



**RECOVERING FROM
DEPRESSION OF MIDDLE-AGED THAI WOMEN :
A GROUNDED THEORY STUDY**

ACHARAPORN SEEHERUNWONG
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**With compliments
of**

บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล

**A THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF NURSING SCIENCE
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY
2002**

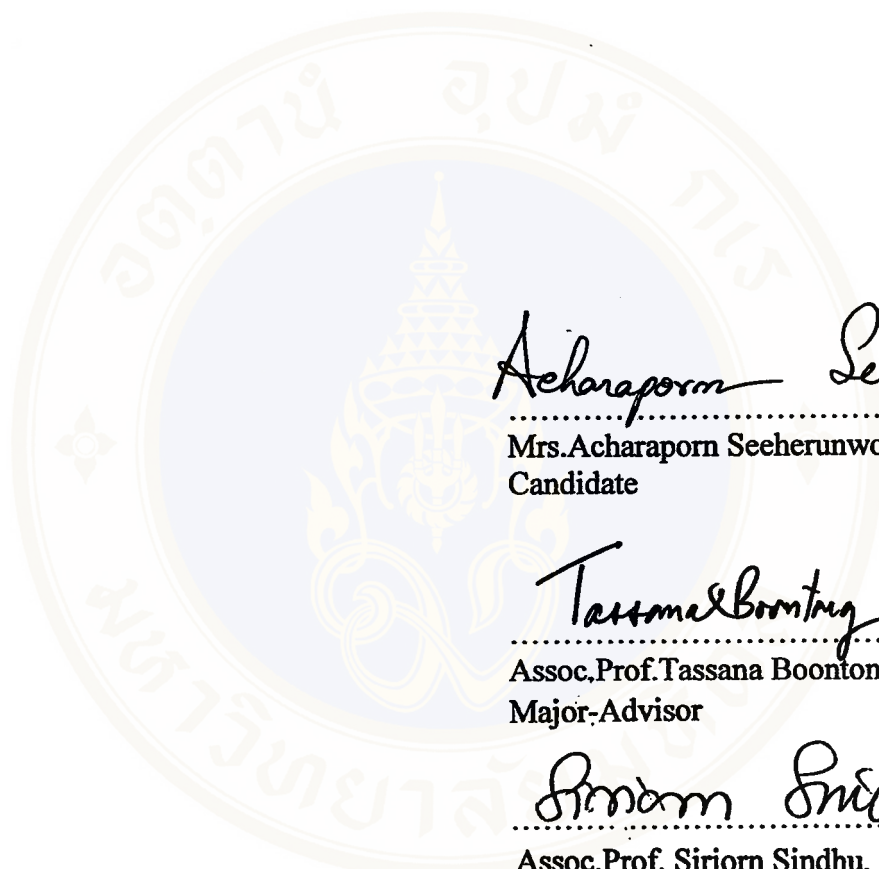
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was submitted to the Faculty of Graduate Studies, Mahidol University
for the degree of Doctor of Nursing Science

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ACKNOWLEDGEMENTS

I would like to express my deepest gratitude and appreciation to my dissertation committee. Assoc. Prof. Dr. Tassana Boontong, the chairman of the dissertation committee. She has connected me to the world of qualitative and quantitative research and gave me advice on the development of grounded theory qualitative research that is comprehensible and easy to follow for readers. Under her leadership, I could overcome various obstacles to the completion of this dissertation. I am deeply grateful to her kindness and support. Assoc. Prof. Dr. Siriorn Sindhu and Asst. Prof. Tana Nilchaikovit, M.D. dissertation committee members, encouraged and trained me to think beyond traditional perspective and has thought me to utilize existing knowledge to explain and interpret new information in various aspects. With their advice, opinion, and queries, I have learned to contemplate my idea in the development of this study and have also found their value in application to my life and work. I truly appreciate their advice and kindness. My warmest gratitude is extended to the external examiner, Assoc. Prof. Dr. Napaporn Havanon, who contributed her knowledge to improve my understanding in the grounded theory qualitative research. Her scholar feed back on this dissertation was invaluable. My gratitude also goes to Assoc. Prof. Dr. Kobkul Phanchareonworakul and Assoc Prof. Dr. Saipin Gasemgitvatana for participation in the examination and continuous help with moral support.

My special thank are also given to Assoc. Prof. Dr. Siriporn Chirawatkul who gave me detailed and precious advice on the study in middle-aged women at the beginning of this research. Dr. Wanlaya Thampanichawat and Dr Ameporn Ratinthorn who devoted their time to read the participant interview and provided me with the open coding for the earlier cases of this study in addition to suggestion for data analysis and deep explanation about qualitative research. Asst. Dr. Prapa Yuttatri who kindly read the findings of this research and provided valuable feedback along with her concern and moral support throughout the study. I am indebted to them.

I am very grateful for Assoc. Prof. Ronachai Kongsakon, M.D. and Asst. Prof. Dr. Prakob Phuviboonsook, M.D. who introduced participants to me and always gave me moral support. Thanks are also due to the nursing staff as well as other clinical staff of psychiatric division, out-patient department at Ramathibodi Hospital, Siriraj Hospital, and Chulalongkorn Hospital who greatly helped me with data collection and information.

My sincere thanks go to my doctoral classmates for their love, knowledge, encouragement and experiences they have shared with me throughout my study. My sincere appreciation also goes to all members of department of Mental Health and Psychiatric Nursing, Faculty of Nursing, Mahidol University, who always concern and support me during my study.

I am very grateful to the collaborative program, Ministry of University Affairs in providing me with financial support for my doctoral study.

I am greatly indebted to my participants who shared their secret and intense painful experiences with me. Many of them told their stories from the deepest of their heart with sincere intention to let their experience be beneficial for other women. I am profoundly grateful to them.

In particular, I would like to acknowledge my parents for their unending support and care throughout my study. Also, I received tremendous support in every aspect in my life from my husband, Mr. Paisarn Seeherunwong, and from my dearest daughter and son, Apapun and Anuntapat Seeherunwong. The love and concern from my family gave me power to accomplish this work.

Acharaporn Seeherunwong

4137118 NSNS/D : MAJOR : NURSING ; D.N.S.

KEY WORD : RECOVERING FROM DEPRESSION/ MIDDLE-AGED THAI WOMEN/ GROUNDED THEORY STUDY

ACHARAPORN SEEHERUNWONG : RECOVERING FROM DEPRESSION OF MIDDLE-AGED THAI WOMEN : A GROUNDED THEORY STUDY. THESIS ADVISORS : TASSANA BOONTONG,Ed.D., SIRIORN SINDHU,D.N.Sc., TANA NILCHAIKOVIT, M.D. 374 P. ISBN 974-04-2477-5

Although, somatic treatments can effectively decrease depressive symptoms, the opportunity of full recovery from depression in women is still limited. This study aimed to explore meaning of depression and discover how middle-aged Thai women experience and manage the problems in their lives and move from depression toward recovery. The qualitative research method of grounded theory was used. The participants consisted of 31 women who were diagnosed with major depressive disorder in the three medical school hospitals in Bangkok. Building rapport and in-depth interviews were the main methods for data collection. Constant comparison and theoretical sensitivity were the basic analysis methods.

The study findings reveal that the meanings of depression continuously changes. They can be divided into four phases. Phase I, *Before access to healthcare services*, depression is viewed as something unknown and as *jai-kho-mai-khoi-dee* (hopelessness or helplessness). Phase II, *Access to healthcare services*, depression is viewed as a disease of the insane, a disease of a loser, or as a tacit disease. Phase III, *Understanding the cause*, depression is viewed as a disease of an obsessive or stressed person or a disease of the love deprived person. Phase IV, *Recovering from depression*, depression is viewed as a part of life, a phase of life, or just as a common problem everyone undergoes. Furthermore, the substantive theory entitle "Self-Regaining from Loss of Self-worth in Depressive Middle-aged Thai women" was discovered from raw data. "Regaining One's Self" has been found to be a basic social psychological process of recovering from depression. This process consists of 3 phases—*Causal condition of depression*, *Learning about depression*, and *Recovering from depression*. The first phase explains how the women lose their self-worth until they recognize the deviance of their life. The second phase consists of three overlapping sub-phases—*Depression self-management*, *Help seeking*, and *Contemplation about my self*. Finally, the final phase involves *Untying the knot* and performing *Self-growth*.

By better understanding the meanings of depression and the process of recovering from depression, nurses and other healthcare providers can develop intervention to facilitate full recovery from depression of middle-aged Thai women. The healthcare policy and education policy can also be implicated with gender sensitivity. Future research also needs to be carried out to derive a formal theory and to expand the scope of knowledge about depression.

4137118 NSNS/D : สาขาวิชา : พยาบาลศาสตร์; พย.ด.

อัญราพร สี่หิรัญวงศ์ : การฟื้นหายจากความซึมเศร้าของสตรีไทยวัยกลางคน: การสร้างทฤษฎีจากข้อมูลพื้นฐาน (RECOVERING FROM DEPRESSION OF MIDDLE-AGED THAI WOMEN : A GROUNDED THEORY STUDY)

คณะกรรมการควบคุมวิทยานิพนธ์ : ทศนา บุญทอง, Ed.D., ศิริอร ลินทุ, D.N.Sc., ธนา นิลชัยโกวิทย์, M.D., 374 หน้า ISBN 974-04-2477-5

ถึงแม้ว่าจะมียาใหม่ๆที่มีประสิทธิภาพในการลดอาการซึมเศร้า แต่โอกาสที่สตรีจะฟื้นหายจากความซึมเศร้าอย่างสมบูรณ์เป็นไปได้ยากและมีความจำกัด การศึกษาครั้งนี้มีวัตถุประสงค์ที่จะค้นหาความหมายของความซึมเศร้า และกระบวนการฟื้นหายจากความซึมเศร้าในทัศนะของสตรีวัยกลางคนที่มีความซึมเศร้า ระเบียบวิธีวิจัยที่ใช้ในการศึกษาครั้งนี้ คือการวิจัยเชิงคุณภาพแบบการสร้างทฤษฎีจากข้อมูลพื้นฐาน ข้อมูลหลักในการวิเคราะห์ครั้งนี้ได้จากสัมภาษณ์เจาะลึกสตรีที่ได้รับการวินิจฉัยโรคซึมเศร้าชนิดรุนแรง ที่มารับบริการในโรงพยาบาลใหญ่ 3 แห่งในกรุงเทพมหานคร จำนวน 31 คน ซึ่งมีทั้งสตรีที่ยังคงมีอาการซึมเศร้าและปราศจากอาการซึมเศร้า วิเคราะห์ข้อมูลจากพื้นฐานการเปรียบเทียบข้อมูลและการตั้งคำถามอย่างมีความไวเชิงทฤษฎี

ผลการศึกษาพบว่าความหมายของความซึมเศร้ามีการเปลี่ยนแปลงอยู่ตลอดเวลาจากก่อนเข้าสู่ระบบบริการสุขภาพจนกระทั่งฟื้นหายจากความซึมเศร้าหรืออยู่กับความซึมเศร้า ซึ่งเริ่มตั้งแต่การไม่รู้ถึงความหมายของความซึมเศร้า รู้สึกว่าใจคอไม่ค่อยดี ความซึมเศร้าเป็นโรคของคนบ้า เป็นโรคของผู้แพ้ เป็นโรคที่จับต้องไม่ได้ เป็นโรคเครียด โรคคิดมาก โรคขาดรัก และสุดท้ายความซึมเศร้าเป็นส่วนหนึ่งของชีวิต เป็นช่วงหนึ่งของชีวิต และเป็นโรคที่ใครๆก็เป็นกัน และผลการศึกษาปรากฏการณ์การฟื้นหายจากความซึมเศร้าได้ทฤษฎีเชิงสาระชื่อว่า “การคืนความสำคัญให้ตนเองจากการสูญเสียความรู้สึกมีคุณค่าในตนเองของสตรีวัยกลางคนที่มีความซึมเศร้า” ทฤษฎีนี้จำแนกเป็น 3 ช่วง ช่วงแรกคือ “เงื่อนไขเชิงสาเหตุของความซึมเศร้า” เป็นช่วงที่อธิบายเงื่อนไขเชิงสาเหตุของการเกิดความซึมเศร้าในลักษณะกระบวนการประกอบด้วยการมีปฏิสัมพันธ์ระหว่างสิ่งที่เป็นศูนย์กลางแห่งชีวิตของสตรีและการประเมินตัดสินการกระทำของบุคคลที่เป็นศูนย์กลางแห่งชีวิตในทางลบ ซึ่งส่งผลให้สตรีรับรู้ว่าคุณค่าไม่มีคุณค่า จึงตอบสนองเป็นอาการซึมเศร้าจนกระทั่งสามารถระลึกถึงการเปลี่ยนแปลงในตนเองได้ ช่วงที่สอง ช่วง “การเรียนรู้เกี่ยวกับความซึมเศร้า” ประกอบด้วยมโนทัศน์ที่อธิบายกลยุทธ์ในการจัดการกับอาการซึมเศร้า 3 มโนทัศน์ที่อาจเกิดขึ้นพร้อมๆกัน หรืออาจเกิดกลยุทธ์ใดก่อนหลังขึ้นอยู่กับเงื่อนไขของแต่ละบุคคล กลยุทธ์ดังกล่าวได้แก่ การจัดการกับความซึมเศร้าด้วยตนเอง การขอความช่วยเหลือ และการไตร่ตรองตนเอง ส่วนช่วงสุดท้ายเป็นช่วง “การฟื้นหายจากความซึมเศร้า” ประกอบด้วยมโนทัศน์การคลายปมและการเติบโตในตนเอง ช่วงนี้เป็นช่วงที่สตรีสามารถฟื้นหายจากความซึมเศร้าได้อย่างสมบูรณ์โดยการคืนความสำคัญให้กับตนเองจากการที่เคยยึดถือและให้ความสำคัญกับบุคคลอื่นเสมือนเป็นศูนย์กลางแห่งชีวิต จึงทำให้รู้สึกถึงคุณค่าของตนเองและกลับกลายเป็นบุคคลใหม่ที่มีความเติบโตในตนเองและฟื้นหายจากความซึมเศร้าไปในที่สุด

การศึกษานี้ให้ข้อเสนอแนะต่อนโยบายสุขภาพและการศึกษาของชาติที่คำนึงถึงความเป็นหญิงชาย แนวทางการปฏิบัติการพยาบาลในคลินิกและในชุมชน และการวิจัยเพื่อขยายความรู้เกี่ยวกับความซึมเศร้าและการพัฒนาให้เป็นทฤษฎีที่มีการนำไปใช้อย่างแพร่หลายต่อไป

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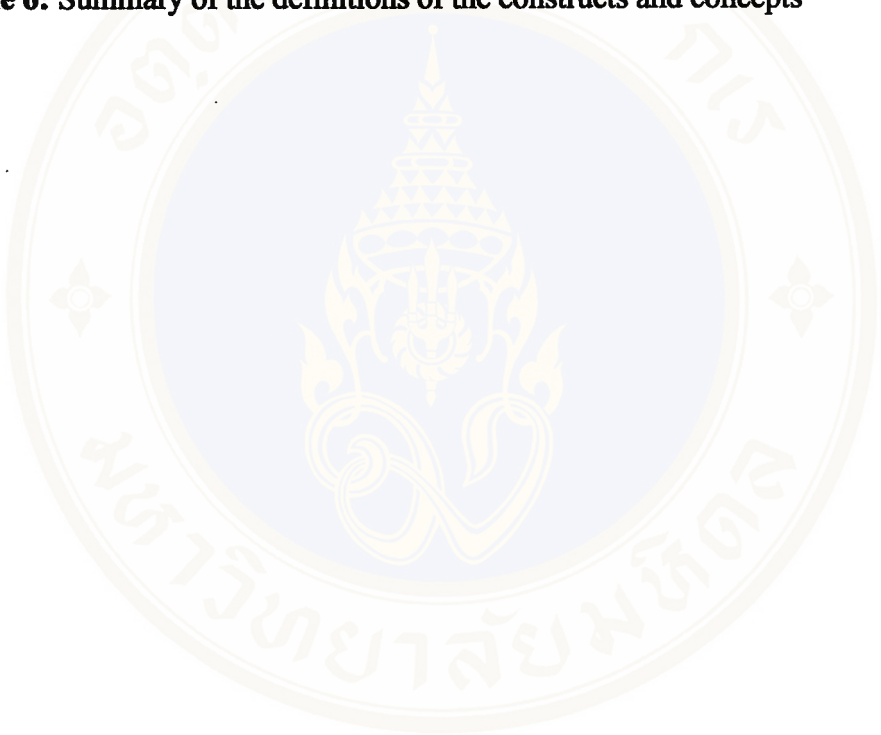
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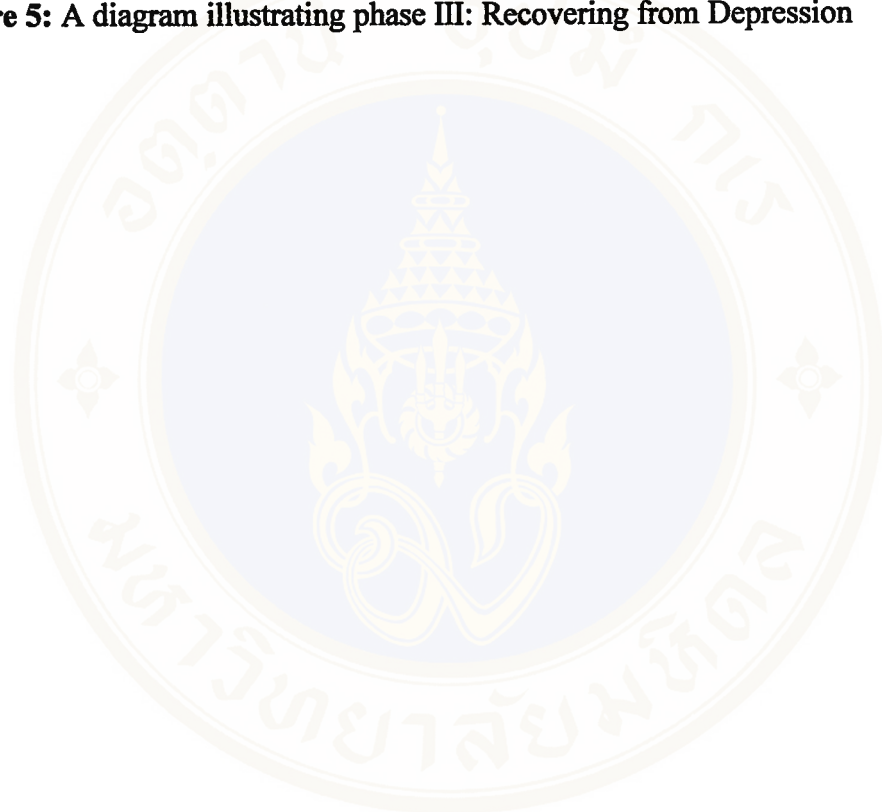
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CHAPTER I

INTRODUCTION

Background

Depression is one of the most common health problems that cause disability and mortality. It is expected to be the second most significant cause of global disease burden in 2020 (up from the 4th in 1990). Two other causes of disease burden, namely violence and self inflicted injuries, have special relevance for women's mental health (Murray & Lopez, Eds., 1996).

Women are more than twice as likely as men to experience clinical depression both in the clinic and in the community and in both developed and developing countries (Nolen-Hoeksema, 1987; Weissman & Klerman, 1977,1985; Weissman, Leaf, Holzer, Myers, & Tischler, 1984). In Thailand, the number of out-patient women in the year 1999-2000 was double the number of men, 13,152:6,254, 11,964:6,021, respectively (Mental Health Department, 1999-2000). Moreover, one in four women can expect to develop clinical depression during her lifetime. Clinical depression can occur in any women, regardless of age, race, or income. In addition, it is serious enough to lead to suicide.

