatment. Some women in this study reported that letter writing was so significant to their treatment that they were continuing to use this skill at the time of the interviews.

They also described the process of learning assertiveness skills as one way of changing how they communicated their feelings and needs. In the past they did not acknowledge their own needs as important and therefore did not seek to meet these needs. At times, they admitted to allowing others to infringe on their needs. They acknowledged that the result of this passive style of communication was a devaluing of

one's self, a resentment of others, and a perpetuation of feelings of depression. The women viewed assertiveness as a way of thinking more positively about oneself and accepting that one has value that is recognized by others:

> *I remember that someone gave me a compliment – I remember when I lifted my head up, the first thing I did was start crying after she complimented me because I couldn't accept it. But today, I lift my eyes up, I can give a compliment and I can accept a compliment whether I believe it or not and I can just say thank-you and I learned that here too.*

In addition to letter writing and assertiveness skills, the women recalled the relaxation skills learned in a mental health day treatment program as an important aspect of their treatment experience. The women identified relaxation skills as increasing their ability to cope with the stressors in their life and the additional stress of being ill, *"I keep thinking of the relaxation group. The therapist was just great though, anyhow, and he just made it a lot of fun"*. Relaxation skills were a means of balancing the emotionally and cognitively difficult aspects of a mental health day treatment program. The women also noted that they were still using the relaxation skills at the time of the interviews.

In addition to the skills previously described, the women also recalled having learned goal setting during their time in the mental health day treatment program. These women viewed goal setting as an important tool that was used to help break seemingly difficult and unreachable tasks into specific and reachable tasks. They described having broad goals for treatment that they were initially uncertain of how to attain. Through developing goal setting skills, they learned to develop strategies for setting small and realistic tasks that would move them towards their larger goals. They also described the

usefulness of goal setting skills in their everyday lives, including home management. These skills were further developed while in the mental health outpatient program:

> *So the occupational therapy (in the outpatient program) has been a real important component because this has really helped me stay paced. There was a point in the occupational therapy work when she went shopping with me. So we made a list, she came for support, she gave me ideas for meals for when I didn't even feel that I could cook, you know relatively simply meals until I felt better and wanted to cook. She told me how to take little steps. [She} was an important support.*

As the women reflected on their experience of treatment, they explained how their depression had improved from the time they initially entered treatment. They attributed their recovery partially to having acquired new insights and skills during their time in treatment. They also noted that their recovery was also enhanced by their continued utilization of these insights and skills following their time in treatment.

Gaining Some Control over Your Illness

Throughout the interviews, the women described changes they observed in themselves over time. When they were depressed, they felt disempowered and helpless with respect to their illness and the issues in their lives that contributed to their depression. These feelings shifted during treatment. At first the challenges in seeking treatment perpetuated their sense of being disempowered and helpless. However, once they were able to access treatment, these feelings began to change.

The women described that their treatment experiences spanned different stages of their illness and occurred over different settings. Regardless of the stage of illness or treatment setting, treatment was therapeutic when their ability to accept responsibility for their own treatment was fostered. The responsibility they accepted for their treatment

was contingent on the acuity of their illness. They explained that as their depression lifted, they became more active in making decisions regarding their treatment and hence their lives. When they were acutely depressed and hospitalized, they felt it necessary for staff members to direct their treatment and for staff to assume responsibility in making decisions regarding treatment on behalf of the women. They recalled and described that they felt overwhelmed and challenged to make decisions regarding treatment while in the hospital.

As the women experienced their depression lifting, they were discharged from hospital. They then engaged in treatment at a mental health day treatment program. They described this aspect of their treatment as leading to a sense of empowerment. Empowerment resulted from accepting increased responsibility for one's own treatment. For some women, making choices and decisions within treatment contrasted sharply with their personal lives where they described feeling that they had little control or power. As they assumed more responsibility over their treatment, they developed a sense of mastery and control over their treatment, their illness, and their lives.

The women cited specific aspects of their treatment that they took control over. For example, they made choices over which treatment components to engage in, such as whether or not to take medications and whether or not to attend particular treatment programs. They also stated that they made choices regarding what to focus on within their treatment. They described being responsible for setting treatment goals and being responsible for their own progress in attaining their goals. They were able to make decisions regarding the amount of work they did in treatment. This meant they decided

how much effort they elected to put into acquiring new skills (for example, assertiveness skills). They also recalled making choices with regards to exploring their feelings as well as exploring the reasons behind their depression, *"It allowed me to dredge up and to discover for myself many of the triggers from my past that eventually led to my collapse".*

The women identified the ability to make choices in treatment as important to them, as fundamental to their recovery. They felt they were responsible for the outcomes of their treatment and this responsibility was essential to them. They recognized that making choices in treatment was fundamental to their recovery. They also recognized that no one else could make decisions for them. Becoming fully involved in decisions concerning their treatment was a meaningful aspect of their experience of treatment, *"I was in charge of how much I wanted to do. It was about me and my journey and working this through".*