In Thailand depression has been found both in rural and urban areas, especially in middle-aged women. Studies show that 38% of people have depression at

the level that requires special intervention and 25.7% have minimal deviation from the normal level (Churujiporn, 1999). In Bangkok, 21.3% of people in Bangkok have mental health disorders, 19.9% of which is considered a major depression, and 7.1% have attempted suicide. A high proportion of cases concern women (Mental Health Department., Faculty of Medicine., & Bangkok Metropolitan, 1997). Furthermore, middle-aged women are one of the most at risk for depression in a life span. It has been found that 27% of the women aged 40 years and over in Thailand suffer from depression (Sukwattana et. al., 1991). Another research result shows that 13% of middle-aged out-patient women with somatic symptoms at Rachaburi hospital were detected for depression (Jittawattanakorn & Pattanakumjorn, 1999).

Middle-aged Thai women are at high risk for depression for the following reasons. First of all, women's lives in middle-aged are in a transition state from youth to elderly. There are many simultaneously occurring changes in this age including physical, emotional and sexual changes as well as changes in professional activities, interests, values, living habits, and more. These changes contribute to life stress, and may lead to an inability to cope with them and then may affect the mental health. Secondly, many middle-aged women have accommodated stress for a long time. For example some women have responsibilities in the family from their teenage years and those in a lower class have had to struggle with chronic poverty, and they have had less opportunity for access to various resources as well. These chronic stresses for Thai women put them more at risk for depression. Thirdly, the health of middle-aged women begins to decrease continuously. Because family roles overload them with work, they often do not have time to care for themselves which leads to declining

health. Suffering from a chronic illness or a life threatening disease puts women at a greater risk of depression.

Fourthly, women at middle age often have to deal with the loss of significant persons through either death or separation. They often have to deal with the death of parents, the leaving of older children and even abandonment by a husband. The loss of support from significant others and the grief that follows often leads to depression. Finally and most importantly, middle-aged women are likely to feel that they are invaluable. For most of a woman's life the well being of the family has been her focus and her responsibility. She has worked hard and measured her success through the achievement of the family, of her husband and her children. Usually in her middle-aged, the family members that used to be dependent on her as wife and mother become independent because of the economic security and the growth of the children, respectively. Thus, middle-aged women often feel a loss of productivity that in turn leads to a loss of self-esteem. On the other hand, a woman who may not have met the expectations of her husband and children and thus experienced failure with her family responsibilities also loses self esteem which may lead her to feel devalued and result in a depressive response as well.

Middle-aged women are important to family, society and nation. Regardless of socioeconomic status, they are at the heart of the family and the young, the adolescents and the elderly depend on them. . They are also valuable resource persons of the family, society and nation because they have accumulated knowledge, skill and experience throughout their lives. This knowledge, skill and experience can be used to develop and cultivate later generations. Middle class women who work outside the

home often contribute to the management systems in their organizations. Lower class women who work outside the home make contributions to productivity in industry. As a result middle-aged women are key persons and if they suffer from depression, the impact is not only on them but the impact can affect both family and society as well.

Depressed patients manifest somatic symptoms, bodily pain, impairment of the capacity to maintain their roles as a spouse, a parent, a caregiver to the elderly, a resource provider and are unable to care for themselves. Thus, quality of life and well-being is decreased. These effects are equal to or greater than many chronic illnesses such as arthritis, diabetes, and hypertension (Wells, et al. 1989, 1992 ; Hays, et al., 1995). In turn, the relatives and children of depressed patients suffer, as demonstrated by the evidence of increased levels of stress, dysfunction, psychiatric disorder, and poorer school performance among relatives and offspring of depressed patients (Keitner & Miller, 1990). The effects of depression extend beyond the patient and his or her family into the community as well. Depressed patients have substantial difficulty functioning effectively in the workplace and school due to high levels of unemployment, underemployment, disability, and decreased work performance. Moreover, the disorder requires medical treatment which may mean high cost and prolonged treatment. The indirect costs due to functional impairments in depression are estimated at 72% of the total 43 billion dollars annual cost of depression in the United States (Greenberg, et al., 1993). Worse yet, 12% still have not recovered in five years and 50% have relapsed after recovery (Lavori, et al., 1994; Van London, et al., 1998).

However, the depressive disorder does not cause great concern in the national health policy because it is an unseen disease, so its medication and welfare are not covered. These women are not cared for despite the widespread allocation of resources. Therefore, this study focuses on the process of recovery from depression in the perspective of middle-aged women in order to prevent dramatically loss of productivity and self-inflicted injuries.

Statement of the Problem

Although health care providers try to decrease the numbers of people with depression, epidemiologic data from a number of countries demonstrates major depression is a chronic, recurrent condition. Between 15% and 20% of patients have symptoms that persist for at least 2 years, and often these patients do not fully recover from depressive episodes (Keller et al., 1982). Epidemiologic studies indicate that the likelihood of an individual who has suffered one episode of depression will experience a second episode is probably greater than 40% (Lavori, et al., 1994 ; Van London, et al, 1998). Furthermore, when a patient experiences a second episode of depression, the probability that he or she will develop a third episode is increased (Lavori, et al., 1994). Although, somatic treatment is a great success for recovery from syndromes symptoms, it is not successful for recovery from functional symptoms (Angst, 1999; Ferrier, 1999). Therefore, the results indicate a need for continued progress in developing optimal treatment strategies for full remission and to maintain long-term recovery.

In Thailand, all of the studies conducted on depression used a quantitative design. The majority of studies were conducted to satisfy thesis requirements of a master's degree. The conceptual frameworks were derived from theory generated in western culture. Risk factors of depression or factors related to depression were the most investigated. A few investigated the effect of a program on the depression of the clients. Subjects were children, adolescents and elderly, but women as a subject was overlooked. From the empirical evidence on depression, it can be divided into two groups.

Group one explored prevalence, explained related factors and predicted depression symptoms in various risk groups. These groups are elderly in homes of the aged (Chaturongsang, 1997; Sartra, 1988; Charoenkhum, 1992) and in community (Tupmanee, 1998; Foongpaisarn, 1996), postpartum women (Gerdprasert, 1999), menopausal women (Euw, 1996), adolescents both in school (Bouthgern, 1995) and in the central delinquent home (Intaburan, 1995), and children with somatic illness (Homkosol, 1995). All of these studies were not concerned with gender difference. However, recently, a study conducted on predictors of depression in Thai women found that psychosocial factors including sense of belonging, and perceived social support played a significant role in the stress process, which in turn affected the severity of depression. In addition, interpersonal conflict was found to be one of the most important predictors of severity of depression among the four types of stress-number of stressful life events, women role strains, interpersonal conflict and parental role strain-, having the greatest indirect effect on severity of depression through perceived social support and sense of belonging (Sangon, 2001).

Another group used a quasi-experimental design for studying the effectiveness of various programs in order to decrease depression symptoms. Three studies were conducted with elderly in homes for the aged (Seartapumin & Tungvorapongchai, 1999 ; Civilize, 1989 ; Tunsiri, 1992) and three studies were conducted with patients with chronic illness (Jitsuwan, 1992 ; Pattarayotin, 1991 ; Physansuthidetch, 1988). The therapeutic programs included supportive group, health education, the application of religion teaching, meditation training, and relationship group. All of the programs used in the studies had significantly decreased depressive symptoms and the depressive symptoms in the experimental groups were less than those in control groups. One study looked at the clinical response of depressive patients with 3 months of supposedly acceptable psychiatric care. The results demonstrated that income, family conflict and the history of bereavement were the predictive factors for the response to the psychiatric care. Moreover, the improvement of functioning was not statistically significant in the short term of the acute treatment (3 months) and there was a low correlation to good clinical improvement (Kongsakon, 1999).

The evidence illustrates that the extensive body of literature on the course and outcome of depression has not addressed the subjective experience of the process of recovering from depression in the Thai context. Quantitative studies that follow people during and after treatment tend to examine effective treatment in relation to their symptoms and disability of depression. They do not cover the complexity of the recovery. Therefore, it is important to find out this knowledge to add to the information about recovering from depression.

Significance of the Study

Learning from their experiences on recovering from depression will shed light on the facilitating conditions and obstacles in the recovery process. Various conditions that relate to strategies the women used to recover from depression are concerned such as meaning, value and resources toward recovering. Moreover causes, contexts, contingencies, consequences, and covariance in the process of recovering are also considered such as economic limitations, acute and chronic stressors, low education, reduced self esteem, and the effects of violence (Mullhall & Boyd, 1993). These situations often occur with women and may affect women in relapse, recurrence and those living with depression through out their lives more than men (Lewinsohn, Zeiss, & Duncan, 1989).

Understanding strategies that the client manages herself/himself toward recovery in their culture and context will be an advantage to complement the knowledge of health care providers to help clients recover from depression. Pluralistic management techniques to decrease the cost of medical treatment which corresponds with the special needs of women in Thai society is also expected to be discovered. In addition, information about the strategies will be spread to prevent depression and promote mental health in women in the country.

This study contributes new knowledge in the nursing discipline. The goal of the nursing discipline is the health and well-being of people while emphasizing holistic nursing care. Nurses are required to practice with depressive persons in all dimensions. However, in Thailand, there are no studies that focus on women with depression and deal with their healing process using a holistic approach. In addition,

no theory and research are available to guide any practice in this area. Therefore, understanding the process of recovering from depression for middle-aged women through their life experiences will contribute new knowledge that is absent in the existing knowledge in the science of nursing. The research can provide information about holistic nursing care that is congruent with context, social, and Thai culture. As a result, Grounded Theory is a suitable methodology to investigate the phenomenon.

Purpose of the Study

The purpose of the study was to generate a substantive theory that described and explained how middle-aged Thai women, diagnosed with major depressive disorder, experience and manage the problems in their lives and move from depression towards recovery. The meaning of depression along with the process of recovery was also described. Grounded theory was the methodology used for this study to generate a substantive theory. Specifically, the study's aims were as follows:

1. To explain the meaning of depression from the perspective of middle-aged Thai women who were diagnosed with major depressive disorder.
2. To discover how middle-aged Thai women experience and manage the problems in their lives and move from depression towards recovery.

CHAPTER II

EMPIRICAL AND THEORETICAL BACKGROUND

In this chapter, empirical and theoretical evidence about depression in middle-aged women is discussed, in both Thai and international contexts. Despite the scarcity of information about middle-aged women and depression in Thailand, the literature in this area that has been published in western countries may provide a body of knowledge in this area of interest. In addition, any gaps in knowledge may be revealed. Most importantly, as a grounded theory study, the literature can be used to stimulate theoretical sensitivity, to stimulate questions, to direct theoretical sampling, to be a secondary source of data, and to serve as a supplementary validation (Strauss & Corbin, 1990).

This chapter consists of five sections. These include 1) social structure of middle-aged women 2) definitions of depression 3) various perspectives related to middle-aged women with depression 4) impact of depression and 5) recovering from depression.

Social Structure of Middle - Aged Thai Women

Social and Cultural Background of Thailand

The Kingdom of Thailand is a country in Southeast Asia located on the Indochina peninsula. The country has a total population of around 60 million people

and a land area of some 500,000 square kilometers (more than 300 million rai). Thailand may still be considered to be a rural society as 86% (38 million people) of the total population lives in rural areas, while 70% of the population works as farmers whereas only 10% work in industry and 20% in trade and service areas (Sengpracha, 2001).

External influences such as spread of western influence and globalization are felt much more in urban than rural areas and so there are some differences between the two sectors of society. However, this gap is becoming narrower as a result of the development of technology and communications and through people moving to cities for work or education. The remaining distinctive characteristics of Thai society and culture can be described as follows.

Firstly, Thai society maintains the patron and client system. In the past, family background was the main criterion to distinguish between senior officer and bureaucrat groups on the one hand and common people or *Prai* groups on the other hand. Even nowadays, while there is no obvious outward sign of discrimination, this system still persists in Thai society since people are so accustomed to it. Furthermore, Thai people also socialize their children in the belief that they can become superior people through obtaining honor and convenience in their lives. As a result of this idea, Thai people prefer to have a luxurious lifestyle which inspires others to admire them, for instance, dressing in expensive clothes and showing off property and other consumer goods without consideration of their actual economic status.

Secondly, Buddhism is the national religion of Thailand. However, people are permitted to follow other religions such as Hinduism, Islam, Christianity and Taoism

and some choose to do so. According to residence registration, the majority (94%) of the total population is Buddhist. Nevertheless, they also simultaneously maintain other beliefs such as animism, Hinduism, Brahmanism and shamanism (Sengpracha, 1995). As a result of having lower levels of understanding of Buddhist ethics, therefore, most Thai people do not follow the Buddhist way of life consistently and so are unable to achieve religious ideals (Sengpracha, 2001). Nevertheless, people do follow some of the precepts of Buddhism such as, for example, making merit, respecting the elderly and maintaining good relations in society. For making and accumulating merit, Thai people believe that this activity can bring them happiness such as fortune, high ranks and titles, as well as good physical and mental health even if they might not obtain these benefits in this life but have to wait for the next life. Thus, making merit still represents a hope for the future even if tangible benefits cannot be seen at the moment and so people have a good reason to continue accumulating merit no matter what their current situation.

Lastly, Thai society is a centralized society, which has Bangkok metropolis as the center of the country. Most economic and political activities are located in Bangkok, including Government offices; registered schools and hospitals and also those institutions, which are situated in rural areas, are mostly regulated and administered from the city. As a result, many people have migrated from rural areas to Bangkok, either permanently settling there or just temporarily moving so as to use public services such as gaining access to good quality hospitals or educational institutions for their children. Currently, the government has sought to distribute power to the regions but this process is only just starting.

Social Construction of Thai Women

The culture, tradition and social values, which define Thai women's way of life, are an integration of authentic Thai culture with those of China and India through the mediation of Buddhism, Brahmanism and Hinduism. Western civilization has also been influential in some ways. Primitive Thai families may be likened to lion herds: the male lions (husbands) lived under the supervision of their wives who held complete domestic power and so males were unable to contribute to domestic life (or to any other area) without the permission of their wives. Every married woman assumed the position of "female owner of the house," no matter from which social group they derived. For a woman, the act of marriage was called "going out of her house." It was thought that this meant physically moving domicile from parents' house to husbands' house. In fact, the process was more akin to according honor to the woman who has demonstrated through getting married that she has become a mature person who could become the core pillar of the family capable of sustaining the role of principal domestic caregiver. Historically, the "male prai" or common male was eligible for military duty for the crown. During the Ayudhaya period, this service was required every other month throughout the year - six months service, therefore, every year. As a result of this system, men could not stay continuously at home and they became disconnected from the domestic routines and unable to carry out domestic duties: women therefore were reinforced in their position as the core pillar of the family and men were considered to be subordinates. The role of a father and husband in Thai culture, therefore, increasingly became that of providing a sense of peace and security for their wives and children whom they take care of from afar. While they would return whenever danger or trouble threatened their families, they were not able

to be permanently present. This is quite different from the ideal of a husband, which now prevails.

The division of responsibilities by gender described above led to a form of sexual discrimination. Historically, the realm of the government and of religion has been considered to be more important than that of the economic. Since men were prominent in the former and women in the latter through housework, agriculture and trading, the value of women's work and of women themselves was considered to be less important than that of men.

In addition, the family system further encouraged chauvinism if the man did not pay sufficient attention to the woman's needs and feelings. The family system of Thai society permitted polygamy in a way similar to that of Chinese society. However, Thai wives had the honor of having the right to their own houses. This led to the "big house, small house" system in which a second wife would have the right to her own house. By contrast, Chinese wives were required to reside in their husband's single house surrounded by his parents, cousins and other relations.

In Thai families, if the man had sexual intercourse with any woman, it meant that they established a sexual relationship too. The woman could therefore claim the right of being the man's wife and he was obliged to become her husband without equivocation. According to tradition, therefore, men had to be responsible to the women with whom they had sexual intercourse, even if the women were slaves in the man's house. Temporary sexual relations, which are prevalent today, were not then permitted. This was different from the Chinese, Indian and Western systems in which sexual intercourse did not inevitably lead to a formal sexual relationship. The western

concept of monogamy has subsequently become increasingly prevalent. In this, men who have sexual relations with other women cannot claim them to be his wives but only his mistresses (Sukpanich, 1998). Nowadays, women's and men's social values have become different from each other, with men preferring to maintain the aspiration towards polygamy while women are focused upon monogamous relationships. This has become a cause of social and mental problems for women.

The role of women aged between 40-60 years old was particularly problematic. Previously, their lives and customs were dominated by the social values which existed then and which, in some cases, still exist now. These women would often take the role of integrators of traditional and modern modes of thinking and would be responsible for mediating acceptable ideas of social change to the next generations. Clearly, this situation could give rise to some tension and conflict between the old and the new. The following section describes the influence of Thai social norms on this situation.

Social Expectation for Middle-Aged Thai Women

The middle-aged woman is required to adopt many roles, including woman, mother, wife and daughter. Each of these roles brings with it a set of expectations in terms of behavior and status and these are now described. Expectations of being a woman

Expectations of Being a Woman

In every region of Thailand, the qualifications of being a good woman are the following: 1) Preserving their virginity until marriage; 2) Having a

spouse; 3) Respecting their husbands; 4) Supporting their husbands; 5) Having valuable assets and good qualifications. These qualifications for being a good woman have all been identified and delineated by men. In other words, being considered a good woman or not depended entirely upon the woman's performance in relation to the men in her life (Kaewthep, 1992: 91) as the following describes.

Preserving Virginity Until Marriage: This qualification came from Chinese values, according to which every woman was required to preserve and cherish her virginity much more even than her life. The worth of a woman before getting married was solely related to the preservation of her virginity, which could then be offered to her husband. Thai values, by contrast, were more concerned with relationships between married women and other men. In other words, men were expressly forbidden from seducing married women (Sukpanich, 1998). Moreover, for Thai society, virginity (or chastity) concerned both single and married women. The need to preserve virginity (or maintain chastity) extended to the promulgation of regulations concerning the touching of hands (Kaewthep, 1992) and the need to avoid the embarrassment that would be caused by revealing passionate feelings towards a man (Komonsathitikul, 1991).

Having a Spouse: Society set the basic rule that a woman must get married and preferably early in her adult life. An unmarried woman risked being called an "old maid" which implied that the woman had no worth and was unable to find or unworthy of having a marriage partner. This is of course a primitive value. Most parents hoped and expected that their daughters would marry rich men and feared they would lose face if this did not occur. This fear among parents and

guardians still persists since it continues to be believed by many that the value and merit that women may command depends upon their having a suitable husband (Vasikasin and Hemaprasit, 1998). However, these days many unmarried middle-aged women have become successful in their lives, so the perception of the importance of this value was decreased to some extent.

Having Valuable Assets and Good Qualifications: Not only do women have to have beautiful faces and figures but they are also required to be well qualified in areas such as being a care-giver, kindness, modesty, calmness, sophistication and culinary skills. However, this factor has diminished in importance somewhat as women are now more often found working outside the house as men traditionally have always done (Pongpaiboon, 1992: 106-107).

The qualification of being a good woman in two area: respecting husband and supporting husband will be discussed in the topic of expectations of being a wife.

Expectations of Being a Daughter

Being a good daughter mostly entails embodying the same values required in being a good woman. However, there is a gender distinction between offspring in that it is the daughters who are expected to take care of parents, assuming domestic responsibility and completing housework as well as, in some cases, continuing with the family business (Vasikasin and Hemaprasit, 1998). More recently, being a good daughter has entailed a wider range of responsibilities since the woman is now also required to be valuable to herself, her family and society through external

labor just as men are responsible and she has less time to stay at home and fulfill her responsibilities there.