Accepting responsibility for treatment was difficult to do at times. They were not always comfortable with or confident in their ability in making choices. When depressed, they felt unsure of their abilities to accomplish the goals for treatment that they had set for themselves. The support inherent in the group program motivated the women to make decisions. These decisions led to changes within each individual. The women identified that the changes led them to gain greater control over their illness and hence their lives:

> *I think it is helpful to encourage people to face up to things, to push ourselves a little bit. For myself, one of the aspects of depression is giving up. Knowing that you need to make changes but not having the will power to do it. Being in group, you were with other people and you had encouragement. This would force me to own up to things that I needed to*

> *change and to say I can change it. It made me realize I could do it and gave me that little extra push so that I did do it.*

Treatment was a means of gaining control over their depression and over their lives. In reflection they identified that their making decisions in treatment led to the control they needed. Once a treatment program was explained, they had to make a conscious decision regarding how they would commit to and engage in the treatment process. Part of this decision-making occurred when one treatment program was concluding and further treatment options were offered. Each treatment program they participated in built on their ability to take responsibility and hence gain control over their illness. Although they participated in three distinct treatment programs, each program provided an opportunity to take more control over their illness. They emphasized that each treatment program was essential to their overall recovery. They also believed that the control they developed over their depression would not have been possible without the entire treatment experience.

CHAPTER V

Discussion

The findings from this study contribute to the overall research literature of women's experiences with treatment for depression, an area where relatively little research has been done and yet has been identified as an area where research is required (Karp, 1996; Jack, 1991; Olfson et al., 2002). It helps to identify what is important to women who find themselves within various treatment programs. One of the main findings is the importance of women's relationships with staff working in the programs and their relationships with other patients. While the establishment of therapeutic relationships between patients and health professionals have been a continuing theme in the mental health, psychiatric literature, less attention in the professional literature has been given to patients' relationships with other patients. The themes making connections with others in a similar situation and finding therapeutic staff members address the importance of therapeutic relationships and treatment.

A second finding relates to how vulnerable a person is when experiencing severe depression and how important a sense of safety can be to the person, and yet they must achieve this safety within a foreign and often puzzling environment. Within the theme seeking a sense of safety and relief the women's need for safety was captured, while the theme frustration of learning to navigate the system, spoke to the environment of the psychiatric programs and how women experienced these.

The final area that this research explored is what a woman gains as a result of treatment for depression. It addresses the learning that takes place and what this enables

the person to envision; that of gaining control over her illness and her life. Severe depression is a very disabling condition. It takes away agency or autonomy of the person and leads to despair and disempowerment. Treatment, especially within day treatment and outpatient treatment, attempts to return both agency and the ability to use that agency through empowerment. The remaining themes, learning new insights and skills and gaining some control over your illness explore treatment outcomes as experienced by these women.

This chapter highlights the three areas presented above, to further explore these areas, and to relate them to the literature. It covers therapeutic relationships, safety, and treatment gains.

Therapeutic Relationships

Therapeutic relationships between patients and staff are an integral aspect of treatment for depression, regardless of the setting of treatment (WHO, 2001). When patients with depression engage in treatment, they connect with and express their extremely intimate thoughts and feelings with staff members. This intimate connection with staff members allows patients to work through these thoughts and feelings, which hopefully leads to recovery from depression. The importance given to relationships with staff was reported in many of the research studies reviewed (Beech & Norman, 1995; Langle et al., 2003; Remnik et al., 2004; Ricketts, 1996). Women in this study also stated that therapeutic interactions with staff were important aspects of their treatment. They cited that staff presence was important to them during a time of feeling afraid and feeling at risk of harming themselves. Other research suggests that a patient's experience with

staff members and staff presence is important and beneficial to a patient in a psychiatric setting (Moyle, 2003; Rowe, 1983). Listening to, type of communication, or just being with the patient have all been rated as important aspects of therapeutic relationships.

When staff members are present with patients, they are able to form a therapeutic alliance with patients. Alliance with staff members provide support to people with depression and is the type of professional support that Hupcey and Morse (1997) described in their study. They defined professional support as provision of specific services to patients and that these services are governed by professional practice guidelines as opposed to social support that they felt excluded the provision of goods and services. Staff members were further found to be therapeutic when they provided emotional support and encouragement. Such support provided the environment for women to work through their feelings of depression and the reasons behind their depression. As described by the women in this study, the support provided from clinicians fostered their process of self-discovery, and this process led women to view themselves more positively and competently.