Expectations of Being a Wife

Being a good wife means not just being faithful to her husband but also agreeing with him and supporting him too. A study of the attitudes of Thai society toward women and the values expected of them (Vasikasin and Hemaprasit, 1998) found that most respondents believed that it was the duty of the wife to take care of and obey her husband.

The wife, it is held, should let her husband make the decision in all areas and should also support him in the progress of his career. Moreover she has no right to refuse whenever her husband wants to have sex with her. If the husband has an affair with another woman, it is considered to be a fault of the wife. The respondents also agreed that wife would rather accept being tortured than divorced. The result of this study confirms the situation that the husband holds power over his wife still exists in Thai society.

Expectations of Being a Mother

Society expects the mother to take the central role in taking care of her children. As a result, children tend to become much closer to their mothers than to their fathers. Should there be any problem between the parents, then the mother would mostly have to take care of her children alone (Vasikasin and Hemaprasit, 1998: 47). However, as recompense for this labor, society requires children to be grateful to their parents and to take care of them in their old age.

Basis of Evidence reveal that Thai society still determines and evaluates the behavior of women according to double standards. Society judges men and women who exhibit the same behavior in different ways. For example, if the husband is unfaithful, society will not judge that it is his fault; on the other hand, if the wife is unfaithful, society will judge it to be a serious fault. That this discrimination is embedded in the structure of society is an issue, which can be the cause of serious mental health problems for women. Depression, and the causes of depression, will be described in the next chapter.

Definitions of Depression

The concept of depression has been of interest to both practitioners and researchers from a wide variety of disciplines for many decades. It originated in Greek and Roman thought as melancholy, a long sickness that afflicted those who were solitary by nature, great students, given to much contemplation, and leading a life of contemplation rather than action. It was believed to be born under natural causes and related to black bile secrets (Burton 1621 cited in Whybrow, Akiskal, & McKinney, 1984:21). Later, Freud's paper (1917) clarified the distinctions between grief or love melancholy and melancholia such as exists in mourning: in love melancholy it is the world which has become poor and empty; in melancholia it is the ego itself (Whybrow, Akiskal, & McKinney, 1984:34). These origins reflect the current dictionary definitions of depression, which predominantly describe the concept as being related to exertion or stress.

Dictionary and encyclopedia definitions of depression can be categorized into three groups. Firstly, it means the state of being depressed or depressing (Webster & Mckenchnie, 1980,1993). Secondly, it means the act of depressing including a decrease in force, activity, amount, etc. (Webster & Mckenchnie, 1980, 1993). Thirdly, it means mood including low spirits, gloominess, dejection, and sadness (Webster & Mckenchnie, 1980,1993).

In dictionary definitions related to health, definitions of depression can also be categorized into three groups. These are a lowering or decrease of vital functioning activity (Anderson, Anderson, & Glanze, 1994 & Miller-Keane, 1992); a mood disturbance characterized by feelings of sadness, despair, and discouragement resulting from and normally proportionate to some personal loss or tragedy (Anderson, Anderson, & Glanze, 1994); and lastly, an abnormal emotional state or a morbid sadness, dejection, or melancholy, distinguished from grief, which is realistic and proportionate to a personal loss (Anderson, Anderson, & Glanze, 1994 & Miller-Keane,1992). The extension of these definitions will be presented later.

The concept of depression from the literature reviewed varies from transient mood, or a group of symptoms to an illness or disorder that has to be treated. In the past, the concept of depression was not clear and there has been some overlap between transient mood and the illness because there has been no systematic categorization. Until now there has been The Diagnostic and Statistic Manual of Mental Disorders, fourth edition (DSM IV) (American Psychiatric Association, 1999), the accepted American standard for categorical nomenclature for the purpose of defining treatments, for the creation of severity scales to stage its development, and for

predicting responses of intervention (Beeber, 1996:237). A definition is more congruent and easier for comparison with other meanings of depression. However, there are some problems because the definition or the manual cannot sharply categorize and capture the full spectrum of psychopathology in the general population and primary care settings, as well as in the specialty mental health sector (DeGruy & Pincus, 1996; cited in Pincus, Davis & McQueen, 1999). In the next section depression will be explained in terms of mood, symptoms and illness.

Depression as a Mood

As a way of feeling, depression is a synonym for sadness, grief, emptiness, loneliness, boredom, despair, helplessness, and hopelessness (Beeber, 1998a:155). For ethnographers, depression is described as a feeling state of unhappiness, sadness, hopelessness, lack of pleasure with the things of the world and with social relationships, and demoralization that may be as fleeting as a momentary nostalgia or as lasting as prolonged grieving (Kleinman & Good, 1985:3). These feeling experiences are transient moods which happen when a specific psychosocial stressor develops or on the anniversary of significant event (Abraham, 1991:529). This meaning of depression is used in Anthropology, Psychology, Sociology and Nursing.

Depression as Symptoms

As symptoms, depression is described as a wide range of behavioral symptoms such as retarded initiation of voluntary responses, sadness, suicide, lack of energy, apathy, psychomotor retardation, sleep disturbance, difficulty in concentration, lowered self-esteem and dependency. Depressive symptoms are prevalent and

associated with significant costs and disability. They are observed more in primary care and community populations than in specialty settings. Varying conceptualizations have been applied to define these conditions. These concepts include depression symptoms, sub-threshold depressive symptoms, minor depression, mixed anxiety depression, sub-threshold depressive disorder etc. With regard to definition, in several instances different symptom sets have been given the same name and different names have been given to the same symptom set. Depressive symptoms have been conceptualized as conditions that do not meet (i.e. fall below) the full descriptive criteria for a specific disorder (e.g. in major depressive disorder, having fewer than five out of nine symptoms) but meet the clinical significance criterion for DSM IV (i.e. have clinically significant distress or impairment associated with them)(Pincus, Davis & McQueen, 1999).

Depression as an Illness

As an illness or a psychiatric disorder, depression is associated with episodes of long duration, high rates of chronicity, relapse and recurrence, psychosocial and physical impairment, and high suicide rate.

Depression has been classified in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) as a Disorder of Mood that can be either bipolar or depressive. The depressive disorders include three categories of depression: 1) major depressive disorder 2) dysthymic disorder, and 3) depressive disorder not otherwise specified. For a diagnosis of major depressive disorder one of two critical features must be observed by others or reported by the client: (1) depressed mood most of the day, nearly every

day (dysphoria) or (2) loss of or markedly diminished interest or pleasure in all or almost all activities (anhedonia). One of these two criteria must be accompanied by at least four of nine other key symptoms for a period of two weeks. For a diagnosis of dysthymic disorder, a depressive mood must be presented for most of the day and accompanied by a least two of six key symptoms, for at least two years. Additionally, during the depressed mood the person never meets the criteria for major depressive disorder.

Mood disorders can be distinguished between primary and secondary psychiatric diagnoses (Abraham, Neese, & Westerman 1991:530). The primary diagnoses are those for depressive illness proper, and include the DSM IV categories of major depressive disorder, dysthymia, and bipolar disorder. Secondary diagnosis entails organic mood disorder, adjustment disorder with depressed mood (accompanied by anxiety), depressive disorder due to general medical condition, substance-induced mood disorder, and bereavement.

In this study, depression refers to major depressive disorders. Depression as a mood ranges on a continuum from mild to severe. Furthermore, etiology, symptoms, and rate and time of recovery for major depressive disorders are different from other categories of depressive disorder. Therefore, recovering from major depressive disorders is an important phenomenon to investigate.

Course of Major Depressive Disorder

Major depressive disorder is often manifested firstly during adolescence and young adulthood. The average age is late 20s, but the disorder may begin at any age.

The symptoms of major depressive disorder typically develop over days to weeks. Prodromal symptoms, including generalized anxiety, panic attacks, phobias, or depressive symptoms that do not meet the diagnostic threshold, may occur over the preceding several months. In some cases, however, major depressive disorder may develop suddenly (e.g., when associated with several psychosocial stress). The duration of major depressive episodes is also variable. Without treatment, the episode typically lasts six months or longer. Patients who remain untreated have a significantly lower probability of remaining well than treated patients (Maj et.al, 1992). Even when depression is treated, the duration of treatment may be inadequate. The outcomes of these patients are also somewhat negative. With effective treatment, patients should progress from response to remission and recovery, but these positive outcomes may be interrupted by periods of relapse and recurrence.

Various Perspectives Related to Middle-Aged Women with Depression

Depression is a common illness, and it is more common in females than in males. Understanding this gender difference may lead to an effective treatment and precise prediction of the disease. In this chapter, we will emphasize etiological explanation and management of depression in women, especially middle-aged women who exhibit either clinical depression or depressive symptoms. Empirical evidence from both quantitative and qualitative studies is included.

Biomedical Perspective

Biomedical theorists define depression as a disease. They believe the roots of depression are to be found in a genetically vulnerable nervous system and an imbalance of biochemical mechanism underlying brain function. As a result of the pervasiveness of women's greater vulnerability to depression across cultures, biological characteristics unique to women are considered the cause of the gender difference in depression. In addition, the menopause transition often occurs in middle age. Thus, two groups of hypotheses for a biological explanation of depression have been proposed, firstly, genetic vulnerability, and secondly, hormones and mood.

Genetic Vulnerability

Major depression is a familial disorder, and its familial nature [perhaps familiarity is the technical term but my understanding of it is different] mostly or entirely results from genetic influences. A meta-analysis of relevant data from primary studies of the genetic epidemiology of major depression reveals that the five familial studies of major depression provided strong and consistent evidence in support of the familial nature of major depression (Sullivan, Neale & Kendler, 2000).

Several genetic factors have been posited to explain why women are prone to depression. Hypotheses have been formulated to explore these linkages. For instance, the X-linkage hypothesis examines the transmission of affective disorder from parents to children and investigates mutant genes on the X chromosome. There is no consistent evidence to support a greater genetic predisposition to the disorder in women (Nolen-Hoeksema, 1987:271). Moreover, a recent meta-analysis study

suggests similar genetic effects on liability to major depression in males and females (Sullivan, Neale & Kendler, 2000); men and women share most but not all genetic influence for major depression (Kendler & Prescott, 1999:43).

Although the evidence shows that genetic inheritance influences the development of a major depression illness, the evidence also shows that environmental influences specific to an individual are etiologically significant (Sullivan, Neale & Kendler, 2000). Therefore, major depression is a complex disease that does not result from either genetic or environmental influences alone but rather from both.

Hormones and Mood

Another biological characteristic unique to women is the significant changes in hormonal levels related to reproductive events. It is widely believed that hormonal fluctuation strongly affects moods in women. Women are believed to be more prone to depression during the premenstrual period, the postpartum period and menopause, each of which is characterized by changes in the hormonal levels.

The menopausal transition, usually indicated by irregularity of cycles and an increasing interval between menses, is marked by a reduction in estradiol and progesterone production, and more frequent occurrence of anovulatory cycles. Following the cessation of menses, estradiol levels remain very low (Woods & Mitchell, 1996:112). There is no consistent evidence relating hormonal levels and depression. However, two hypotheses can be formulated from some empirical evidence.

The first hypothesis states that a drop in estradiol level precipitates a biochemical cascade resulting in a “blue” mood [Blue is informal and colloquial; I would use depressed]. The evidence for this hypothesis is indirect. Montgomery and Studd (1991) identified a number of these clinical trials and claimed that most data confirmed the beneficial effects of estrogen therapy on such disorders; in addition, the data provided some evidence of similar positive results in the use of progestogen therapy.

However, drawing from other researches, Ballinger (1990) claimed that depression in menopausal women did not respond to estrogen-replacement therapy, but some women might respond well to anti-depressant medication. Antidepressant drugs affect neurotransmitter functioning at synaptic level throughout the brain. Antidepressants were thought to reverse depressive symptoms by increasing the synaptic availability of two neurotransmitters, norepinephrine (NE) and serotonin (5-HT). The monoamine neurotransmitters norepinephrine and serotonin influence many behaviors such as mood, memory, sleep and appetite (Dinan 1996; Leonard 1996).

Some evidence links levels of estrogen and progesterone in women with levels of certain neurotransmitters implicated in depression. Two studies of women given estrogen and progesterone therapy noted that there was increased serotonin uptake (Cone, Davis & Coy, 1981; Ladisich, 1977 cited in Nolen-Hoeksema, 1987: 269). In some studies, declines in estrogen and progesterone levels were also associated with increases in the activity of monoamine oxidase (MAO; Grant & Pryse-Davies, 1968; Janowsky et al., 1971 cited in Nolen-Hoeksema, 1987:269) Monoamine oxidase facilitates the breakdown of norepinephrine, and, consequently, norepinephrine

depletion is associated with depression (J.W. Mass, 1975 cited in Nolen-Hoeksema, 1987:269)

Although, there appears to be considerable evidence about neurotransmitter mediated reductions in estradiol and a depressed mood in women, there are many studies that do not support this explanation (Janowsky & Rausch, 1985; Rubinow & Roy-Byrne, 1984 cited in Nolen-Hoeksema, 1987:269) Thus, whether or not depressive symptoms are a result of lowered estradiol has been argued. In addition, biological evidence that supports explanations linking mood and hormones is not clear.

The second hypothesis links reduction in estradiol levels to vasomotor symptoms such as hot flashes and sleep disturbances that, in turn, produce depressive moods. A study revealed that the effect of menopausal transition was indirect and mediated through menopausal symptoms of hot flashes, night sweats, and menstrual disturbances (McKinlay, Brambilla, & Posner, 1992). These symptoms generally progressed during the perimenopausal period and were more noticeable among women who had a longer transition to menopause (McKinlay, Brambilla, & Posner, 1992). The Seattle Midlife Women's Health Study revealed that vasomotor symptoms were more prevalent among women with emerging, consisting, and resolving depression than among women with absence of depressed mood on data from Years One and Two. Moreover, women with consistent depressed mood in Years One and Two revealed greater severity of vasomotor symptoms than women with resolving depressed mood in Year Two (Wood & Mitchell, 1996). However, when considered in the context of other factors in the everyday lives of midlife women, menopausal phenomena may

have less influence (Wood & Mitchell, 1997; Avis et al, 1994; Kaufert, Gilbert, & Tate, 1992; Matthews, et al, 1990).

In Thai midlife women, linkage between severity of menopausal symptoms and depressed mood is inconsistent. A study in the outpatients' clinic at Ratchaburi Hospital showed a significant association between depression and the severity of menopausal symptoms. A high severity of symptoms was found in midlife women with moderate and major depression at 20 and 23.3% respectively (Jittawatanakorn & Pattanakumjorn, 1999). In contrast, no association between menopausal symptoms and depressed symptoms in midlife clients was found in a study at the menopausal clinic at Chulalongkorn Hospital (Euw, 1996). It is hypothesized that stress may change catecholamine levels and estrogen hormones and, in turn, produce vasomotor symptoms (Ballinger, 1990).

Psychodynamic and Psychoanalysis Perspective

This group of theorists believe [I think you need to say at this point who the theorists are; or "A group of theorists believe"] that the intrapsychic, dynamic nature of women [not quite sure what you mean by this] leads to the development of depressive phenomena. Their studies emphasized the significance of personal experience. Depressive symptoms as a result of aggressive impulses turned against the self (Abraham, 1911 cited in Whybrow, Akiskal, & McKinney, 1984), objected [objective? object?] loss derived from separation or disruption of an attachment, and loss of self-esteem derived from a sense of helplessness or lack of control in attaining one's desires.

According to anger-turned inward theory, depression is viewed as an inward turning of aggressive instinct, instead of the anger being directed at the appropriate object. It is accompanied by feelings of guilt. The process is initiated by the loss of an ambivalently loved object that the person both loves and is angry at, but is unable to express anger towards. This theory is popular although it has not been substantiated. Women are often angry about the injustices of their life situations. They are angry because of their enforced powerlessness and the imposed prohibitions against expressing that anger. Women are not supposed to become angry; they are only allowed to become ill or depressed.

Regarding object loss theory, Bowlby (1960 cited in Whybrow, Akiskal, & McKinney, 1984) has the most extensive and complete exposition of the object-loss model. He postulated that the early attachment bond served as a prototype for all subsequent bonds with other people and with the world at large. The adult predisposition to depression is held to be directly related to whether early separation from important loved ones was successfully managed. Hence, nurturing infants with a secure attachment to significant others and providing social support can prevent the progression of psychopathology that leads to clinical depression. Later, this model is used to study the linkage between life events and the onset of illness. Despite considerable methodological problems, this literature offers convincing evidence that the onset of a variety of medical and psychiatric disorders is frequently preceded by certain types of life events. The events that lead to separation, which top the list of the Holmes-Rahe life inventory are events such as bereavement, divorce, and loss of a love relationship. This theory is used to make women feel guilty about leaving their children, to make mothers feel responsible for the psychological welfare of their

children, and to rationalize why women should 'stay home' with young children. In fact, it has been found that consistent nurturing by anyone during a loss period prevents later problems (Murphy, 1985). From the literature, women who experienced loss during childhood had a greater likelihood of developing depression as adults (Sadowski, et al., 1999). However, some factors resulting from loss during childhood such as poverty and psychological conflicts were not analyzed. In addition, menopause may induce some women who previously had negative concepts about the consequences of menstrual cessation to worry about future losses such as the loss of family role as a mother and physical loss (e.g. wrinkle). Evidence of a dysfunctional attachment style has been shown in a cross-sectional research which found that the severity of depressive symptomatology in women was associated with fear of loss of the attachment relationship, intense proximity seeking and lack of use of the attachment figure (West, et al., 1999).

Later, Bibring (1950 cited in Whybrow, Akiskal, & McKinney, 1984) and Jacobson (1945 cited in Whybrow, Akiskal, & McKinney, 1984) both emphasized the loss of self-esteem as central to understanding the intrapsychic mechanism of clinical depression. Bibring - expanding traditional psychoanalytic theory - viewed depression as a result of fixation of psychological development from which traumatic childhood experience. This experience lead to the frustration of any narcissistic aspiration that could precipitate a loss of self-esteem and the associated depressive mood. Bibring placed great emphasis upon depression as a disorder of the ego itself, rather than the conflict between the ego and the superego. According to Jacobson, anything that interferes during the child's development with the distinction between the self-representation and the object-representation (individuals and objects outside the

person), and identification with love objects leads to a very unstable and poorly integrated superego. This latter may then assume excessive control over the day-to-day functions of the ego and the individual's behavior. Superego dominance, reflected as a need for order and control, has been described as a characteristic of many pre-depressive personalities. Loss of control, withdrawal of love, the falling short of a goal that is predetermined by the ego ideal, then all become capable of generating a rapid and profound lowering of self-esteem, the consequence of which is the depressive illness. These two theories of Bibring and Jacobson explain how depressive illness might originate from both traumatic childhood experience and the intrinsic character of women.

Psychoanalytic and psychodynamic perspectives have some limitations in explanations of depression in women because these theories do not consider other aspects affecting women. These perspectives explain the occurrence of depression based on patriarchal perspective which reflects the perfectly of men and the weakness of women. They provide limited role and opportunity of women and tendency to pick up psychological illness in women. Therefore, most females would have depressive disorders according to these theories.

Cognitive Behavioral Perspective

Cognitive behavioral theorists believe that environment, cognition and behaviors of people reciprocally interact. They emphasized on interpreting situations and events and one's ability to change the interpretative. The philosophical underpinning is that 'we cannot know things in themselves. We only know our interpretations of events and of ourselves' (Blackburn, Davidson, & Kendell, 1990:17).



These beliefs and values have led cognitive behaviorist to investigate and to propose the hypotheses of a depression phenomenon. They have advanced hypotheses that attribute a causal role to cognition in the etiology of depression, but they differentiate the specific nature of the cognitions which are assumed to lead to depression. These include Lewinsohn's Behavioral explanation (1974), Beck's Cognitive model (1967,1984), Rehm's Self control theory (1977), Seligman's learnt helplessness model (1974,1975) and Abrasom's Hopelessness model (1989).

From a behaviorist point of view, they defined depression as a weakening of behavior. Depression results when a woman is no longer in a position where she receives frequent positive reinforcement. This deficit of positive reinforcement most likely corresponds to a reduction in social activity and/or social contact (Lewinshon cited in Gordon & Ledray, 1986:29). Another hypothesis is that a high rate of punishing experience in women also causes depression. Punishing events are particularly important for depression. They fall into three clusters: marital discord, work hassles, and receiving negative reactions from others (Lewinsohn & Amenson, 1978 cited in Rosenbaum, Frank & Jaffe (Eds.) 1983; 157).

Consistent with this explanation, the gender role stereotyping in our culture limits women from social interactions. These include cessation from work and becoming a homemaker, lack of social activities because of family responsibility, socioeconomic problems, divorce and deception of spouses, family problems, limited role in work situations, stress at work and limited access to resources. These factors aggravate depression in women.

According to Beck's cognitive model of depression (1967, 1976, 1984), depressive patients showed dysfunctions in the processing of information, which led to or maintained depressed effect and behavior. In the processing of information, three classes of cognitive variables intervene between stimuli (events) and responses (mood and behavior). These are schemata, cognitive processes and content of thoughts. Depressed individuals show negative biases at all three levels of thinking. (Blackburn, et. al., 1995:20)

Schemata are stable knowledge structures that represent all of an individual's knowledge about him/herself and his/her world. They are made up of beliefs about other people, oneself and the world in general. Some of the typical schemata (cognitive structures), which have been elicited from depressed patients in the course of therapy or from questionnaires, are: "I must be loved by everybody"; "Either I am 100% successful or I am a total flop"; "My value as a person depends on what others think of me."

Cognitive processes refer to the rules, which are applied to stimuli in information processing. Perceptions, thoughts, mental images, associated memories are end products or cognitive products after stimuli have been transformed through cognitive processes. Distortions or errors in cognitive processing maintain the negative bias in the content of thought. Five types of generic errors have been identified, as characteristic of information processing in depression: selective abstraction, arbitrary inference, over-generalization, magnification and minimization, and personalization.

Content of thought in depressive patients is defined in terms of negative view of self, negative view of the world and negative view of the future. Negative view of

self implies that he/she uses a number of self-derogatory terms when describing him/herself. For instance, he/she is lazy, cowardly, unworthy, dishonest, incapable, stupid, etc. Negative view of the world implies that he/she sees his life situation or his/her world as generally unsatisfactory, frustrating and unrewarding. He/she also sees his/her problems as insurmountable and inescapable. Negative view of the future implies that when he/she looks ahead into the future, he/she sees all his/her current difficulties as continuing forever and as getting worse. He/she feels hopeless and helpless as he/she lacks the ability to make necessary changes.

Rhem (1977) has developed a self-control theory of depression in which negative self-evaluations and low rates of self-reinforcement and high rates of self-punishment are seen as leading to the low rates of behavior that characterize depressed individuals. Three processes are postulated to be important in self-control: self-monitoring, self-evaluation, and self-reinforcement. Rehm suggested that depressed persons attend selectively to negative events, that they set stringent criteria for self-evaluation, and that the self-reinforcement of depressives was characterized by low rates of self-reward and high rates of self-punishment. Other self-control theories of depression have also been proposed and reviewed by Rosenbaum and Merbaum (1981 cited in Rosenbaum, Frank, & Jaffe, 1983:158).

Working from an experimental paradigm developed initially with dogs and other animals. Seligman (1974, 1975) proposed a theory of human depression, the central tenet of which concerned the effect of the independence of behavior and outcomes. Learned helplessness is a laboratory phenomenon observed when dogs are exposed to uncontrollable trauma. The main psychological phenomena of learned

helplessness are: (1) passivity; (2) retarded learning; (3) lack of aggressiveness and competitiveness; (4) weight loss and under-eating. The critical antecedent for learned helplessness is not trauma per se but is rather lack of control over trauma. Depressed individuals are presumed to be in situations in which responding and reinforcement are independent. Recovery of this belief that responding produces reinforcement is the critical attitudinal change theorized to cure depression. Responding to criticisms, Seligman (Abramson, Seligman, & Teasdale, 1978) has proposed a reformulation of the learned helplessness theory by incorporating extensions from attribution theory (Weiner et al., 1971). The revised theory suggests that the attributions the individual makes for the perceived non-contingency between his/her acts and outcomes are the source of subsequent expectations for future non-contingency. Dimensions of attributions argued to be particularly relevant to learned helplessness and depression include: internality/externality, generality/specificity, and stability/instability. It is hypothesized that a person is more likely to be depressed, if his or her attributions for failure and lack of control are internal (it's my fault), global (I'm incompetent), and stable (I'm always be like that), while his/her attributions for successes are external (I was lucky) specific (in this particular situation), and unstable (just this time).

Abramson, Alloy, & Metalsky (1989) revised the reformulated theory of helplessness and depression (Abramson, Seligman, and Teasdale, 1978) and called it the *hopelessness theory of depression*. They hypothesized that hopelessness is a proximal sufficient cause and is not included as one of the symptoms of hopelessness depression. The hopelessness depression is a subtype of the depressive disorders, which were proposed in this theory. Hopelessness is viewed as a final common pathway for all of the remaining causes in the theory; thus, attribution styles and other

proposed etiological factors are posited to contribute to depressive symptoms through the operation of hopelessness. In addition, hopelessness is defined as an expectation that highly desired outcomes will not occur or that highly aversive outcomes will occur and that nothing is going to change this situation for the better.

The route to depression was explained by cognitive theorists who proposed that depression was a result of inhibition of adjustment. When women cannot control their environment and have less interaction with the environment, they become depressed. The depressed persons interpret everything as inadequate and they view themselves as a failure person. Depressive symptoms are more likely to occur with the situation that the women are punished or blamed. Therefore, Three groups of women have more depression than others; those with marital discord, those with work hassles and those who receive negative reactions from others. In women lives, they face with repeated failures in their lives which cause the feeling of uselessness and loss of sense of self-value. In addition, in stress situations, these women have limitations of adjustment because of specific nurturing that leads to internalizing the female stereotype. Therefore, treatment of depression in women should reconsider.

Cognitive behaviorists view thinking and interpretative processes that are in almost half of people in the world, i.e. women, as a dependent and powerless person. These women have been socialized to be dependent on others and uncontrollable the environment. In addition, they are targets of punishment from their society. However, cognitive theorists ignored why these people have become powerless. Does not gender discrimination lead to the socializing process and determine the female role as

dependent and powerless. Moreover, it contributes to the way a woman views herself, her present and her future in negative way and, finally, makes her feel despair.

Gender role Perspective

Gender roles are socially constructed. The term 'sex' refers to the biological differences between women and men. The term 'gender', in contrast, refers to those characteristics of women and men that are socially and culturally determined - that is, the different behavior, roles, expectations, and responsibilities all women and men learn in the context of their own societies. Because societies are different, and because every society develops and changes in its practices and norms over the course of time, gender roles and relations are not fixed and universal. They differ in different places and in every society they change over time. (WHO, 2000a)

In almost the entire world, the role of females has been determined through patriarchal society. This affects female psychological health worldwide. Evidence drawn from some societies where females have an equal role with males shows no gender difference in the incidence of depression (Egeland & Hostetter, 1983 cited in Nolen-Hoeksema, 1987:272).

The role of females as providers of nurturance and emotional support to others gives them fewer opportunities for social activities and for earning an income. They are taught to play the roles of mother and wife. When they get older, they lose these roles or become limited in them. As a result, they feel less useful and less successful, and are induced to have the kind of depression called "The empty nest syndrome" (Oliver, 1977 cited in Gordon & Linda, 1985). On the other hand, for

middle-aged women who have responsibilities to their husbands, to parents that are ill and to their grandchildren, the risk of depression increases. Moreover, this work is not considered to be as important as work outside the home, which provides household income. The feeling of devaluation causes additional risk of depression.

Depression in women is not only affected by biological factors but also by gender role, resources, perception and environment.

Socio-Cultural Perspective

For sociologists, depression is defined as a common mental health disorder. The cause of depression is outside the individual and shaped by society. They emphasize the role of environmental and social factors related to well being and depression. Both objective measures of rank and subjective correlations of events related to subordinate status or lower rank have been used to explain depression phenomena in women.

Numerous studies have revealed the relationship between various objective measures of rank and the increased likelihood of depression and anxiety. Low educational status, unemployment or low employment status, homelessness and insecure housing tenure, inadequate income and poor social support including unsatisfactory interactions with neighbors and relatives have all been found to be associated with increased rates of depression and anxiety and they often interact with one another in reciprocal relations (Goldberg et al., 1990; Belle, 1990; Pill, Peters & Robling, 1993; Ustin & Sartorius, 1995 cited in WHO, 2000 b: 42).

Subjective experiences, severe events and life difficulties have an overwhelming etiological significance in the development of depression in women. A recent study reported that 85% of women from the community who developed 'caseness' for depression in the two years study period experienced a severe event in the six months before onset (Brown, Harris & Hepworth, 1995). For depression to occur, they have documented that the severe event or events will be accompanied by provoking agents such as important losses and disappointments and vulnerability factors such as a non-confiding marriage, especially when associated with low self-esteem and inadequate support. A matching of the nature of a current severe event with a pronounced ongoing difficulty has also been found to be critical (Brown, Andrews & Harris, 1986; Brown, Bifulco & Andrews, 1990; Brown, 1998).

Another subjective experience that is linked to depression is a sense of loss and defeat, especially that characterized by entrapment, and humiliation denoting devaluation and marginalisation (Gilbert, 1992; Craig, 1996; Allan & Gilbert, 1997; Gilbert & Allan, 1998 cited in WHO, 2000 b: 37). A study, testing predictions of the social rank theory of depression, found that entrapment and defeat added substantially to the explained variance of depression after controlling for the other social rank variables (Gilbert & Allan, 1998).

For anthropologists, depression is viewed not only as mood but also as the symptoms of depressive illness (Kleinman & Good, 1985:3). They are interested in the meaning of depression in cross-cultural contexts, how members of other societies experience what we call depressive emotion and depressive illness, and how difference in cultural meanings significantly alters the experience of depressed mood and the

symptoms of depressive illness. A methodology is used to explore phenomena, based on interpretation of individual cases and careful translation across cases to make controlled comparisons. The knowledge is different from the previous perspectives.

Much evidence from this field concludes that culture constructs emotion and depressive illness experiences. The way people experience emotions, in the symptomatology, and structure of the types of depression they experience in society interacts with the expressive system (Schieffelin, 1985: 127)

The meaning and form of expression, of 'dysphoria' - sadness, hopelessness, unhappiness, and lack of pleasure with the things of the world and with social relationships - are dramatically different in different societies. For Buddhists, taking pleasure from the things of the world and social relationships is the basis of all suffering; a willful dysphoria is thus the first step on the road to salvation (Obeyesekere, 1985: 134). For Shi'ite Muslims in Iran, grief is a religious experience, associated with recognition of the tragic consequences of living justly in an unjust world; the ability to experience dysphoria fully is thus a marker of depth of person and understanding (Good, Good & Moradi, 1985:387). Some societies, such as the Kaluli of Papua New Guinea, value full and dramatic expression of sadness and grieving (Schieffelin 1985:107-183); Balinese and Thai-Lao, in contrast, "smooth out" emotional highs and lows to preserve a pure, refined, and smooth interior self. Members of such societies vary not only in how they express dysphoric emotion; they seem to experience forms of emotion that are not part of the repertoire of others (Kleinman & Good, 1985:3).

Regarding symptomatology, western patients experience depressive syndromes through psychological factors (e.g. feelings of sadness, hopelessness, worthlessness) whereas with non-western patients the emphasis is primarily on somatic symptomatology (e.g. vague aches and pains, stomach malaise, insomnia, loss of vitality) (Schieffelin, 1985:101). In addition, these differences in symptom patterns often appear so striking that they could virtually represent different disorders (Marsella 1979:27 cited in Schieffelin, 1985:101). The matter is further complicated by the fact that many cultures, such as China, (Kleinman, 1980) classify symptoms of depression in a different way from the West. Thus, specific therapeutic approaches or professional management that is appropriate to people of particular cultures is necessary for depressive illness (Schieffelin, 1985: 123).

Thai society is the summation of many cultures, which have their own details. Hence, the definition of depression varies. However, depression is a psychological illness that ranges from mild to severe, from simple unhappiness to insanity. Depression may be categorized into three groups. First, supernatural forces, which is caused by ghosts or spirits as a result of improper behavior of people or of bad luck. Second, preternatural forces, which can hardly be explained by any reasons. This includes a variety of sorceries. Finally, imbalance of substances in the body which is caused by genetics or the unexpected loss of a lover (Mesub, 1989).

These meanings and patterns of beliefs lead people to different strategies for treatment of depression. The first group considers hospital as the last choice, and always initially seeks a miracle worker. The third group do not consider depression as an illness, but as the product of nature. Therefore, they do not go for treatment but let

the condition resolve spontaneously (Mesub, 1989). The idea that depression is a symptom of insanity makes them feel embarrassed and causes delays in seeking treatment.

Middle-aged females in Thailand are affected by a culture that teaches them to control their emotional expression and have tight relationships to their family. During their middle age, some situations can cause instability in relationships to their family such as the death of parents or a husband or their children leaving to start new families. Menopause is considered in Thai society as a natural change in body substance. Hence, depression in this age group may be viewed as a natural phenomenon. However, the constant influence of western culture, which affects mainly the people of Bangkok may modify their experience of and response to depression.

Nursing Perspective

The nursing perspective emphasizes contributing knowledge for practice and providing holistic nursing care. The nursing perspective views depression as a health problem and develops strategies to manage the problem. Descriptive severity continua that describe clinical phenomena associated with shifts from mild to severe forms of depression have been developed (Swanson, 1978; Beeber, 1980; Kerr, 1987 cited in Beeber, 1996:238). These are useful in managing acutely depressed persons, particularly in predicting suicidal attempts and in assessing responses to interventions (Beeber, 1996:238).

In addition, depression has been described from the nursing perspective as a mood, a psychiatric disorder and a health problem (Beeber, 1998a :155). As a mood, in Peplau's interpersonal theory, depression is described as a transient feeling; the nurse investigates this expression by a client in order to understand what it means to the person (Beeber, 1998a :155). The International Classification of Nursing Practice (ICPN) defined depression as nursing phenomena pertaining to emotion with the following specific characteristics: feeling of severe sadness, low mood and lethargy (ICPN, 1996: 50). Hauenstein (1996a, 1996b & 1997) has developed a treatment program for rural women with major depressive disorders. Recently, Beeber (1998a : 156) developed a theoretical model of self, relations, transitions, and health. She has defined depression as a health problem that presents as a group of depressive symptoms and phenomena that affect well being and quality of life. She believes that this definition brings it into the scope of nursing practice and legitimizes the care of people who are suffering from depressive symptoms. This model can explain why some people who do not meet the medical guidelines for formal diagnosis and treatment and clients who are ill or terminal or who have cultural or religious reasons do not accept the standard treatment. Moreover, nurses can intervene before symptoms have met the necessary criteria, without which psychotherapy or medication is not possible. This might occur with a client who is ill or terminal or who has cultural or religious reasons for not accepting standard treatment.

Varied methodologies are used to study depressive illness phenomena in women. Both empirical and interpretative paradigms are used to understand, explain, and predict the phenomena. Moreover, the nursing perspective is concerned with the gender difference (Meleis, 1997).

Regarding middle-aged women, a study identified them as having: feelings of helplessness while meeting demands of today's society, anger in relation to dependency on husbands, fear of failure as mothers, pressures and burdens related to caring for elderly parents and feelings of loneliness and isolation (Gordon, 1982).

Evidence supports the need for clinicians to look beyond menopausal status to the broader context of midlife women's lives. A feminist study, a multidimensional model of depressed mood experienced by Seattle women during midlife, found that stressful life context and poor health influence midlife depression. The effect of menopausal changes and vasomotor symptoms were not significant. The negative socialization of midlife and poor health status contributed to the onset of depressed mood through its influence on how women perceive midlife women (Wood & Mitchell, 1997). Furthermore, Wood and Mitchell (1996) revealed that four patterns of depressed mood in Seattle midlife—consistent, emerging, resolving depressed mood, and absence of depressed mood—were related to stressful life context, past/present health status, and social learning about midlife. Menopausal status did not differentiate women with patterns of depressed mood from those without depressed mood. Women who were recovering from depression had more social support, less life stress, greater family resources and better health status, were more likely to be employed, had a less frequent history of premenstrual syndrome, or postpartum blues and were socialized more positively about midlife and menopause than those with consistently depressed mood.

Another feminist phenomenological study revealed that depression, for middle-aged women recovering from clinical depression, was an existential means of

surviving through a stressful and often impoverished childhood and early adulthood until as older adults the women could learn more effective ways of coping with life. Five phases in the recovery process were existential alienation/pain, crises of adulthood, the first turning point, the second turning point, and becoming a gardener. A garden as a metaphor can be a useful tool in enabling a woman to visualize her potential move toward wellness (Steen, 1996).

Moreover, growth-support intervention of the treatment of mild depression in women of middle years was developed to ameliorate specific societal problems. The fourteen group sessions used a holistic health approach that incorporated concepts from cognitive-behavior-affective models. The effect was significant in reducing depression as measured by the significant others, but on the self-report form was not significant. Possibly the depressed women may be good at masking the effects and symptoms of depression to those around them and the sample size was too small ($n=10$) (Gordon & Ledray, 1986).

The nursing perspective views depression as a continuous health problem that needs holistic nursing care for reduction and prevention. The nursing discipline has been influenced by multiple paradigms that have emerged. Thus varied theories and methodologies have been derived to guide researches and practices. The present study is being undertaken to contribute knowledge in nursing science. Philosophy in the nursing discipline directs the investigation of recovery from depression for middle-aged women by concerning itself with their experience, with the empowerment of women and with promoting social change by looking at new ways of knowing and being for women.

Impact of Depression

Several pieces of evidence related to the course and outcomes of depressive patients showed that they have suffered from a number of functional limitations including poorer physical, psychosocial and role function, and an increased number of disability days (Well et al., 1989, Broadhead, et al., 1990, Bennett et. al., 2000, Judd et.al., 2000). Three studies reported that even a few depressive symptoms (Subthreshold), below the diagnostic threshold for mild depression, dysthymia, or major depressive disorder, are associated with a small but significant increase in psychosocial disability compared with months when the same patients are asymptomatic (Judd, et al., 1994; Judd, et al., 1996 & Judd, et al., 1997). The first longitudinal study confirmed previous studies. The study investigated the degree of psychosocial disability in the same patients while they were experiencing three different level of depressive symptom severity (Subthreshold, mild depression, and major depressive disorder) and the asymptomatic status during the long-term course of unipolar major depressive disorder. The result found that disability varies directly with the level of depressive symptom severity during the course of illness and disability is state dependent - when depressive symptoms are present, disability is present; when the same patients are asymptomatic, disability decreases significantly and psychosocial function is good or very good. Moreover, the result showed that psychosocial disability associated with unipolar major depressive disorder is pervasive and chronic, affecting most areas of everyday function (Judd et.al., 2000). Consistently, a finding of acute treatment with either sertraline or imipramine showed that the level of psychosocial functioning in most areas of patients with double depression or chronic major depression who reached full symptomatic response

(remission) equaled those of community samples. However, in a five-year study it was reported that approximately half of the subjects with major depression recovered within the first six months. Subsequently, the annual rate of recovery declined markedly during a follow up at five years years. For the patients still depressed, the likelihood of recovery within the next month declined by 1% to 2% per month during years three, four and five of the follow up. 12% of the subjects still had not recovered after five years (Keller, et al., 1992). In addition, during follow-up periods of 10 to 20 years or more, up to 12% of patients were rehospitalized for depression, 11% to 34% experienced a poor outcome, and suicide was common (Lee and Murray, 1998; Kiloh et al, 1988; Thornicroft and Sartorius, 1993; Surtees and Barkley, 1994 and Angst and Preisig, 1995 cited in Angst, 1999:6). Therefore, disability caused by depression can impact on individual psychosocial functioning and well being, family functioning and well being, and societal cost during an acute depressive episode and chronicity.