The personal connection between patients with depression and staff members suggests that an appropriate 'fit' is a determinant to successful treatment (Sheeran, 2003). Personalities of patients and assigned clinicians affect the dynamics of the therapeutic relationship. In addition to personalities affecting the alliance between patients and staff, the theoretical background and clinical biases of clinicians is an influencing factor (Pettit & Joiner, 2006). Other factors influencing the relationship between patients and clinicians include the clinician's style of working with patients, the age of patients and

clinicians, and the similarity of background and/ or the life experiences of patients and clinicians. The findings from this study indicate that patients sometimes feel supported and heard by clinicians, and this is therapeutic. Conversely, patients have reported that they have experienced staff to be unsupportive and distant. In an ideal treatment setting, patients would be matched with staff that might best meet their treatment needs. However the reality of our current health care system is that treatment for depression can be difficult to access, and as a result, patients have little control over choosing their clinicians.

How patients relate to staff members is one aspect of the treatment of depression (Siponen & Valimaki, 2003). Another dimension of treatment experience is how patients relate with one another (Thomas et al., 2002). Inpatient units and group psychotherapy (including day treatment programs) usually include patients with a range of psychiatric diagnoses including depression, psychosis, manic episodes, and personality disorders. The treatment needs of patients are related to their diagnosis, and treatment programs seek to meet these diverse treatment needs. Given the fact that patients with depression often experience treatment that includes other patients, relatively little research was found that explored the part that other patients play in the experience of women with depression. It is important to consider the connections with other patients as social isolation is common during depression and treatment programs help reduce isolation. When women with depression relate to others during their treatment experience, they may experience understanding, trust, acceptance and respect. Only Berghofer et al. (2001) specifically addressed patients' satisfaction with other patients. These researchers

found that patients with a longer course of inpatient treatment and outpatient treatment rated relationships with other patients more favorably than did those patients with less experience with treatment. Thomas et al. (2002) did not specifically study patients' experience with other patients, but they found that when patients described their experience with treatment they favorably described their interactions with other patients. In this study, the women reported that it was therapeutic to connect with other patients. These women described that knowing others had similar experiences helped reduce the isolation of their depression.

Safety

Safety as Simonds (2001) emphasized is a multidimensional concept that includes physical safety or protection from self-harm. It cannot be overemphasized how significant the need for safety is to women with depression who are at risk of harming themselves during the acute stage of their illness when treatment usually occurs on an inpatient unit. The need for safety while in treatment was an important finding from this study and those in the literature. One of the primary reasons for a person's admission to hospital during acute depression is to have the need for physical safety met (Bowers, 2005). Bowers stated that the mandate of inpatient treatment is to promote patient safety. This involves preventing patients who are at risk of harming themselves from doing so. The need for safety is an immediate need of treatment for persons during an acute stage of depression, and Temkin and Crotty (2004) described a new tool for assessing the risk for self-harm, based on a patient's behavior. Such tools allow for standardized suicide risk assessments among all staff.

When considering the impact patients have on one another, the inpatient treatment experience and the environment needs be considered. Inpatient treatment occurs within a confined space in which patients are in close proximity with one another. In many cases patients share bedrooms with persons they do not know. Inpatient treatment often means that men and women are treated together on the same unit. There is a risk of physical aggression within psychiatric treatment settings, including inpatient units, which raises issues around patient safety and security. The women in Cutting and Henderson's (2002) study clearly expressed that they did not feel safe while in hospital. The women I interviewed did not express any specific violations of safety during their treatment. The women did describe events on the inpatient unit as being "strange" and "unfamiliar" and that it took time to adjust to the treatment environment, including adjusting to other patients.

In addition to physical safety needs, women in this study described needing to feel safe to explore and express their thoughts and feelings while in treatment. According to Simonds (2001), when a treatment environment provides patients suffering from depression with a break from the demands of daily living, patients have an opportunity to explore the reasons behind their depression. As patients participate in treatment for depression, they also have an opportunity to gain confidence in themselves and in their ability to cope with life. Such confidence leads to a sense of control and autonomy over one's life and a sense of security in one's life.

When one reflects on the idea of participating in treatment for depression, it becomes clear that discussing painful thoughts and feelings associated with depression

requires a sense of safety. Depression is often associated with life situations that have threatened one's sense of safety, either emotional or psychological. In order to address these difficulties, it is important that the treatment environment meets the need for emotional and psychological safety.

Safety needs were raised by the women in this study who also described their frustration, confusion, and being overwhelmed while seeking treatment for depression. Seeking treatment occurs during a period when women are feeling vulnerable and powerless as a result of depression. The complex mental health care system is foreign to many people. It can be confusing and scary to seek treatment for depression, especially when there are many stereotypes and prejudices around what occurs within psychiatric settings. Media has historically portrayed mental illness in a sensationalistic manner and treatment to be inhumane and barbaric (Lauber, Carlos, & Wulf, 2005).