Impact on Individual Psychosocial Functioning and Well being

Patients with either current depressive disorders or depressive symptoms are uniquely associated with limitations in well being and functioning that were equal to or greater than those of chronic general medical conditions such as diabetes and arthritis and hypertension (Well et al., 1989). Moreover, at the end of the second year, these limitations were similar to or worse than those attributed to chronic medical illnesses (Hays et al., 1995). Importantly, patients with chronic medical conditions and depression have greater bodily pain and functioning impairment than patients with no depression (Well et al., 1989).

Impact on Societal Cost

Societal cost is directly affected by disability days, days lost from work and cost-utility. A prospective epidemiologic survey, controlled for psychiatric and medical co-morbidity, social support and life stress, found that the risk of disability for major depression is 4.78 times more than for asymptomatic individuals. Employed persons with major depression were 4.36 times as likely to have a disability as asymptomatic individuals (Broadhead, et al., 1990). Recently, a cost-utility analysis obtained by McSad was applied in a cross-sectional survey of 105 patients who had experienced at least one episode of major depression in the past two years but were currently in remission. Utility scores provide the weights required to calculate quality-adjusted life years (QALYs) for cost-utility analysis. Utility scores were .59 for mild depression, .32 for moderate depression, and .09 for severe depression. It means that for an individual who can be expected to live another 20 years, the QALY figure associated with spending the entire 20 years in the mild, moderate and severe depression health state would be $11.8(20 \times 0.59)$, $6.4(20 \times 0.32)$, and $1.8(20 \times 0.09)$, respectively. Thus, 5.4 and 4.6 quality-adjusted life years are gained as a result of an intervention that moves an individual from the moderate to the mild, and the severe to the moderate, depression health state. For the untreated mild, moderate, and severe clinical markers of health status show that depression is in fact associated with poor health-related quality of life. Compared with published utilities for chronic physical disease, mild depression is in the same range as kidney dialysis: the utility for moderate depression is below that reported for "being blind, deaf, or dumb" (Bennett et. al., 2000).

Impact on Family Functioning and Well being

Studies using various methodologies and fairly diverse groups of patients have consistently shown that during an acute episode the families of patients with major depression experience substantial difficulties in many areas of their family life such as family communications and problem solving (Biglan, et al., 1985; Hops, et al., 1987; Birtchnell, et al., 1988; Keitner, et al., 1987). Overall, the families of depressed patients appear to experience more difficulties than do families of patients with schizophrenia or bipolar illness (Crowther, 1985; Miller et al., 1986) or families of patients with rheumatoid arthritis or cardiac disease (Bouras et al., 1986).

Regarding depressed women, since they play a major role in their families, the disabilities that depression places on them dramatically affect well being of the families as the following evidence shows. A study found that during an acute episode, depressed women were more submissive and dependent, less affectionate toward their spouses, experienced more friction, and argued more frequently with their husbands than did non-depressed control subjects. These women also experienced more friction with their children and were reluctant to discuss personal feelings (Weissman and Paykel, 1974 cited in Keitner and Miller, 1990). Interacting with their families, these women displayed less problem-solving behavior than their husbands and were less self-disclosing in their families than non-depressed women (Biglan, et al., 1985). These depressed women and their families appeared to be locked into an interacting style that promoted high rates of aversive interchanges among family members (Hops, et al., 1987). Their marriages were significantly worse than those of the control

subjects, because of a greater need for both intimacy and support of the depressed wives (Birtchnell, 1988).

Most importantly, children in families with a depressed parent functioned more poorly than did children in non-clinical control families. In addition, these children appear to be at a much higher risk, not only for affective illness, but for psychopathology in general (Keitner and Miller, 1990). Depressed mothers reported high levels of inconsistency in discipline and control and tended to be highly protective of their children (Susman, et al., 1985). Furthermore, depressed mothers complained of difficulties in coping with unruly and disobedient behavior in their children (Birtchnell, 1988).

In summary, depressed women tend to be aversive to others and to exhibit impaired parenting; the family as a whole experiences difficulties in their ability to solve problems. Therefore, these problems lead to impaired overall family functioning and well being. On the other hand, good family functioning can help depressed women to recover (Keitner and Miller, 1990).

Recovery from Depression

The existing body of knowledge on recovery from depression has mostly focused on recovering from depression as 'a state' and 'a goal'. Related issues involve the study of the course and outcomes of depression, achievement of the interventions, and factors associated with recovery from depression. More recently, the inquiry of knowledge has expanded from the traditional inquiry to the naturalistic inquiry. A

number of researches viewed recovery increasingly as 'a process'. These researches described and explained experiences of the depressive persons and the process of recovering from depression from their perspective. Knowledge of recovering from depression both as a state and as a process was integrated and reviewed as fellow.

Recovery as a State

The term of recovery as a state was mostly used in the medical model. However, it still was diverse in meaning depending on the specific context in which the resolution of symptoms occurred and on the theoretical orientation of the observer. A recovery in the context of psychopharmacologic or psychotherapeutic treatments may be understood differently from one observed in the absence of any formal intervention. Thus, Frank et al. (1991) defined the concept of recovery, and this was widely used in the medical studies.

Recovery as 'a state of no symptom' or 'few symptoms' in the cluster of terms in the course of major depressive disorder - response, remission, recovery, relapse, and recurrence - was identified by Frank et al. (1991). These definitions were obtained based on observable, measurable phenomena, such as severity, signs, or functional status. Thus, this definition was addressed to symptomatic phenomena which were based exclusively on severity (number and intensity) and duration of clinical symptoms. These following definitions are provided.

Response and Partial Remission. A response is when partial remission begins. A partial remission is a period of time during which the individual improves sufficiently so as no longer to meet syndromal criteria for the disorder, but continues

to evidence more than minimal symptoms. Treatment is not a requirement of the definition; partial remission can be spontaneous.

Full Remission. A full remission is a relatively brief period during which an improvement of sufficient magnitude is observed in which the individual is asymptomatic (i.e., no longer meets syndromal criteria for the disorder and has no more than minimal symptoms).

Recovery. Recovery is an extended period during which symptoms are only minimal. Recovery can be spontaneous and can persist for an indefinite period. The term is used to designate recovery from the episode, not from the illness per se.

Relapse. Relapse is a return of symptoms satisfying the full syndrome criteria for an episode that occurs during the period of remission, but prior to recovery as defined previously. A relapse can occur while the individual is in either partial or full remission.

Recurrence. Recurrence is the appearance of a new episode of major depressive disorder and, thus, can occur only during a recovery.

Although, the group of definitions is provided, the term of recovery in the researches related to recovery was still defined in varying ways. It may be that in the criteria for recovery there was no range of time indicated. For example, a study by Shea et al. (1992) defined recovery as stable symptomatic remission from MDD, minimal or no symptoms for a minimum of eight consecutive weeks following completion of treatment. Whereas the definition of recovery by Peselow et al. (1994:350) was a 50% reduction in the Hamilton score from acute depressive episode,

a final score on the Clinical Global Impression (CGI) scale of 2 or 1 (much or very much improved), and a final Hamilton score of 11 or less.

Recovery as ‘a state’ or ‘a goal’ was greatly used by health care providers to indicate a change point in the course of depressive illness that can be applied in researches and therapeutic decisions. Therefore, the concepts of remission, recovery, relapse, and recurrence are most likely to be studied in order to understand knowledge around the change point.

Recovery as a Process

Recovery as ‘a process’ is the subjective experiences from the client’s perspective. Recovery from mental illness from the client’s perspectives referred to a journey to wholeness and health; though they are living with a disability, they are taking their own responsibility for it. In their recovering journey there are various dimensions to deal with such as dealing with being labeled. It does not only refer to absence of symptoms. It consists of healing process and building a new life for oneself (Deegan, 1993).

Recovery is a process, not an end point or a destination. Recovery is an attitude, a way of approaching the day and the challenges they face. The speech of a mentally ill woman was as follows:

To me recovery means I try to stay in the driver’s seat of my life. I don’t let my illness run me. Over the years I have worked hard to become an expert in my own self-care. For me, being in recovery means I don’t just take medications. Just taking medications is a passive stance. Rather I used medications as part of my recovery process. In the same way I don’t just go to the hospital. Just ‘going to the hospital’ is a passive stance. Rather, I use the

hospital when I need to. Over the years I have learned different ways of helping myself. Sometimes I use medications, therapy, self-help and mutual support groups, friends, my relationship with God, work, exercise, spending time in nature - all these measures help me remain whole and healthy, even though I have a disability (Deegan, 1993: 10).

Recovery in terms of a process is mostly studied from the women's perspective in naturalistic inquiry. Because there is no study in a Thai context, the evidence that reveals experiences of recovery from depression in western culture are integrated and reviewed in the next section.

Factors Associated with Recovery from Depression

Formerly, there have rarely been direct studies involving factors associated with recovery from depression. Only recently, has the World Health Organization introduced the concepts of impairment, disability and handicap; the aspect of psychopathology related to the disability has been of increasing interest rather than the core syndrome or symptoms. In this section, the results of the researches that identified factors contributing to or acting as a barrier to recovery from depression between 1982-2001 were classified into personal factors, i.e., clinical and demographic factors, and psychosocial factors; situation factors, i.e., depressive management by delivery health care system, and depressive management by experiences of lay persons; and environment factors, i.e., family functioning.

Personal Factors

Clinical and Demographic Factors

Evidence related to clinical and demographic factors in recovery from depression most likely to explore risk factors in the criteria that are used to assess outcome of treatment include remission, recovery, relapse, and recurrence. The clinical and demographic predictors in each phase are presented below.

Predictors of Remission. A prospective study following 100 depressed inpatients over 18 months found that younger age at onset, longer illness length, higher depression and anxiety ratings, predicted delayed remission onset or risk of chronicity, and the severity of the episode predicted relapse (O'Leary et al., 2000).

Predictors of Recovery. Evidence predicting progressive recovery was rarely found. In contrast, major evidence was likely to predict non-recovery in depressed patients. Among this evidence, two longitudinal studies by Keller and colleagues (1992, 1996) were frequently referenced. They demonstrated that the longer the patient is ill, the lower the current rate of recovery. In addition, a study following up major depression in the first two years, identified that long duration of index episode before intake, marital status, relationship difficulties, low family income, admitting research center, and a history of non effective psychiatric disorders were predictors of a chronic outcome from major depressive disorder (Keller et al., 1982). Other predictors of longer time to recover were secondary unipolar subtype, inpatient hospitalization at entry, and secondary or co-morbid illness such as anxiety

disorders and alcohol/substance abuse (Lepine, 1997). Additional socio-demographic variables were which were found to predict a lower recovery rate included older age and female gender (Maj, 1994).

Presently, studies involving recovery from depression tend to separate recovery into syndromal and functional recovery. A study following 219 cases of first-episode major effective disorder with psychotic features illustrated that time to syndromal recovery (6.1 weeks to 50% of subject recovered) was shorter for patients who had bipolar disorder, were married, were aged 30 or older at onset, lacked co-morbidity, required relatively brief hospitalization, and received fewer medicines. On the other hand, functional recovery by 6 (30.4%) and 24 months (37.6% of patients) was 2.6-2.7 times less likely than syndromal recovery; 63.1% of those recovering syndromally did not recover functioning by 2 years. This was associated with older age at onset and shorter hospitalization (Tohen et al., 2000).

With regard to chronic major depression or non-recovery, early-onset chronic major depression was associated with a longer index major depressive episode and higher rates of recurrent major depressive episodes, co-morbid personality disorders, lifetime substance abuse disorders, depressive personality traits, and a history of psychiatric hospitalization (Klein et al., 1999). However, the early-late onset distinction was not associated with differences in symptom severity, functional impairment, or treatment response (Klein et al., 1999).

A large cohort comprising both inpatients and outpatients using chart review and telephone contact by Swindle et al. (1998 cited in Baldwin, 2000) reported that risk factors for sustained depression in a large cohort included lower educational

attainment, more severe initial depression, depression in the setting of physical ill-health (especially heart disease), previous under-treatment and few close relationships.

Predictors of Relapse. A study by Paykel et al. (1995) demonstrated the effect of the presence of residual symptoms after partial remission impacts on the outcome of depression. Residual depression, which has been characterized as a Hamilton Rating Scale for Depression (HAM-D) score above 8, has been reported in one third of patients with major depression. Residual symptoms occur more frequently in patients with more severe illness and include anxiety, negative thought content (e.g., guilt and hopelessness), and impairment of activities, anorexia, and early insomnia. The presence of residual symptoms may be a strong predictor of relapse or recurrence of depression.

Predictors of Recurrence. A review study of the recurrence of MDD summarized that frequent or multiple episodes, 'double' depression, preexisting dysthymic disorder, longer duration of individual episodes, a family history of affective disorder, incomplete resolution of symptoms and co-morbid anxiety or substance abuse are all predictors of recurrent depression (Keller & Boland, 1998). Moreover, up to 15 years of perspective follow-up data on the 485 subjects also found that a long depressive episode before intake, and more prior episodes were significant predictors of a recurrence. Additional demographic predictors were female gender, and never marrying (Mueller et. al., 1999).

In brief, demographic factors that interrupted the recovery process included younger age at onset, older age, female gender, lower education, few close relationships, and lower family income. On the other hand, demographic factors that

contributed to the recovery process included marriage, aged 30 or older at onset, lack of co-morbidity, and shorter hospitalization. Clinical factors that delayed recovery or interrupted the maintenance of the recovery state included longer illness length or long duration of index episode, severity of depression, co-morbidity, multiple episodes, a history of psychiatric hospitalization, and incomplete resolution of symptoms. Among these factors long duration of index episode was the best predictor of time to recovery (Lepine, 1997).

Psychosocial Factors

Self-care agency and health seeking resources contributed to recovery while; lack of self-confidence interrupted the recovery process. A study by Surtees and Wainwright (1996) indicated that psychosocial factors, in particular neuroticism and a lack of self-confidence, have the greatest prognostic significance. Indeed, limited self-confidence is strongly related to the subsequent first recurrence of affective disorder. On the other hand, patients' perception of self-care agency after hospital discharge may be helpful in maintaining some stability when symptoms of the illness do occur. A study by Cutler (2001) found that perception of self care-ability or self-care agency was significantly correlated with functional symptom management at two months post-hospitalization. It explained 37% of the variance in symptom management.

Health-seeking resource is a factor promoting recovery through adaptive functioning. Adaptive functioning was defined as the ability to perform self-care activities and function appropriately in social roles whereas health seeking consisted of two variables: social interest and learned resourcefulness (Zauszniewski, 1994). Two studies by Zauszniewski (1994, 1995) illustrated that learned resourcefulness in

63 depressed inpatients and 126 depressed outpatients with or without hospitalization significantly predicted adaptive functioning whereas social interest and depressive symptoms were not significant. However, social interest and learned resourcefulness were postulated to be positively related to adaptive functioning. The results indicated the importance of learned resourcefulness in facilitating optimal daily functioning in depressed persons. Managing activities that exemplify adaptive functioning include personal care, social relationships, vocational skills, and leisure activities.

Situational Factors

Depressive Management by Health Care Delivery System

Because of the various perspectives used to explain depressive illness and the diverse manifestations of depression, a multiplicity of therapies has been developed. These therapies can be classified into two categories. These are pharmacotherapy and psychosocial interventions.

Pharmacotherapy.

Pharmacotherapy is the predominant approach in the health care delivery system. Several classes of drugs have been developed. Until now they have been equally effective agents, but with differences in side effects. These classes include 1) Tricyclic antidepressants (TCA) which include amitriptyline, imipramine and nortriptyline; 2) Monoamine oxidase inhibitors (MAOIs) which include phenelzine, tranylcypromine, and isocarboxazid; 3) Atypical Antidepressants which include trazodone, venlafaxine, bupropion and etc.; and 4) Selective serotonin reuptake inhibitors which include fluoxetine, sertraline, paroxetine, fluvoxamine and

citalopram. Each class is different in mechanism of action and side effect profiles (O'Toole & Johnson, 1997; Glod, 1996).

The medication is selected upon the fundamental criteria of efficacy, side effect profile, and cost to the client. According to American Psychiatric Association Practice Guidelines (Karasu et al., 2000), the initial selection of an antidepressant medication should largely be based on the anticipated side effects, the safety or tolerability of these side effects for individual patients, patient preference, quantity and quality of clinical trial data regarding the medication, and its cost. On the basis of these considerations, the following medications are likely to be optimal for most patients: selective serotonin reuptake inhibitors (SSRIs), desipramine, nortriptyline, bupropion, and venlafaxine. In general, monoamine oxidase inhibitors (MAOIs) should be restricted to patients who do not respond to other treatments because of their potential for serious side effects and the necessity of dietary restrictions. Therefore, in clinical practice, many psychiatrists start with SSRIs first, because of the more favorable adverse effect profile.

Psychosocial Interventions.

There is a range of psychosocial interventions that may be useful in the treatment of major depressive disorder suggested by American Psychiatric Association Practice Guidelines (Karasu et al., 2000). These included cognitive behavioral therapy, behavior therapy, interpersonal therapy, marital therapy and family therapy, and group therapy. In clinical practices, patients may be treated with a combination or synthesis of various approaches and strategies; these in turn are

determined by and individually tailored to each patient on the basis of that person's particular conditions and coping capacities.

Over two decades, there have been a number of evidences reporting effectiveness of the interventions and comparisons among psychosocial interventions, antidepressant drugs and combine psychosocial interventions and antidepressant drugs. Overall interventions with cognitive behavior therapy have been the most studied in over 80 controlled trials. The consecutive studies are on interpersonal therapy. However, the efficiency of the interventions were not unity because of difference in criteria that were used to include or exclude trials (e.g., characteristics of study populations, interventions or control conditions, or outcome measures used). For instance, some meta-analyses have concluded that effect sizes for cognitive behavior therapy are larger than for pharmacotherapy (Gloaguen et al., 1998; Dobson, 1989; Gaffan, Tsaoasis, & Kemp-Wheeler, 1995; Blackburn & Moore, 1997; DeRubeis et al., 1999; Hollon et al., 1992; Jarrett & Rush, 1994), whereas others suggest they are equally effective (Clark et al., 1994). Effect sizes for cognitive behavior therapy have generally been at least as large and, in some cases, larger than for other forms of psychotherapy such as behavior therapy, interpersonal therapy, or brief dynamic psychotherapy (Jarrett & Rush, 1994). On the contrary, in one trial conducted among depressed psychiatric patients, interpersonal therapy was found to be superior to non-scheduled controls and comparable to other active treatments, including cognitive therapy or antidepressant medication (Jarrett & Rush, 1994). In the NIMH treatment of Depression Collaborative Research Program study, interpersonal therapy was also reported to be more effective than placebo plus clinical management and comparable to cognitive behavioral therapy or imipramine plus clinical management. However, in



subanalyses, interpersonal therapy, cognitive behavioral therapy, and imipramine plus clinical management were no different from placebo plus clinical management among those with mild depression severity (defined as scores of <20 on the Hamilton depression rating scale or >50 on the Global Assessment of Functioning); among those with more severe major depressive disorder, both interpersonal therapy and imipramine plus clinical management were more effective than either cognitive behavioral therapy or placebo plus clinical management (Elkin, et al., 1989).