Findings from this study about learning to navigate the system speak to the unfamiliarity people have with psychiatric settings and how confusing it can be for them. Karp's (1996) exploration into the meaning of depression briefly addressed the hospital experience and while for some it was a "wonderful place" for others it was "devastating". For the latter it was not a comfortable place to be. There are still a number of stereotypes and a stigma the public hold about psychiatric hospitalization. As Quirk and Lelliott (2001) suggested life on psychiatric units is still a "patchy, inconsistent, and vague picture" (p. 1568).

Treatment Gains

In an effort to correct false impressions regarding mental illness and its treatment, there has been an increase in the amount of available, current, and accurate information regarding mental illness and its treatment, including where treatment occurs. The recent movement within psychiatry is to "integrate mental health services into all healthcare practices" (Thompson, 2006, p. 72) in an effort to increase community awareness of and tolerance for mental illness. This means that mental health treatment is no longer restricted to hospital settings, but is offered in different locations within the community. It also means that mental health treatment is being partnered with family medical practice and community social services. Shared care models between mental health services and general practice emphasize a patient-focused approach to treatment in a recovery-based model of care (Homer & Asher, 2005). Such a shift in focus of treatment might promote patients' mental health. Despite these recent changes in the delivery of treatment, women in this study experienced significant challenges in accessing treatment.

In describing their experience of treatment, the women in this study identified a number of coping skills they learned during their time in treatment. The women also stated that it was the combination of skills learned in treatment that lead to their progress towards recovery. Several other research studies have concluded that a comprehensive treatment approach fostering the development of multiple skills is an effective means of treatment of depression (Austin, Liberman, King, & DeRisi, 1976; Dufton & Siddique, 1994; Edwards, 1982; Howes et al., 1997; Ogrodniczuk & Piper, 2001; Pang, 1985; Piper et al., 1993). These researchers described mental health day treatments as fostering the

development of many skills for managing mental illnesses, including depression. The reviews and outcomes of day treatment programs conducted by these researchers support the finding from this study that treatment for depression should focus on the development of multiple skills.

The skills learned in treatment led the women in this study to develop further insights into the reasons underlying their depression, including the dynamics of their interpersonal relationships. The women in this study referred to gaining insights into their relationships with family members and understanding of other people's behavior. Crowe and Luty (2005) have also described the benefits of treatment that focuses on exploring interpersonal relationships. When women gain understanding of their relationships, they report moving towards recovery from depression. Some key relationships explored by women with depression include their childhood family experiences. Maynard (1993) emphasized exploring family of origin issues as a key component of a psychoeducation approach to treatment of depression in women.

Despite changes to the delivery of psychiatric care, the focus of treatment remains on helping patients resolve their underlying issues and problems. Changes have been made to the structure and focus of treatment, sometimes resulting in briefer hospital admissions and shorter periods of outpatient treatment. Such changes raise the question regarding patient satisfaction of treatment. The results from the literature review indicate that patients are mixed in their satisfaction with treatment, which suggests that not every treatment will meet the needs of all patients in all settings at all times. The findings

indicate that patients experienced challenges in accessing treatment and this is an issue that could be addressed as changes to treatment services are carried out.

The experience of patient treatment includes the experience of illness as well as the experience of recovery. Treatment for depression is a journey from illness towards recovery. Recovering from depression was seen as quite meaningful to the women in Steen's (1996) study. Steen reported that there were five key stages of depression ranging from early childhood to present-day. These stages describe the movement by people suffering from depression from painful experiences into depression and finally towards recovery as experienced by people with depression. The women in this study spoke about how their experience of treatment helped them move towards recovery by helping them gain control over their lives and their illness. Other researchers have noted that empowerment is an important aspect of coping with depression and in the recovery process (Barker 2001; 2002; Skarsater, Dencker, Bergbom, Haggstrom, & Fridlund, 2003). Skarsater et al. reported that as women changed and took responsibility for their recovery, they became empowered. The findings from several other studies indicated that gaining control over depression is a detailed process that warrants focused research (Chernomas, 1997; Peden, 1996; Schreiber, 1996; Schreiber, 2001; Steen, 1996). These researchers described the process of gaining control over depression as one aspect of recovery, and they each described recovery differently.

Findings from this study suggest that there are a number of nursing practice, education, and research implications and these will be outlined in the next chapter.

CHAPTER VI

Limitations and Implications

This chapter is divided into two sections. Limitations of the present study are presented in the first section. Implications of the study are discussed in the second section with respect to nursing practice, education, and research.

Limitations

There are some limitations associated with this study. Throughout the data analysis stage, I was challenged to separate my personal beliefs and clinical experiences from the data. As the women in this study reflected on their experience of treatment, they described specific components of their treatment programs and the staff members they encountered. I have personal knowledge and experience with some of these program components and staff members. In describing the experience as lived by the women, I continually examined the data to ensure that my interpretation was based in the data and was not influenced by my personal opinions. As I interpreted the data, I repeatedly asked myself if my interpretation reflected the women's experience or if my interpretation was influenced by my clinical knowledge of the treatment programs under study. By returning to the transcripts, I was able to reduce this potential biasing of the results.