Depressive Management by Experience of the Laypersons

Symptom management techniques are both wellness promoting and leading to instability. A content analysis of functional symptom management in the patients two months after discharge from the hospital was classified into three categories. These were seeking help from others including: being with or calling trusted friends or family, talking with the therapist, attending activities, helping others, calling a hotline, and verifying one's suspicions with others; activities by oneself including crying, sleeping, reading, listening to music, exercising, taking PRN prescribed medication, removing oneself from a situation to handle anger, watching TV, journaling, regular eating patterns, breathing, meditation, and relaxation techniques; and cognitive techniques including thinking positive thoughts, trying to "get past" the troublesome symptom, praying, finding ways to resolving conflict sensibly and rationally, being patient, slowing down, distracting oneself, and thinking toward the future. However, the dysfunctional responses included taking high doses of over-the-counter medications, denial, blaming oneself, and keeping feelings to oneself when hurt (Cutler, 2001). Another study also revealed that help-seeking, attempts to feel better,

fighting back and distraction were contributing to health and, isolation and escape behavior were methods that could lead to instability (Murphy & Moller, 1993).

Environment Factors

Family Functioning. Evidence revealed that healthy family functioning promoted recovery from depression. A study was conducted by using initial levels of good and poor family functioning as a basis for analyzing changes in family functioning over the course of an episode of major depression, from hospitalization through a one-year follow-up (Keitner, 1995). The study found that patients with good family functioning at hospitalization generally maintained their healthy functioning and were more likely to recover by 12 months than patients with poor family functioning.

Although, there are widespread of effective approaches in caring for depressive persons, the long-term outcomes of the therapies were not satisfactory. Evidence reveals that long-term outcomes were poor; both in the controlled and naturalistic settings, the recovery was interrupted with periods of relapse and recurrence. Moreover, the non-recovered patients did not decrease. According to a longitudinal study in a naturalistic setting, a course of MDD was clearly revealed. A five-year follow up study reported that approximately half of the subjects with major depression recovered within the first six months. Subsequently, the annual rate of recovery declined markedly during a follow up after five years. For the patients still depressed, the likelihood of recovery within the next month declined by 1% to 2% per month during years 3,4 and 5 of the follow up. 12% of the subjects still had not recovered by five years (Keller, et al., 1992). In addition, during follow up periods of

10 to 20 years or more, up to 12% of patients were rehospitalized for depression, 11% to 34% experienced a poor outcome, and suicide was common (Lee and Murray, 1998; Kiloh et al, 1988; Thornicroft and Sartorius, 1993; Surtees and Barkley, 1994 and Angst and Preisig, 1995 cited in Angst, 1999:6). It appears a gap exists between depressive management by the health care delivery system and the problems of real life.

Experience of Recovery from Depression of Women in Western Culture

All of the evidence relating to women's recovery from depression was underpinned by an interpretative paradigm. Both grounded theory methodology and phenomenological methodology were used to study the phenomena. Feminist perspective, symbolic interactionist perspective, or both of them, and Peplau interpersonal theory were used as a theoretical framework to synthesize the studies. The findings from this evidence are organized as follow.

Recovery from depression is a subjective experience that is explained as a continuing process rather than a single event. The process starts when women feel pain or suffer in their early life that leads to initial thoughts of changing their lives by managing their inward and outward situations. The recovery process from depression consists of sub-processes in various phases that lead to recovery. Recovering from depression is a dynamic process, which moves among categories and phases. In addition, some categories occur simultaneously. The recovery process is influenced by social context, culture, and religion. A grounded theory study which discovered core

concepts that described the recovery process from depression for women who identified themselves as having recovered from depression, and were living in Southern Ontario and in two bordering U.S. States was called (Re)Defining My Self. (Re) Defining Myself is a dynamic process with an overall direction from the experience before her encounter with depression towards the end of the process. At the end of the process, the women is able to answer the question, “Who am I?” by searching within and outside herself to determine the answer. (Re)Defining My Self consists of six phases: “My Self Before”, “Seeing the Abyss”, “Telling My Story”, “Seeking Understanding”, “Cluing In”, and “Seeing with clarity”.

The meaning of the recovery process is consistent with feminist phenomenological studies such as Steen (1996) and Chernomas (1997). On the other hand, Black West-Indian women managed their depression in culturally defined ways by “Being Strong” and not showing vulnerability. Being Strong included three sub-processes, “dwelling on it,” “diverting myself,” and “regaining my composure.” Another sub-process, “trying new approach,” was categorized for the women who were less limited in their range of cultural and behavioral boundaries than were the others, and began tentatively to explore other options for themselves. Empirical evidences related to experiencing depression and women’s perspective in recovery could be categorized into four themes: the background of women with depression, living with depression, turning point and caring need.

Background of Women with Depression

The early life of the women with depression was a painful feeling of not being wanted, not being understood, or being neglected, abused, abandoned, or

depressed in some way. In some women, this phase lasted into early adulthood. A study called “My Self Before” was characterized by five properties: Being Clued Out, Living With Conflictual Relationship, Living Out Role Expectations, Caring For Others while depleting herself, and Making Uninformed decisions. In addition, in a feminist approach, this phase clustering under the theme of existential alienation/pain, was grouped into three sub themes: aloneness, abuse and damaged self-esteem. This phase seems to characterize a condition that precipitates or leads to the depression.

Living with Depression

Experiences of living with depression ranged initially from mild to severe, from mood to clinical depressive disorder. Evidence consistently pointed to the importance of self, loss of control, and the transformations that occur within the self as being representative of the individual’s experiences. Chernomas (1997) reflected depressive experiences from women’s perspectives in recovery in seven themes. “Losing the Self” was identified as the central experience. “Loss of self” was a significant and dominant perception that threads through participants’ lives, affecting their inner sense of self, participants felt powerless and vulnerable. Other themes include “Transformed Self”, “Wanting and Monitoring”, “The Self as Healer”, “Revealing vs. Concealing”, “Acceptance and Belonging”, and “Making Sense of Depression-meaning and understanding.” The theme of “Transforming self” in the study with depressive women (Chernomas, 1997) was congruent with the process of “Turning identity” in the study with 20 male and female diagnosed and treated for unipolar depression (Karp, 1994). In the study by Karp (1994), the respondents arrived at the definition of the situation in their life through the career process. The key points

in the career processes are (1) having inchoate feelings of distress, (2) coming to feel that something is “really wrong,” (3) having a crisis, (4) coming to grips with an illness identity, and sometimes, (5) defining depression as a condition one can get past. Each of these stages corresponds to transformations in persons’ self-conceptions. In contrast, lived experiences of self of older women currently being treated for depression were “Aloneness.” “Aloneness” in depression and “Aloneness” in recovery were different. When the women were depressed, “Aloneness” was viewed as vacuous and imposing. The women worried about what was going to happen to them; they felt frightened, helpless, and out of control. When they recovered from depression, “Aloneness” was viewed as an opportunity, a blank canvas to be colored with their own unique thoughts, needs, and experiences. They were able to make decisions, to regain a sense of hope, to be resourceful, to enjoy the freedom to come and go and do as they wanted, and to explore their sense of self (Wilkinson & Pierce, 1997).

Turning Point

Before going through depression toward recovery, women had a personal crisis and readiness to make change that began the recovery process (Peden, 1993, Steen, 1996). Peden (1996) described how readiness to make change indicated a belief that depression is controllable and a belief that people can change the situation that results in a depressed mood. However, readiness, in nature, is dependent upon the individual. The turning point is actually a crisis that leads women to seek help from the mental health profession. After this point, women were determined to get well and never again to allow themselves to get as sick as they had been. In the determination

phase, the support of friends and family (Rhea, 1989; Peden, 1993), work-over-time, and success are components which stimulate and maintain the process of recovery. The turning point phase in Peden's study (1993) is congruent with the phase "See the Abyss" of Schreiber (1996) in which the women confront the fact of their depression. Women enter the phase in which two processes are occurring simultaneously, "Telling My Story" and "Seeking Understanding". In some of the research, two phases of turning points were described. The first was a process in which women seek help from other people. The second was a process by which women learned about their selves and their world (Schreiber, 1996; Steen, 1996). In the second turning point the women became active participants rather than passive participants in their treatment and gained more control in their life.

Caring Need

Caring needs depended on a stage of the process in which the women entered. The women who were the most recovered all said of themselves that they had at least one person who was there to help them (Schreiber, 1996). Moreover, the major aspects of the care needs by women recovering from depression were education and information about depression. In addition, supports or psycho-educational groups, cognitive techniques to manage their depression, activities that helped them fight the depression, relaxation techniques to help decrease stress, and learning to put themselves first are also women's care needs (Peden, 1996).

Summary

Thai society is an integrated multi-culture including Chinese, Indian, and Western culture. Individual behavior is decided by double standards. There is not equality in various aspects between male and female. This social structure may lead to women's vulnerability to depression especially in the middle-aged. Depression has various meanings depending upon the domain of each discipline. Depression is defined as mood, symptom, illness and others. The nursing discipline views depression as a health problem that ranges on a continuum from mild to severe. Varied theoretical frameworks and methodologies are a guide to study the depressive phenomena. However, the time to full recovery can be long and there are many patients living with disability and impairment. Evidence reveals the gap of knowledge relating to recovering from depression between health care provision management and the demand of laypersons. In order to understand depression and provide the guidelines to care for depressive women's well being especially in Thai middle age, the literature suggests that a study through women's experiences is the way to direct change in the social structure.

CHAPTER III

METHODOLOGY

This chapter describes the methodology used for this study. It is divided into two sections. The first section introduces the methodological perspective driving this study, including historical background, philosophical features of grounded theory and methodological features of grounded theory. Another section focuses on a detailed description of the method or research design used in this research, including sample, setting, recruitment method, instrument, pilot study, protection of human subjects, data collection, data analysis, and establishment of trustworthiness.

Methodological Perspective

A grounded theory study design is used to investigate the research questions. To provide understanding of the grounded theory method, historical background of grounded theory philosophical features of grounded theory, and methodological features of grounded theory are presented.

Historical Background

Grounded theory was discovered through the original monographs about dying (Glaser & Strauss, 1965 & 1968) by two sociologists—Barn Glaser and Anselm Strauss (Glaser, 1978 & 1992; Glaser & Strauss, 1967; Strauss, 1987). They came from quite different backgrounds. Glaser was trained in quantitative research,

methodology, and theory generation at Columbia University. His thinking concerning research was influenced by Paul Lazarsfeld, known as an innovator of quantitative methods. On the other hand, Strauss was a symbolic interactionist from the Chicago school of qualitative research (Glaser, 1998: 21-23). His thinking was inspired by a group of scholars including Park (1967), Thomas (1966), Dewey (1922), Mead (1934), Hughes (1971), and Blumer (1969). Both of them were collaborative in developing a qualitative research methodology which is regarded as a systematic inquiry to develop substantive theory or formal theory data. Its essence is to counterbalance the heavy emphasis on hypothesis testing research and quantitative methods (Glaser & Strauss, 1967) then in vogue in sociology.

After that, Strauss continued to conduct, teach, and discuss research methodology with colleagues and students in multidisciplinary. He published a textbook to provide a set of techniques for analyzing data as well as a guideline for beginning researchers on how to do grounded theory. These included *Qualitative Analysis* (Strauss, 1987), *Basics of Qualitative Research*, first and second editions (Strauss & Corbin, 1990 & 1998). On the other hand, Glaser (1978) published a small book elaborating on the concept process of grounded theory. Although many of the essentials of the original grounded theory method of those books were maintained, there were some differences in strategies. However, the result of the study finding of both methods were similar according to the study of Kendall (1999).

The grounded theory approach became an influence on knowledge generation in nursing in the 1960s and expanded over the next two decades through the scholar nurse community. By the 1980s, published grounded theory research by nurses had

increased greatly in both scope and direction. The foci of these studies included adaptation to illness, infertility, nurse adaptations and interventions, and status passages of vulnerable persons and groups (Benoliel, 1996). Furthermore, textbooks related to grounded theory and critique article related to grounded theory methods in nursing also increased in quantity.

Philosophical Features of Grounded Theory

The philosophical underpinning grounded theory is symbolic interactionism (Glaser & Strauss, 1967). It is a theoretical perspective that was influenced by the philosophy of pragmatism, work of Charles Darwin, and behaviorism. As a result, it focuses on interaction rather than on personality or social structure. It also places its emphasis on definition rather than response, the present rather than the past, and the human as an active rather than passive participant in the world (Charon, 1995: 23). To understand philosophical basis of grounded theory, characteristic of symbolic interactionism is briefly presented below.

1. A human behavior was constructed based on Blumer's three premises (Blumer, 1969: 2-6). Firstly, human beings act toward things on the basis of the meaning that the things have for them. The things refer to persons, objects, institutions, ideas, activities of others, and situations that individuals encounter in their daily life. Secondly, the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. This premise refers to the source of meaning that is formed in the context of social interaction and is derived by the person from that interaction. Thirdly, these meanings are handled in and modified through an interpretative process used by individuals in dealing with the things they encounter.

The interpretative process involves the process of self-interaction that the things have their meaning and then handling meanings by selecting, checking, suspending, regrouping, and transforming the meaning in the light of the situation in which they are placed and the direction of their action.

2. Human beings are viewed as active beings—a thinking, creative, self-directing, defining dynamic actor, or one whose ability to use symbols, define, and alter the environment results in a unique being in nature. Human beings learn perspectives in interaction and use perspectives to define reality.

3. Social interaction is simply a mutual social action that involves symbolic communication and interpretation of one another's acts. Social interaction also involves role taking and organizing our acts as we take one another into account (Charon, 1995: 163). What we do in a situation depends on our interpretation of other people's actions; their action depends on their interpretation of ours. Thus, action unfolds over time.

4. Symbols are one class of social objects which result from interaction, and are defined according to use. We create and use symbols to communicate and represent something to others and to ourselves (p. 45). Words are the most important symbols, making human thinking possible (p. 52). The other symbols include physical objects, human acts, and perspectives that are a set of symbols.

5. The self, like symbols, is a social object toward which the actor acts. It continues to be defined and redefined in interaction. As we communicate toward self, we are able to see ourselves in the situation, to recognize who we are in relation to others and vice versa, as well as to evaluate our own action in the situation. We are

able to judge ourselves and to establish an identity (p. 86). According to Mead (1934; cited in Charon, 1955: 88), self is referred to 'the me' which is social self and controlled by the actor. On the contrary, 'the I' referred to the actor that is constantly acted toward 'the me.'

In addition to symbolic interaction, there is a theory about human behavior, which is an approach in inquiring about human conduct and group behaviors (Blumer, 1969). As an approach, symbolic interaction asserts that "Reality" for empirical science exists only in the empirical world, can be sought only there, and can be verified only there (p. 22). Therefore, its methodology stance is direct examination of the empirical social world through scientific inquiry or empirical science including raising problems from empirical world, gathering data carefully and examining them in relation to that world or relation between categories of such data, formulating propositions and weaving such proposition into a theoretical scheme, and testing the relation through renewed examination of the empirical world.

The relationship between symbolic interactionism and grounded theory are steeply congruent. Milliken and Schreiber (2001) asserted that symbolic interactionism penetrates grounded theory from epistemology, methodology, method, and even the technical level including sampling, memoing, data collection, and data analysis. To achieve the purpose of the grounded theory research, it is necessary that the researcher engage in symbolic interactionism.

Methodological Features of Grounded Theory

Grounded Theory focuses on theorizing. It is different from description and conceptual ordering. Describing is depicting, telling a story,

sometimes a very graphic and detailed one, without stepping back to interpret events or explain why certain events have occurred and not others. Conceptual ordering is classifying events and objects along various explicitly stated dimensions, without necessarily relating the classifications to each other to form an overarching explanatory scheme. Theorizing is the act of constructing from data an explanatory scheme that systematically integrates various concepts through statement of relationship. A theory does more than provide understanding or paint a vivid picture. Rather, it enables users to explain and predict events, thereby providing guides to action (Strauss & Corbin, 1998: 25). As a result, grounded theory methodology is equivalent as a mean to develop theory that has the following main features:

✓1. Phenomena of interest are actions or processes and/or trajectory resulting in identifiable stages and phases.

✓2. Several sources of data are used for developing concepts and theories. Not only technical literature but various others types of published and unpublished materials are also sources of data. They can foster conceptualization through generated questions for interview and ideas for theoretical sampling and making comparison.

✓3. Not only does collecting data allow for sampling on the basis of immersing concepts, but it also enables validation of concepts and hypotheses as these are being developed. Those found not to 'fit' can then be discarded, revised, or modified during the research process.

✓4. Concepts and theory are grounded in data by using coding procedures and verifying data.

5. During the coding procedure, three essential methods of analysis are utilized to help researchers gain a better understanding of data. These include making comparisons, asking questions, and theoretical sampling. Theoretical sampling refers to data gathering driven by concepts derived from the evolving theory and based on the concept of “making comparisons.”

6. Sampling continuously changes according to the type of coding one is doing (open, axial, and selective coding), until all categories are saturated; that is, no new or significant data emerge and categories are well developed in terms of properties and dimensions.

Research Design

Sample

A purposive sample of 31 participants was obtained from 35-to-65-year-old Thai women who were diagnosed with major depressive disorder and who came in a psychiatric out-patient clinic for follow-ups. The participants who had delusion or hallucination were excluded because of their thinking distortion and perception dysfunction.

There is no agreement on when middle age begins. Both chronological age and cultural of which defines developmental time tables for taking on various roles are significant determinant of entrance into the middle years (William,1992:783). It is generally accepted that middle-aged chronologically begins between 35 and 45 years and ends between 60 and 65 years. However, Thai cultural is also important toward

roles and functions of the women. Therefore, researcher indicated the range of the middle-aged was from 35 to 65 years with two reasons. First, most of Thai women get married from 15 years up, so dramatically changes in their life are most likely to occur from 35 years up such as loss of their husbands and significant others, disappointed in their children and significant others. Second, majority of Thai women are housewives, so there are not clearly separate between adult and the aged because they are not forced into retirement. They may feel that they are in the aged when they see the physical changes which may clearly appear around 65 years up.

Setting

Ramathibodi Hospital, Siriraj Hospital, and King Chulalongkorn Memorial Hospital were selected as the settings of data collection because depressive persons are more likely to go to the general hospital than to a special psychiatric hospital. Moreover, these are large university hospitals located in an urban community in Bangkok, Thailand, thus they provide easy access to individuals from every part of the country. Apart from teaching and researching facilities, these three hospitals have 1,200 to 1,500 beds, offering services to as many as 3,500 out-patients per day.

With regard to psychiatric department, each hospital has twenty-four beds for inpatient unit, averaging one hundred out-patients per day. The psychiatric clinic in the out-patient department provides services from 8:00 a.m. to 12:00 p.m. every workday. Other than that, emergency services are provided all day long in the emergency room. In terms of mental disorders, the services offered by these hospitals include pharmacotherapy, psychotherapy, and other psychosocial therapies. Depressive patients come to the out-patient unit more frequently in the initial phase of

the therapy (1-3 weeks) and the duration of follow-ups extends up to the recovery of symptoms (2-6 months). The patients whose symptoms are so severe that there is a tendency that they may be harmful to themselves or others would be admitted in the inpatient unit of the hospital.

Ramathibodi Hospital was the main site of the study as 28 participants were obtained from the hospital. As for the rest, two participants were recruited from Siriraj hospital and one from the Thai Red Cross Council. The last participant had given up treatment in the hospital and was recruited based on psychiatrist suggestion.

Recruitment Method

Potential participants at Ramathibodi Hospital contacted the researcher through staff nurses and psychiatrists. In other words, potential participants who visited the clinic and met the criteria for the study were asked by the staff nurse or psychiatrist to consider participating in the study. In other settings, the researcher contacted the potential participants based on self-selection by reviewing the history of illness from the patient file.