Lipson (1991) cautions about doing research in one's own clinical area and suggests that it can be difficult to interpret qualitative data objectively when you have clinical knowledge of the findings. Lipson cautioned that in order for a researcher to separate oneself from the data, one must carefully examine one's one values to determine

if your values are influencing your interpretation of patients' experiences. She also cautioned that novice researchers do not research their own areas, and suggested that if one does do research in their area of practice that they work with a mentor. Field (1991) emphasized that graduate students may have a particular difficulty in separating themselves from the data and recommended close collaboration with committee members who can assist in carefully identifying the research question and also assist in the data analysis process. With the changes in health care administration to a more regional approach, my need to combine work and study, and the ethics requirement of having a third party help with recruitment, it was inevitable that I would have women from my clinical area. While I made every effort to separate clinical from research, it is a possible limitation.

Another limitation of this study is the breadth of scope. I studied the experience of treatment for depression by focusing on women's experience within three separate treatment programs that contained many treatment modalities. Any one of these program areas could have been studied individually. In particular the inpatient stay had less emphasis in the current study. This could have been because of the severity of the women's condition at the time of hospitalization. They may not have been able to recall details of their treatment experience as well as in later treatment programs. The findings from this study suggest that there are aspects of the experience of treatment from women with depression that could each be explored more fully if the research focus of this study had been more limited.

Implications

The results of this study have several implications for mental health nursing. These implications are described under the subheadings of nursing practice, nursing education, and nursing research.

Implications for Nursing Practice

As identified in the professional literature and in this study, safety is a primary need for women with depression. Nurses working in treatment programs for depression are responsible for meeting patients' safety needs, including physical safety during an acute stage of depression when individuals are at risk of harming themselves. At this point, treatment usually occurs on an inpatient unit. Nurses need to be aware of the need for safety experienced by women with depression. Nurses can reassure women with depression that their safety needs will be met, and explain how staff members will monitor their activities to ensure their safety. The findings from this study reinforce that it is the professional responsibility of all nurses working with people with depression to be familiar with the safety policies and guidelines implemented within each treatment program.

In addition to addressing physical safety needs, nurses can help ensure that emotional safety needs of women are met in treatment settings aimed at helping them address their thoughts and feelings behind their depression. In their communications with women with depression, nurses can discover what these women identify as their need for safety and whether these needs are being met in current treatment programs.

Emotional safety occurs when there is a strong therapeutic alliance between staff members and clients that conveys respect and understanding of the individual. Findings from the literature (Grant & Hartman, 1997) and from this study indicate the importance of a therapeutic alliance between staff members and patients. . Nurses should make the relationship between themselves and women with depression a priority. As the findings from this study indicate, a therapeutic relationship with staff enhances the treatment and recovery of women with depression. Such a therapeutic relationship provides women with depression an opportunity to work through the issues behind their depression.

In order to form therapeutic alliances with staff members, women with depression need to first be able to access treatment. When access is denied or is perceived as a complicated and confusing process, women feel frustrated. The frustration expressed repeatedly by the women in this study suggests that treatment must be more accessible. According to the women's experience, this would mean a smoother (less waiting, less staff members involved) assessment in the emergency department. Nurses could also advocate with physicians for persons who need to be admitted to hospital. Greater access to treatment might include nurses working towards increasing available services, such as more emergency services and more inpatient services. This might include long-term planning involving many levels of the health care system. Another possible strategy to increase access to treatment would be reducing wait times for treatment, as wait times were determined by the women in this study to be a barrier to treatment. This would imply reducing wait times in emergency as an initial access point for treatment, and it also implies reducing wait times for treatment programs for depression. Reducing

barriers to treatment would also mean improved communication with women seeking treatment for depression regarding available treatment options and a more efficient referral process among services.

Relationships with other persons participating in treatment for depression were also noted to be a relevant part of women's treatment for depression. Nurses can assist in creating treatment experiences that foster opportunities for individuals with depression to connect with one another. Regardless of the setting for treatment, nurses may facilitate group discussions and activities that allow clients to share experiences with one another. As indicated in the findings of this study, it was therapeutic for women with depression to learn from their discussions with others seeking treatment that they were not alone in their feelings or experiences. Nurses can play an important role in facilitating peer interactions within various treatment settings.

Implications for Nursing Education

Nursing education includes topics such as how to meet the safety needs of women with depression and how to establish therapeutic relationships with women with depression. Continuing education sessions on these topics may help nurses working in this area to maintain their skills. Such education sessions might include current research findings that nurses may implement into their practice. Education could also include current information on available treatment programs for depression, including how to access them. When nurses have this education, they can more effectively care for women with depression.

For nursing students preparing to enter practice, or for nurses new to the field of mental health, understanding the findings of this study may prepare them for working with women who have depression. The findings of the study may provide those with little experience in mental health, including students and nurses for different clinical backgrounds, with important insights on how women perceive their treatment.

Implications for Nursing Research

The frustration expressed by the women in my study suggests that further research is required on the experience of women seeking treatment for depression. Qualitative research to address this area would enhance our understanding of what it is like to seek treatment for depression. Such research may reveal what persons perceive as barriers to treatment and highlight policies and practices that may need to be changed to better meet the needs of people in need of treatment.

A more in depth, focused study on the skills and insights perceived as beneficial to recovering from depression may be useful. Qualitative research would address how people perceived the efficacy of their treatment programs, including how they developed the skills they found to be significant and how did they developed the insights into depression that were key to effective treatment. Such research may positively influence the delivery of treatment and improve treatment outcomes.

Results from the literature and from this study suggest more research is needed on how therapeutic relationships are formed between women with depression and staff. Such research might also address how therapeutic relationships are sustained, once they are established. By learning more about the effect of therapeutic relationships on women

with depression, clinicians may better utilize this relationship to help women move towards recovery.

Women with depression often experience their treatment in the presence of other clients, but we have limited knowledge of how women with depression experience their interactions with one another. Given the paucity of available literature on the meaning of patient interactions with other patients, more research is needed to explore how other people who are seeking treatment influence the treatment of women with depression.

Summary

This phenomenological study explored the experience of women being treated for depression. To date, this has been an understudied phenomenon. In order to investigate how women with depression experience their treatment, six women were recruited for this study. All women had participated in treatment in three different programs: inpatient programs, mental health day treatment programs, and mental health outpatient programs. The experience of treatment across different programs represents the total treatment experience of these women. This experience describes what it was like for these women to receive treatment for depression.

The findings of this study indicated that women found certain aspects of their treatment to be important to them. They described some of the challenges and frustrations they encountered when they initially sought treatment. Once treatment was accessed, they described feeling safe and relieved. After they engaged in treatment, they described important connections with others in their treatment programs and staff members. For these women, treatment involved gaining new insights into their depression and skills to manage their depression. Such insights and skills led women to gain a sense of control over their illness.

This study makes some important contributions to the literature. Most of the current literature on depression focuses on what depression is (including its causes) and how to treat depression. However, little research has previously been done on how women with depression experience treatment. The results from this study may increase awareness among nurses of how women with depression experience treatment and this

awareness may in turn influence nursing practice. The findings from this study also hold implications for further research and education.

This study is timely in light of current changes to the delivery of mental health care services. By understanding what it is like to receive treatment for depression, nurses and other mental health care providers may integrate this understanding into changes to services. For example, the findings from this study indicated that accessing treatment for depression is often difficult and challenging. As we continue to change how mental health care services are delivered, we can hopefully reduce these barriers to accessing treatment. In order to accomplish this objective of increasing access to treatment, a collaborative effort would need to be made involving various levels of the health care system, including funding agencies, administration, direct patient-care providers and consumers of mental health services.

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Appendix A – Consent Form

Consent Form

STUDY TITLE: Women's Experience of Treatment Programs for Depression: A Phenomenological Study

PRINCIPAL OR QUALIFIED INVESTIGATOR:
Jill Cumby R.N.,B.Sc.N.
Mental Health Day Treatment Program
3rd Floor Abby Lane Hospital
5909 Veteran's Memorial Lane
Halifax, NS
B3H 2G2
Tel. 473-2991 (work)

STUDY SPONSOR: N/A

Part A – Research Study

1. Introduction

You have been asked to take part in a research study. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

The researcher will:

- Discuss the study with you
- Answer your questions
- Keep confidential any information which could identify you personally
- Be available during the study to deal with problems and answer questions

2. What will I learn from reading this?

This form tells you what will happen, and about any inconvenience, discomfort or risk. There is also a complete description of the study.

Please read this carefully. Take as much time as you like. After you have read it, please ask questions about anything that is not clear.

3. Do I have to take part in this study?

No! It is completely up to you. Whether you take part or not is for you to decide.

If you decide not to take part in the study this will not affect your health care. If you do decide to take part, you can still change your mind and stop participating at any time.

4. Will the study help me?

There are no therapeutic benefits to taking part in this study.

Part B – Explaining the Study

5. Why am I being asked to join the study?

You have been asked to join this study because you have participated in the Mental Health Day Treatment Program as part of your treatment for depression.

6. Are there other choices?

You do not have to be in this study to receive treatment for depression. Your decision to participate or not participate in the study will not affect your current or future treatment options for depression. This study is not part of your therapy and is separate from your current treatment.

7. Why is this study being done?

Depression is a major health problem that affects many women. There are different programs for treating depression. Some programs include inpatient programs, the Mental Health Day Treatment Program, and the Mental Health Outpatient Department. There is little known about what it is like for women to attend these different treatment programs. This study will explore what it is like for women with depression to attend these programs.