After potential participants had already seen their psychiatrist, all of them were informed about the purpose, procedure, and benefits of the study and given opportunity to ask questions. Thirty-one potential participants agreed to participate in the study and signed a consent form, after which most of the participants began to be engaged in the interview process. Two participants made an appointment for the interview the next time they came to the unit.

A few potential participants refused to participate in the study because they felt uncomfortable to be interviewed and to have their conversation tape-recorded. A few did not have time for interviews because they had to return to work or had other forms of engagement.

Pilot Study

A pilot study was implemented with three middle-aged women who were diagnosed with major depressive disorder at Siriraj Hospital. The purpose of the pilot study was to test the feasibility of the research project and the interview questions. After the completion of the pilot study, the research project and the interview questions were not modified. Two of the participants in the pilot study became study participants; the other one was not taken in owing to her thinking distortion.

Research Instrument

The researcher took a major role in the process of inquiry because the findings of the study would depend on the interaction between the data and the creative process of the researcher (Munhull & Boyd, 1993: 206). As a result, the biography of the researcher is crucial and should be provided for the readers.

The researcher is a forty-one-year-old Thai woman. She came from a middle-class family in the south of Thailand. At the age of fifteen, she relocated to Bangkok to further her studies. At present, she is married to a Chinese-Thai man with a thirteen-year-old daughter and a ten-year-old son. She holds a bachelor's degree in nursing and a master's degree in educational psychology. Although she has lived in an urban area just as the participants, her social location is a professional nurse. She

has been a faculty member in the Department of Mental Health and Psychiatric Nursing at Mahidol University for eleven years, teaching students to care for depressive patients who are hospitalized in the inpatient unit of the psychiatric hospital. However, the researcher is unable to follow up on the patients until they recover as they are generally discharged from the inpatient unit when their symptoms are absent or when their conditions have improved. As such, the researcher does not have a chance to close observe the recovery process, a main issue of interest in the present study.

The researcher herself has direct depressive experience and personal bereavement when her beloved sister who was under her care committed suicide nine years ago. She had to suffer the feelings of guilt and desperation for a long time. Thanks to her strong family ties and strong social network, she was encouraged to take care of herself. She tried to heal by going to swim on every holiday and do daily meditation. As she considered herself and the situation she was in back and forth, she gradually gained new perspectives from the religion. She came to learn that she was able to bring herself out of depressive feelings. However, as a psychiatric nursing instructor, she was concerned that such a realization may not be scientific knowledge easily explainable to guide her patients to the road of recovery in the Thai culture. A lot of trials and errors would definitely be unavoidable.

To provide the researcher's theoretical sensitivity in gathering, interpreting, and presenting data, her academic background information related to this study is presented. She graduated with a master's degree in the psychology discipline. Influenced by behaviorism during her studies in the educational psychology field, she

was particularly interested in cognitive behavior perspectives. In 1986, her master thesis, selected to test theory of reasoned action, was entitled “Predicting and Understanding the Mothers’ Infant Feeding Intentions and Behaviors According to the Theory of Reasoned Action.” This theory was developed in social psychology perspective and most importantly derived from symbolic interaction theory. Therefore, symbolic interaction perspective was accommodated in her theoretical thinking and sensitive in the process of analysis.

All of this information is sensorial perceived and immediately transformed into conceptualized experiences and has been anchored in the researcher’s quest and creation of knowledge ever since.

Protection of Human Subjects

Approval for involvement of human subjects was sought and obtained from two committees for the protection of human subjects—The Committee on Human Rights Related to Human Experimentation at Mahidol University and Ethics Committee at Faculty of Medicine, Siriraj Hospital. Upon entry into the study, each participant was informed about the purpose and nature of the study, and her rights as a subject. Participants were also encouraged to ask questions to ensure their thorough comprehension. After their questions were discussed, participants were asked if they were still willing to be in the study. A written consent was obtained once they decided to participate in the study. In all cases, a signed informed consent form was obtained.

Although the experience related to depression was sensitive, the researcher expected that the opportunity for the participants to tell their stories and to have empathic ears would help them substantially reduce their emotional stress. Moreover,

revisited past experiences would enable them to review and consider themselves in another time. However, all participants were advised that they could directly tell the researcher when they did not want to respond to a specific question or did not want to talk about a particular subject. They could also withdraw from the study if they wished to do so and that such decision would not affect the treatment and service they would receive from the hospital. Besides, the researcher kept alert during the interviews for signs of emotional distress. During many interviews, participants wept as they had emerged feelings of sadness, anxiety, depression and self-worthlessness. When painful feelings arose, time was allowed for their expression. Participants were provided with the opportunity to become composed before continuing the interview. In addition, the researcher's telephone number was provided to them and her availability was confirmed should the participants need to contact her after the interview session for information and consultation. However, none of the participants called for consultation, but a participant called to share her gratitude of having a good opportunity to narrate her story and invite the researcher to lunch.

Efforts to strictly maintain confidentiality of the study data was made by removing names and any other identifying information such as place of employment, location of residence, and names of psychiatrists from the typed transcripts. Participants were identified by numbers only on tapes, transcripts, and interview guides, and only the researcher had access to names, telephone numbers, and addresses of participants. All study materials were kept in a locked cabinet and was destroyed immediately upon completion of the study. Furthermore, all of the tape-recorded interviews were transcribed by the researcher herself to ensure confidentiality.

Data Collection

Grounded theory calls for an open approach to data collection rather than adherence to structured procedures. The purpose of data collection is to get as wide as possible in the effort to capture data that pertain to the phenomenon of interest (Glaser & Strauss, 1967; Strauss & Corbin, 1990). In the present study, a variety of sources of data were obtained. Middle-aged women who were diagnosed with major depressive disorder were the primary sources of data collection. In-depth interviews were the main method for collecting data from the participants. Documents from technical literature and non-technical literature served as the secondary sources of data. Technical literature included research publication and existing theories related to experiences of depression, management, and recovery from depression. Non-technical literature included diaries, biographies, and other materials related to depressive persons in the magazines, or descriptive experience on a television talk-show program. Medical records of the participants, general observations made during interview process and during home visits, and interviews of psychiatrists were also employed as secondary sources. The reason for the use of secondary sources was to increase theoretical sensitivity and guide questioning for collecting and analyzing data. As the study proceeded, data collection was modified as necessary in order to focus on concepts with relevance to the emerging theory.

Interviewing

Tape-recorded, open-ended, interactive interviews were conducted with each participant after the informed consent form was signed. The interview began by asking for the symptoms of the interview day and tracing back to the history of their

experience with depression from the first moment they realized that something was wrong with them, even if they did not initially define the problem as depression. When asked, "Please tell me what it is like for you since the beginning of your illness" at the beginning of the interview, five participants were encouraged to recollect their experience from beginning toward recovery as much as they could. The interview guide (See Appendix C) was employed as appropriate during the interviews. Gentle probes were also employed to enrich the description of the experience and to maintain the focus of the interview. Interview questions were modified throughout the study according to the emergence of the information to verify hypotheses and concepts. However, the initial interview guide was still used with all participants if the time was available because the new information from the participants was also interesting as it added range of dimension and led to the discovery of new concepts.

These interviews were conducted individually and privately so that the interactions were not interrupted and the participants were assured of secrecy. Mostly, the interviews occurred in a private room at the out-patient unit in the hospital. However, two interviews were carried out in the Lumpini Park, one at a food court in a department store, two at the participants' home, and one at the participant's workplace. The reasons that the majority of the participants preferred to be interviewed at the out-patient unit were as follows: Some wanted to avoid disclosure of their mental illness to family members or colleagues, while others did not want the members in their household such as their husband to hear their secrets. Most importantly, it was not convenient for those who lived in an urban area to entertain guests at home.

Evidently, discussion of issues related to depression often involves recounting painful and emotionally sensitive experiences. During the interviews, several participants expressed suffered feelings and cried. The interviews were paused and opportunity was given to the participants to express their feelings until they felt better. The researcher used touching techniques and expressed emphatic understanding. Most participants were willing to continue their discussion until the end of the interview except for one participant who had a hyperventilate syndrome. After the interview had been carried on for about ten minutes, she felt that all muscles in her body were stiffened and she experienced faster breathing. The researcher let her lie down on a bed in the private room and called the staff nurse. After she was physically examined by the psychiatrist and after the staff nurse did body scan, she rested for a while before getting better. The researcher made an appointment for the next interview on the next follow-up. The second interview went uneventful until the end of the session.

Before the end of each interview, the researcher made sure that the participants were in a peaceful state of mind, observing their feelings and asked for the feelings they were having at that moment. The researcher and the participants parted only when it was certain that they were emotionally calm.

Each interview lasted at least 30 minutes and most ran for well over 2½ hours. The average was 112 minutes (S.D. = 48.85). The variation of the time was due to the personality of the participants as well as the richness and complexity of information. For instance, some participants had considerable self-observational skills and analytical skills, so they could describe their experiences in detail. Of the 25 participants, two were interviewed twice to capture the complexity and the richness of

the participants' experiences and to test some hypotheses. For other participants, the interview was conducted only once because they did not come to see the doctor on the appointment date and the researcher could not communicate with them because they lived in a remote province and they moved around, so they could not remember their address. Finally, for some participants, the researcher considered that the data elicited from the first interview was rich enough, so the second interview was not necessary.

All of the second interviews conducted lasted longer than the first interview. As the researcher had met with the participants before, there was some degree of familiarity, and the participants were more at ease to talk. Thus, they told their stories with deeper details though the core matter remained the same. They also asked the researcher more questions as they were more willing to express their doubts than they were during the first interview. Besides, the researcher prepared issues and questions that may have needed clarification and explanation from the first meeting.

The first interview was conducted after the participants had seen their psychiatrist because the researcher did not know the participants before. In addition, it was hoped that the participants would feel free to engage in the interview and would not be worried about the time. As the researcher knew when the next follow-up for the participants would be, she made an appointment with the participants two hours prior to the time when they were supposed to meet their psychiatrist, an approximate waiting time between their arrival to the hospital and their examination.

The sequence of the interviews was not strictly controlled as each interviewed proceeded differently depending on the suitability and availability of time and

information. However, the researcher made an attempt to cover all the issues included in the interview guide with all participants.

Before wrapping up each interview, to summarize and prompt the participant to reflect the fruitful data, the two last questions were asked—“What advice would you have for someone experiencing depression or having the same illness as yours?” and “Is there anything else I should know about recovering from depression that I didn’t ask you?”

Once the interviews were nearly completed, and the relations between the concepts from the previous analysis were emerged, to test the hypotheses against the data, the researcher would ask a number of questions such as “Others have told me that they went back to consider and review their past experiences. Has this been your experience as well?” This allowed the participants to say no or validate the hunches and elaborate on what they were meant for them.

After finishing the in-depth interviews, personal information and depression related data were elicited. Also, severity of the depressive symptom was assessed by means of semi-structured interviews (See Appendices D and E).

Demographic and Depression Related Data

Demographic data were obtained from each participant. Information concerning the participants’ age, ethics, income, level of education, marital status, number of children, and occupation was obtained. From the participants’ out-patient card, the past and current medical histories were also drawn. This information yielded

the description of the sample and ensured that the participants had experience to enrich the data.

Assessment of Severity of Depression

To obtain information regarding severity of depression, the Hamilton Rating Scale for Depression (HAM-D Thai version) was used to assess the participants at the end of the interview. The HAM-D scale was designed to measure severity of illness in the patients already diagnosed with depression. The scale contained 17 items that assessed somatic symptoms, insomnia, working capacity and interest, mood, guilt, psychomotor retardation, agitation, anxiety, and insight.

The method of assessment was fairly straightforward. There was an initial interview conducted in a relaxed and easy manner, giving patients time to unburden themselves, speak of problems, and ask questions. For some symptoms, it was difficult to elicit enough information from the patients to permit full quantification. In such cases, if a symptom was present, the score of 2 would be given; if it was absent, the score of 0 would be given instead. If the existence of symptoms was doubtful or trivial, the score of 1 would be given. For those symptoms where more detailed information could be obtained, the score was expanded: 2 indicated mild symptoms, 3 moderate symptoms, and 4 severe symptoms. Therefore, the higher the score, the more severe the depression.

Most people with clinical depression scored 14 or more on the HAM-D. The maximum possible score for the 17-item HAM-D was 52. In practice, very few patients scored above 35. Most people with depression scored 14 or more. A score of 30 or higher was more typical of severity depressed patients.

HAM-D Thai version (Lortrakul, Sukanick & Sukying, 1996) has been widely accepted and used as a measurement of depression in Thai patients. The kappa value of the scale was 0.87. The Spearman's correlation coefficient which indicated the validity was $-0.8239(p < 0.00001)$. The internal consistency was good (standardized Cronbach's alpha coefficient was equal to 0.74).

Writing Field Notes

The researcher wrote field notes as soon as possible after each interview ended. The interactions, observations, and events occurring during the interviews were recorded. These included the general appearance of the participants, nonverbal behaviors they used during the interview (e.g., facial expression, posture, gesture, or tone of voice), location and circumstance, as well as the researcher's perceptions, opinions, and working hypotheses. Filed notes were used to remind the researcher of the events, actions, and interactions, and trigger thinking processes.

Participant/Researcher Relationship

In general, relationships between the researcher and the participant profoundly influenced the nature of the data. In this study, there were several aspects of participant and researcher relationship that merited interactions leading to open and candid sharing of experiences.

The difference between the role of healthcare provider and researcher was realized during the interviews. The researcher informed the participants that she was a doctoral student from the Faculty of Nursing, Mahidol University and that she used to be a psychiatric instructor at the setting. In addition, the knowledge of recovery from

depression as told by the participants was valuable in helping other women to go through the therapeutic process. The researcher respected the participants as a knower and their information was interesting. Facial expressions, gestures, and responses to interactions were shown with genuine sincerity during the interviews. The researcher attentively listened to what the participants had to say, asked for clarification and explanation, and did not assume that the meaning of the participants' words and statements were already known. Moreover, questions leading to expected answers were intentionally avoided.

During the interviews, the participants asked some questions. The researcher considered if the questions might involve the process of recovery that the participants foretold, they would be followed up on. The researcher kept on interviewing and were committed to answer these questions at the end of the interview. Even if the answers were not related to the process of recovery, the researcher gave them the answers until they were satisfied. Sometimes the researcher's personal experience was shared with the participants to build rapport and to provide other perspectives.

As the researcher had been familiar with counseling, there were both pros and cons. As for advantages, the researcher could control excitement in the early phases of the interview both at the out-patient unit and the participants' home. The rapport with the participants occurred rapidly, probably due to the researcher's warm and trusting personality. Moreover, most of the participants trusted healthcare providers and felt reassured that they could keep their confidence. Several participants were confident that even though they did not want to tell anyone, they told the researcher what they had encountered. For example, they could tell the researcher that their daughters used

to have illegal abortion or their child used to abuse drugs. They said that they had never disclosed these stories before, except to their doctor and the researcher. As for barrier, techniques in the counseling were used in the interview in the earlier phases such as restating, reflecting, and questioning. Sometimes the researcher followed their stories and did not clarify some issues. However, after reading the verbatim transcription of the interviews, the non-clarified issues were marked and subsequently discussed during the second interview or with other participants.

Although it is impossible to know what information the participants might have withheld, the researcher found it was quite remarkable how openly and candidly most of those interviewed spoke about their experiences. Their willingness to shared their experiences was clearly shown in the following statements:

I am willing to give the information. Since the beginning, I thought it could be useful for others. It was like helping others in a way. Even though I couldn't help much, it was still better to do something. I have already thought that what you include in your research can more or less help others for whatever reasons. If I can help others, I am willing to do my best (11.1.12.410-420).

R: Do you think talking to me causes you discomfort of having to talk about past experiences?

P: No. I feel good having a chance to tell you about my stories. I am willing to tell you about them because I feel better after talking to you. Every time I talk to you, I feel good. This is because I don't have to conceal anything. If I talk to friends, they might tell somebody else afterwards (10.2.8.277-281).

Data Analysis

The data analysis procedure in grounded theory is the tool to generate new concepts and theories from the data in the phenomenon of interest. The analysis procedure of Strauss and Corbin (1990, 1998) is different from that of Glaser (1978) in



the steps of analysis that are not complex and clearly understandable for novice researchers, but the outcome is the same (Kendall, 1999; Schreiber, 2001). Therefore, this study chose to follow the procedure of management and analysis data that was presented by Strauss and Corbin (1990, 1998). The analysis procedure began after the first interview was transcribed verbatim until the writing of the findings was finished, over one year and three months. Three types of coding, constant comparison, theoretical sampling, and memo writing were used as the main strategies through the established theoretical sensitivity of the researcher. In addition, consultation with the experts and reflective colleagues enabled the researcher to gain more understanding and wisdom to the analytic thinking. In the following section, the procedure of analysis is presented chronologically with some examples.

Coding

Through conceptual coding, raw data were transformed to be theory. Categories and their properties and dimensions were emerged by coding data and comparing the code with the data. There were three types of coding including open, axial, and selective coding. When these coding overlapped, the researcher continued the process forward and backward until the end of the analysis.

Open Coding

The verbatim raw data were carefully examined line by line, and the words, phrases, sentences or paragraphs were conceptualized involving substantive or in vivo code. The data were compared incident to incident to identify similarities and differences. As the analysis proceeded, open coding was still used wherever possible to add new codes.

To demonstrate the process of open coding, an example is given here. The words of the participants were: *"Since I had children, my life changed completely. I used to be scared of ghosts, I didn't dare to do anything, and I hardly used my head to think of what I should do. Now I have to be good at everything for my kids. I have to change in every way."* These statements clearly indicated that "daughter and son are my life." Another example is, *"It began when my husband wanted to bring a mistress into the house. I could not accept that. The problem started here."* Such sentiments showed "Disrespectful behaviors."

As a number of open coding proliferated, the researcher turned to examining and collapsing codes into categories or higher level concepts. The previous example, "Daughter and son are my life," was collapsed into a category named "The center of my life," while "Disrespectful behavior" was collapsed into "Negative appraising reactions from those who are the center of my life."

Once a category was identified, the researcher began to develop categories in terms of their specific properties, and dimensions and then those properties became to be definitions of the categories. This involved the analytical technique of asking questions and making comparisons. For instance, the researcher labeled disrespectful behaviors, physical psychological and sexual abuse, and neglect and deception as behaviors that shared the characteristic of "my value was not recognized" because it led to loss of self-worth and suffering feelings. The researcher came up with the name "my value was not recognized." This was because as we compared each event against itself and other events in the data, the researcher noted that these events shared the common trait that it led to the suffering feelings, whereas care and support by the

others led to positive or maintained self-worth. Therefore, definitions of the categories and subcategories were defined through its particular characteristics or properties. In addition, the variation of the properties along their continuum or dimensional ranges was located. For instance, the response to abusive behaviors was more emotional suffering than that to neglects or deceptive behaviors. Through this procedure, all categories had their properties and dimensions by asking questions of why, when, how, what, where, and others toward the meaning of categories and theoretical sampling to discover variation (See Table 1).

Axial Coding

The aim of this procedure is to systematically develop and relate categories. The categories were linked to subcategories along the line of their properties and dimensions through a coding paradigm involving conditions, contexts, action/interactions or strategies, and consequences. The researcher looked for the answers to questions such as why or how come, where, when, how, and with what in a phenomenon, and then relationships among categories were uncovered. For instance, in the loss of self-worth phenomenon, the questions were: "How did the loss of self-worth happen?," "When did the loss of self-worth occur?," and "What was the result of the loss of self-worth?" The answers for the questions were the categories "The center of my life" and "Negative appraising reactions from those who are the center of my life" which were the conditions that led to the consequences "Perceived loss of self-worth." The three previous categories were formed as subcategories of the categories "Loss of self-worth" (See Figure 1). Furthermore, "Perceived loss of self-worth" had become a condition of "Symptoms of depression."