8. How is the study being done?

This study involves interviews between the researcher and each participant. The purpose of the interview is to learn about each participant's experience with treatment for depression.

9. How long will I be in the study?

Each interview will take approximately 60 minutes. The second interview will be scheduled approximately one week after the first interview. The times of the interviews will be set to meet the needs of each participant.

10. Can I be taken out of the study without my consent?

Yes. The researcher may take you off the study at any time, if:

- You become extremely upset in discussing your treatment experiences.
- Your depression has become worse.
- You refuse to discuss your treatment experiences with the researcher.

11. How many people will take part in this study?

A total of six to eight women will be interviewed for this study.

12. Who can take part in this study?

The participants in this study will be women who:

1. have undergone the following treatments for depression at the Abbie Lane Hospital, Halifax, Nova Scotia, in the order listed:
    a. Hospitalization on a mental health unit
    b. Participation in the Mental Health Day Treatment Program
    c. Received follow-up treatment through the Mental Health Outpatient Department
2. have attended the Mental Health Day Treatment Program for any six-week period between January 2002 and January 2003.
3. have been diagnosed with unipolar depression.
4. are between the ages of 30 and 50 years old, regardless of ethnicity.
5. are able to read, speak and write English the language used in the programs under study. In phenomenology, the spoken word is the data. Therefore, it is important that the researcher and participants speak the same language.
6. have agreed to participate in the study.
7. are not hospitalized or attending the Mental Health Day Treatment Program at the time of the study.

13. What will happen if I take part in this study?

The researcher will interview each participant twice. Interviews will be done at a time and place agreed upon between the participant and the researcher. Locations will be chosen which will ensure privacy and freedom from interruptions during the interview. Locations will also provide for the emotional and psychological comfort of the participant. The first interview will be to find out about the participant's experience of treatment programs for depression. During the second interview, the participant will be asked to clarify the researcher's interpretation of the first

interview. This clarification will provide a more complete understanding of the experience. The interviews will be unstructured which allow each participant the opportunity to relay information she believes to be significant. The interviews will be audio recorded and transcribed.

14. Are there risks to the study?

There is risk that participants may experience emotional distress during and following the interview. This risk is identified in the consent form. The researcher will contact each participant the day following the interview in order to identify if she is experiencing emotional distress and to determine if emotional support would be beneficial.

The researcher will provide any participant who is experiencing distress with a name and telephone number of a support person, and will assist the participant in contacting the support person, if necessary. This support person will be arranged in consultation with the program coordinator of the Mental Health Day Treatment Program.

An inconvenience associated with participation is the time required of each participant. Each woman who participates in the study will be asked to consent to two interviews. The first interview is expected to take approximately 60 minutes.

15. What are my responsibilities?

Each participant is asked to participate in two interviews with the researcher. It is expected that participants in this study will cooperate with the interviews and will describe their experiences of treatment for depression.

16. Will it cost me anything?

There is no cost to participants for being part of the study. No participant will receive any money for taking part in the study. If a participant becomes distressed from participating in the study, support will be provided through the Mental Health Day Treatment Program at no cost to the participant. Whatever happens, you will always have your legal rights.

17. What about my right to privacy?

Participants will each be asked to select a pseudonym to be used in transcriptions, on audiotape labels, in field and journal notes and in presentations of the study. Tapes, transcriptions, and journal entries will be kept under lock and key at the researcher's home and will be accessible only to the researcher. Neither the names, pseudonyms nor any other identifying information will be used in reporting findings. Only the researcher will know the identity of participants. The identity of participants will not be revealed to

anyone. Interview tapes will be returned to participants (if desired) or destroyed when the study is completed.

18. What if I want to quit the study?

If you choose to participate and later decide to change your mind, you can say no and stop the research at any time. A decision to stop being in the study will not affect your current or future health care. If you withdraw from the study, any data already collected will be destroyed and will not be utilized in the study.

19. What about questions or problems?

If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution. That person is:

Jill Cumby
Tel. 473-2991

20. Declaration of Financial Interest

The researcher, Jill Cumby, has no financial and/or proprietary interest in this study.

21. What are my rights?

After you have signed this consent form you will be given a copy. In the next part you will be asked if you agree (consent) to join this study. If the answer is "yes", you will need to sign the form.

Consent Form and Signatures

I have read all the information about the this study, which is called:

Women's Experience of Treatment Programs for Depression: A Phenomenological Study

I have been given the opportunity to discuss it. All my questions have been answered. I am satisfied with the answers.

This signature on this consent form means that I agree to take part in this study.

_________________________ _________________________ ____/____/____

SIGNATURE OF PARTICIPANT NAME (PRINTED) day month year*

_________________________ _________________________ ____/____/____

WITNESS TO PARTICIPANT'S SIGNATURE NAME (PRINTED) day month year*

_________________________ _________________________ ____/____/____

SIGNATURE OF INVESTIGATOR NAME (PRINTED) day month year*

_________________________ _________________________ ____/____/____

SIGNATURE OF PERSON CONDUCTING CONSENT DISCUSSION NAME (PRINTED) day month year*

Note: Please fill in the dates personally

Appendix B – Approval Letter from Human Investigation Committee

Memorial University of Newfoundland

04/26/04 16:02 FAX 709 737 7037 MUN SCHOOL OF NURSING 002

Memorial
University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

April 19, 2004

Reference #04.28

Ms. J. Cumby
C/o Dr. S. Solberg
School of Nursing
Memorial University of Newfoundland

Dear Ms. Cumby:

This will acknowledge your correspondence dated March 10, 2004, wherein you clarify issues and provide a revised consent form for your research study entitled **"Women's experience of treatment programs for depression: A phenomenological study"**.

At the meeting held on March 4, 2004, the initial review date of this study, the Human Investigation Committee (HIC) agreed that the response and revised consent form could be reviewed by the Co-Chairs and, if found acceptable, full approval of the study be granted.

The Co-Chairs of the HIC reviewed your correspondence, approved the revised consent form and, under the direction of the Committee, granted ***full approval*** of your research study. This will be reported to the full Human Investigation Committee, for their information at the meeting scheduled for April 29,2004.

Full approval has been granted for one year.

For a hospital-based study, it is your responsibility to seek the necessary approval from the Health Care Corporation of St. John's and/or other hospital boards as appropriate.

This Research Ethics Board (the HIC) has reviewed and approved the application and consent form for the study which is to be conducted by you as the qualified investigator named above at the specified study site. This approval and the views of this Research Ethics Board have been documented in writing. In addition, please be advised that the Human Investigation Committee currently operates according to the Tri-Council Policy Statement and applicable laws and regulations.

04/26/04 16:03 FAX 709 737 7037 MUN SCHOOL OF NURSING 003

Notwithstanding the approval of the HIC, the primary responsibility for the ethical conduct of the investigation remains with you.

We wish you every success with your study.

Sincerely,

John D. Harnett, MD, FRCPC
Co-Chair
Human Investigation Committee

Richard S. Neuman, PhD
Co-Chair
Human Investigation Committee

JDH;RSN\jjm

C Dr. C. Loomis, Vice-President (Research), MUN
Mr. W. Miller, Director of Planning & Research, HCCSJ

Appendix C – Letter of Approval from the Research Ethics Board

Queen Elizabeth II Hospital

Research Ethics Board

Room 118, Center for Clinical Research
5790 University Avenue
Halifax, NS B3H 1V7
Phone: (902) 473-5726
Fax: (902) 473-5620

May 31, 2004

Ms. Jill Cumby
Mental Health Day Treatment Program
3rd Floor Abbie J. Lane Hospital
5909 Veteran's Memorial Lane

Dear Ms. Cumby: *'Full Approval'*

RE: Women's Experience of Treatment Programs for Depression: A Phenomenological Study.

REB File #: CDHA-RS/2004-107

The Board acknowledges receipt of your Letter dated May 26, 2004, along with the Revised Consent Form, dated May 26, 2004. I have reviewed your response to our concerns on behalf of the Board, and note that all issues have been addressed. I am now pleased to confirm the Board's full approval for this research submission at Capital Health. This includes approval for:

- Researcher's Checklist for Submissions
- Research Services Study Initiation Form
- Letter from Memorial University, dated April 19, 2004
- Ethics Approval Submission Form
- Consent Form, May 26, 2004
- Research Protocol
- Letter of Support, dated May 14, 2004

Approval by the Research Ethics Board is for scientific validity and ethical acceptability; it does not include any administrative considerations for the use of hospital resources. A copy of your submission has been forwarded to the Centre for Clinical Research; they will discuss any resource requirements with you.

The Board would remind you that, in accordance with ethical guidelines, once a study has been approved, the investigator assumes responsibility to submit an annual progress report on the anniversary date (May 31).

Page 2
File #: CDHA-RS/2004-107

The Board should also be made aware of any serious adverse events, changes to the initial submission, reports/interim analysis or closure of the study within 90 days of the event. Should any material be designed for advertisement or publication with a view to attracting patients, the Research Ethics Board should review it first.

Please note that all approved studies may be randomly audited. Should your research be selected for audit, the Board will advise you and indicate any other requests at that time.

The Research Ethics Board for the Capital District Health Authority complies with the Tri-Council Policy Statement, the ICH Harmonized Tripartite Guidelines: Good Clinical Practice, and Division 5 of the Food and Drug Regulations.

This letter is in lieu of the Health Canada Research Ethics Board Attestation form.

Yours very truly,

RESEARCH ETHICS BOARD

Dr. George Mawko, Ph.D, FCCPM
Co-Chair

/tji