In the axial coding procedure, the initial hunch about how concepts related had emerged. These concepts were called hypotheses, which were then validated through constantly comparing one piece of data to another.

Selective Coding

In the final coding, the major categories were integrated to form a larger theoretical scheme, and the research findings took the form of that theory. The major category or the core category was a central phenomenon that had analytic power able to pull the other categories together to form an explanatory whole. It may evolve out of the list of existing categories or other more abstract terms that all the other categories could be subsumed. In this study, the core category was obtained through writing the storyline, drawing diagrams, reviewing and sorting through memos, and consulting experts. Finally, the core category was a basic social psychological process (BSP) explaining the process of regaining oneself from loss of self-worth of middle-aged Thai women.

Selective Sampling of Data

As the main concepts or variables became apparent, additional data may be collected at this time in a selective manner for the specific purpose of developing the hypotheses and identifying the properties of the main categories or variables. This process was also called theoretical sampling because the data were collected to advance the theory. It was used to direct further data collection and analyses until saturation of data was achieved. The saturation of data occurred when there was no new information about a category from additional analysis (Stern, 1985: 85).

Selective Sampling of the Literature

The existing literature, used as data, was woven into the matrix consisting of data, category, and conceptualization. Literature was carefully scrutinized, and the concepts were compared as data (Stern, 1980, 1985: 84).

Memo-Writing

One of the most crucial steps of data analysis was memo-writing. It was used to explore concepts and relationships and to sharpen emerging ideas about the findings. Four types of memos were used. First, methodological memos were used to record issues in sampling and data collection and to document key decisions. Next, coded notes were used to explain the meaning of conceptual labels and to show their relation to the raw data. Third, analytic or theoretical memos were used to develop ideas about the emerging concepts and to relate them to each other. Finally, summary memos were written for the whole set of interviews with each participant so as to facilitate apprehension of the “whole picture” of the participants.

Establishment of Trustworthiness

As the present study was qualitative research, to maintain the rigor of the study, several inter-related approaches were used to preserve the trustworthiness of the findings. These included attention to credibility, fittingness, auditability, and confirmability which were respectively taken as substitute criteria for internal validity, external validity, reliability, and objectivity in the quantitative method of inquiry.

Credibility

The credibility of a qualitative study could be evaluated by vividness and faithfulness of the description of a phenomenon. The participants and also the readers who had had depressive illness experiences should recognize the researcher's description of the experiences as their own (Beck, 1993a: 264). In this study, activities were designed to increase credibility of the findings as follows:

Firstly, middle-aged women who were representatives and who were knowledgeable of the depressive illness experience were chosen. In addition, they had willingness to be interviewed and to reveal the experiences. Good and trustful relationships between the researcher and participants were established before conducting in-depth interviews related to their illnesses. Although closeness of relationships could enhance creditability, it could be a threat as well (Sandelowski, 1986: 31). To prevent the threat of the researcher becoming too close to the participants and having difficulty separating personal experience from the participants' experience (going native), memos about the behaviors and relationships of the researcher and the participants and the influences of the researcher and the participants to each other were noted. Awareness of this issue was also brought up during the analysis process.

Secondly, triangulation was a mode of improving credibility of data. Data from another source or participant were used to compare and verify with the forthcoming data continuously through the procedure of collecting and analyzing data (Lincoln & Guba, 1985).

Thirdly, peer debriefing was employed for external checking. Two nursing lecturers and two members of research committee were consulted as debriefers. One lecturer whose dissertation focused on psychosocial nursing and grounded theory methodology took independent open coding and discussed with the researcher the first two interview transcriptions. In addition, they were available for ongoing consultation related to grounded theory methodology. Another lecturer whose dissertation focused on women health and qualitative analysis took independent open coding of four interview transcriptions, shared ideas with the researcher, and were available for ongoing discussion related to substantive areas. Although other two debriefers were members of the research committee, they also took the role of debriefers. The first one was a psychiatrist who knew a great deal about both substantive area of the study and the qualitative methodology issue. The second one was a nurse researcher and practitioner who had experience in grounded theory methodology and had been serving as dissertation consultants both local and abroad, and her substantive area was women health. Altogether, these experts reviewed raw data, theoretical memos, and the final theory. Interviewing techniques, procedure of data analysis, and procedure of thesis writing were suggested by them. One sociological researcher who served as an examiner reader got involved in data analysis and a final audit of the theory development. As a result of these debriefing processes, the researcher's biases were probed, meaning explored, and the basis for interpretations clarified.

Finally, member check which was directed at a judgment of overall creditability was established (Lincoln & Guba, 1985: 316). Both formal and informal member checks were used continuously. Periodic checks during interviews were done to provide the opportunity to assess intention, to correct errors of fact, to challenge

what was perceived to be wrong interpretations, and to stimulate the participants to recall additional details that were not mentioned the first time around. Formal checking was also conducted with two fully recovered participants to verify developed theories. Their comments were utilized for consideration and improvement of the theories as well.

Fittingness.

In addition to credibility, fittingness was one of the attempts to maintain the rigor of qualitative research. Fittingness or transferability appraised how well the working hypotheses or propositions fit into a context other than the one from which they were generated (Guba & Lincoln, 1981; cited in Beck, 1993: 264). Thus, transferability depended on the degree of similarity between sending and receiving context (Lincoln & Guba, 1985: 297). The researcher was responsible for adequately describing the context of the study so that the readers could possibly make a judgment of transferability. In this study, theoretical framework, data obtained, and characteristics of the sample were explained in detail. The researcher's background was also presented. In the discussion section, the researcher suggested how applicable this study may be to other groups. However, achieved transferability would occur when an investigator properly knew both the sending context and the receiving context (Lincoln & Guba, 1985: 316).

Auditability.

Auditability or dependability referred to the ability of another investigator to follow the audit trail which included all of the decisions made by the researchers at every stage of data analysis (Beck, 1993: 264). In ground theory research, Strauss and

Corbin (1990: 251) suggested indication of reproducibility or auditability as follows: “Given the same theoretical perspectives of the original researcher and following the same general rules for data gathering and analysis, plus a similar set of conditions, another investigator should be able to come up with the same theoretical explanation about the given phenomenon.” Since the grounded theory process depended on the interaction between the data and the creative processes of the researcher, reflexive notes throughout data collection were kept as records. Cognitive trail of the researcher was immediately recorded in the form of memos.

Confirmability.

Confirmability was the criterion of neutrality in qualitative research. It referred to the findings themselves, not to the subjective or objective stance of the researcher (Lincoln & Guba, 1985: 323; Sandolowski, 1986: 34). Confirmability was ensured by the fact that the whole process of this study was coherent and the results of the study were logical. Words of the participants were quoted appropriately and adequately to show that the findings were grounded in events rather than the researcher’s personal construction.

Most importantly, to evaluate grounded theory research, Strauss and Corbin (1990, 1998) proposed two criteria. The first judgment was made about the adequacy of the research process through which the theory was generated, elaborated, or tested. Another one was made about the empirical grounding of the research findings. Throughout the process of this study, the researcher asked ongoing questions to evaluate the research process and the findings, and put effort to carefully and

thoughtful follow the rule of grounded theory methodology in developing theory that met the two criteria for evaluation.

Summary

A grounded theory study was conducted with 31 middle-aged Thai women with a depressive symptom to generate substantive theory in recovery from depression. The participants were either asked by staff nurses and psychiatrists or selected by the researcher. Most of them were interviewed twice at the out-patient unit at three medical school hospitals. The total interview time for each participant ranged from 80 to 240 minutes, with an average of 112 minutes. The confidentiality of the participants was a major concern throughout the process of data gathering. Procedures of data collection and analysis were carried out according to the strategies for grounded theory by Strauss & Corbin (1990, 1998). The trustworthiness of this study was established based on the four criteria of credibility, transferability, dependability, and confirmability. Formal member check technique was employed by having two fully recovered participants to verify the developed theory. The peer debriefing technique was also employed by having two nursing lecturers and members of research committee review analyzed data and findings. A detailed description of the participants' backgrounds and findings is given in the next chapter.

CHAPTER IV

MEANING OF DEPRESSION & OVERVIEW THEORY OF SELF-REGAINING

The grounded theory reported here emanated from the realization that the process of recovering in Eastern culture is different from that of Western culture. Western culture focuses on the self and individual rights, but Oriental culture focuses on the relationship with others and functional relationships toward significant others. Thus, the findings are specific to understanding depressive Thai middle-aged women and are directed towards caring for them.

The study findings are presented in four sections. The first section, Chapter Four, provides demographic information, which includes family and depressive characteristics of the participants, and cause of depression as perceived by the participants; the meaning of depression with constant comparative analysis and interpretation from grounded data; and an overview 'Theory of Self-Regaining from Loss of Self-worth of Depressive Middle-aged Thai Women.' The second section, Chapter Five, focuses on the causal condition of depression, which is the first phase in the 'Theory of Self-Regaining.' It consists of three categories: 'Tying the Knot,' 'Symptoms of Depression,' and 'Recognition of Depression.' The third section, Chapter Six, focuses on learning about depression. It consists of three categories: 'Depression Self-Management,' 'Seeking Help' and 'Contemplation about My Self.' The fourth section, Chapter Seven, focuses on recovering from depression and consists of two categories: 'Untying the Knot' and 'Self-Growth.' In the presentation, the

constructs and concepts emerging from the raw data in each phase are presented. Statements from interviews are quoted with identification numbers and transcript line numbers. Definitions of each construct and concept, and relationships between concepts are primarily derived from the data and then refined by the literature review.

Demographics of the Participants

Demographic information on 31 study participants was obtained through close-ended interviews and the information is summarized in Table 1. The majority of the participants were from Ramathibodi Hospital. The rest of the participants were from Siriraj Hospital and King Chulalongkorn Memorial Hospital, with two participants from each setting. Age of the participants varied from 35 to 63 years with a mean of 48 and a standard deviation of 8. The majority of the participants (90%, $n=9$) had an age range from 41 to 45 years. Thai was the most common ethnicity of the participants (90%, $n=28$). Three participants were Chinese-Thai in that their fathers and mothers came from China. Since most Thais are Buddhists, almost all of the participants in this study were Buddhists (87%, $n = 27$). Two participants were Christian and two of the participants were Islamic. One person changed religion on marriage. The home province of the participants was diverse; they came from every part of Thailand. The majority of the participants grew up in Bangkok (52%, $n = 16$). Eight participants grew up in the central part of Thailand. However, 23 of them (74%) resided in Bangkok and the suburbs during the time of data collection, whereas eight of them (26%) resided in the provinces. Educational background for the majority of the participants was a

bachelor degree. Nine (29%, $n = 9$) had a primary education. Three participants (10%, $n = 3$) did not attend any school and were unable to read and write.

With regard to working status, the majority of the participants (32%, $n = 10$) were housewives. Two of the housewives left the job before having depressive symptoms and one of them was a retired nurse from the United States. Nine of the participants (29%) were government officials, five were teachers, three were general government officials, and one was a navy. Six of them (19%) were employees. Three of them (10%) were the owner of a laundry, a hairdressing salon, and an account office, respectively. Three of them (10%) sold food.

Table 1: Demographic Characteristics of the participants

Demographic characteristics		Frequency	Percentage
Age (years)	35-40	5	16
	41-45	9	29
	46-50	6	19
	51-55	4	13
	56-60	4	13
	61-65	3	10
Ethnicity	Thai	28	90
	Chinese-Thai	3	10
Religion	Buddhism	27	87
	Christianity	2	6.5
	Islamic	2	6.5
Home province	North	1	3
	Northeast	1	3
	East	1	3
	West	1	3
	Central	8	26
	South	1	3
	Bangkok	16	52
	Suburb	2	7
Current residence	Bangkok	20	64
	Suburb	3	10
	Province	8	26
Educational background	None	3	10
	Primary school	9	29
	High school	2	7
	Vocational school	6	19
	Bachelor degree	10	32
	Graduate degree	1	3
Working status	Housewife	10	32
	Employee	6	19
	Own business/skilled work	3	10
	Government Official	9	29
	Merchant	3	10
Income (Bath/month)	Less than 5,000	7	29
	5,000-10,000	6	25
	10,001-20,000	9	38
	20,001-50,000	2	8

Table 2: Family characteristics of the participants (N = 31)

Family characteristics		Frequency	Percentage
Type of family	Nuclear	28	90
	Extended	3	10
Marital status	Single	6	19
	Married	15	48
	Separated	7	23
	Widowed	3	10
Number of children	None	7	23
	1	3	10
	2	15	48
	3	2	6
	4	4	13
Number of family members	Live alone	4	13
	Live with 2-3 persons	11	35
	Live with >3 persons	16	52

Family Characteristics of the Participants

Type of family, marital status, number of children, and number of family members living in the same household often reflect social support from social networks including spouses, daughters and sons, and/or other family members. Of the 31 participants, 90% (n = 28) were in a nuclear family and 20% (n = 4) were in an extended family. It was found that most participants were married (48%, n = 15). Seven of the participants were separated from their husbands. Five of them were separated because their husbands had minor wives or mistresses. Three participants were widowed and six women were single. Daughters and sons of the participants were mostly adults. The majority of the participants had two children (48%, n = 15). Most

participants lived with family members (spouse, daughters and sons, nephews, siblings or mother in law). Four of them lived alone.

Depressive Characteristics of the Participants

The majority of the participants were diagnosed with major depressive disorder (MDD). Seven of the participants were diagnosed with other mental disorders including dysthymia, panic and personality cluster B. Duration of the mental illness of the participants was diverse ranging from two months to 30 years.

The majority of the participants had duration of mental illness ranging from five to ten years. In regards to the incidence of recurrences, the participants that did not have recurrences of a depressive episode were the most common (61%, $n = 19$). In regards to age when the first episode occurred, two participants had the first episode when they were teenagers, 17 participants had the first episode before the age of 40 and 14 participants had the first episode after the age of 40.

Scores from the Hamilton Rating Scale for depression were used to assess the severity of depressive symptoms of the participants. Twenty-three participants did not have depressive symptoms (score lower than 7). Four of them had mild depression. Four of them had clinical depression and one person had more than depression

With regard to hospitalization experiences, 24 participants were never hospitalized with MDD, whereas seven participants were hospitalized. Of those hospitalized, four participants were hospitalized as the result of attempted suicide. However, the majority of the participants did not have a history of suicide (77%, $n =$

24), while seven participants had a history of suicide. The most common method of attempted suicide was a drug overdose.

Perceived current health status of the participants was also presented. It was diverse from full recovery to on-going problems. However, the majority of the participants had a full recovery (48%, $n = 15$). They perceived they had stable health (32%, $n = 32$). Unstable and problematic health status were perceived in equal amounts of the participants (10%, $n = 3$). In addition, perceived cause of depression by the participants is illustrated in Table 4.

Table 3: Depressive characteristics of the participants (N=31)

Depressive characteristics		Frequency	Percentage
Diagnosis	MDD	24	78
	MDD with dysthymia	5	16
	MDD with panic	1	3
	MDD with personality cluster B	1	3
Duration of mental illness	Less than 11 months	3	10
	1-2 years	8	26
	3-4 years	4	13
	5-10 years	9	29
	11-20 years	6	19
	21-30 years	1	3
Number of recurrences	None	19	61
	1	1	3
	2	6	20
	3	5	16
Age when first ill	Less than 20	2	6
	21-30	4	13
	31-40	11	36
	more than 41	14	45
HAM-D score	No depression (0-7)	23	74
	Mild depression (8-12)	4	13
	Less than major depression(13-17)	-	-
	Major depression (18-29)	3	10
	More than depression (30+)	1	3
Hospitalization experiences	Never	24	77
	Ever	7	23
History of suicide attempts	None	24	77
	1 times	3	10
	2 times	2	7
	More than 2	2	6
Current health status	Full recovery	15	48
	Stable	10	32
	Unstable	3	10
	Problem	3	10

Table 4: Cause of depression perceived by the participants (N=31)
(each participant has one or more causes)

Cause of depression	Frequency	Percentage
Husband had a mistress/ mistresses	16	36
Being overburdened	8	18
Disappointment in daughter and/or son	5	11
Violence	4	9
Loss of wealth	2	5
Loss of job	2	5
Poverty	1	2
Conflict in workplace	1	2
Physical illness	1	2
Loss of husband and children	1	2
Loss of husband	1	2
Loss of freedom	1	2
Disappointment in self	1	2
Unspecified	2	5

Cause of Depression in the Participants

Perceived cause of depression of middle-aged Thai women was obtained through in-depth interviews. There were diverse events that the participants reported as a cause of depression but all of the reported causes were psychosocial problems. None of the participants perceived chemical change or genetic factors as the cause of depression although some of their relatives (siblings, mother) had had mental illness. The majority of the participants perceived their husband’s having a mistress as the major cause of depression (36%, n = 16). Being overburdened, disappointment in their daughters, and violence were also likely to be major causes of depression, respectively (18%, n = 8, 11%, n =5, & 9%, n = 4).

Meaning of Depression

Definitions of depression from the perspective of depressive women are various. The meaning is not constant, with continual changes depending on the interactions that occurred in the process of recovery from depression. Conditions for changing the meaning of depression from the participants' perspective included time, context, severity, and chronicity of the depressive symptoms. From the raw data, the changing meaning of depression can be divided into four phases according to the interaction between participants and the course of their illness. They are as follows:

Phase I: Before Access to Health Care Services

Before access to health care services, the word 'depression' was generally unknown. The majority of the participants had never heard the word before. They had heard '*jit-jai-mai-khoi-dee*,' '*jai-kho-mai-khoi-dee*,'. These words referred to feeling down and would not be likely to signify a major struggle with life itself. However, these words did not refer to an illness that needed treatment. Since, they understood that feeling down is not a disease, they tried to change their feelings by themselves rather than seeking help from health care services. In addition, some women perceived it as normal in any life, so they did not do anything. The meaning of depression in this phase could be classified into two aspects including 'something unknown' and '*Jit-jai-mai-khoi-dee* (hopelessness or helplessness).'

Something Unknown

Several participants did not realize that they were suffering from depression, since the word 'depression' was unknown to them previously. Also, this word was not used in the local language. They perceived that their feelings and signs were nonsense. For example, a participant, after having separated from her husband, felt no encouragement and wished to be dead. She would sit in the corner of the room. However, she did not know what to call this feeling:

Before, I thought it was normal symptom. I thought that I was too sensitive in hearing. While I was sleeping, if anybody called me or there was any ring tone, I would always be frightened. I did not think that I was sick. I did not care for myself. But after that I wondered why I had something wrong. Before I came here to see a psychiatrist, the symptom had occurred but I did not realize it (23.1.1.13-16). Sitting alone in the dark had been my habit for a time long. I sat alone and thought about bad things nearly every evening at 6 o'clock onward (23.1.4.120-122).

Jai-kho-mai-khoi-dee, Jit-jai-mai-khoi-dee (hopelessness or helplessness)

'*Jai-kho-mai-khoi-dee*' or '*Jit-jai-mai-khoi-dee*' refers to feelings of hopelessness, helplessness or mental sufferings. The participants who were treated by health care providers or had not been treated named the depressive symptoms with these terms. In the Thai culture, mental sufferings are explained from the Buddhist perspective. Buddhism focuses on the human mind and connects the mind to the actual life. A teaching of Buddhism is that humans are born to cope with sufferings. Everyone has sufferings, but there are different ranges. Happiness in life means they have perceived little suffering. Happiness in life or suffering in life refers to the matter of the mind. Thus, the participants thought of their own mental sufferings as their own faults, as their own deviant behavior:

At that time, I had lots of family problems. I thought that it started because of that reason and since then I felt that my mind was discouraged (*jit-jai-mai-khoi-dee*). In the past, I also used to see a psychiatrist at the Veteran Hospital (17.1.1.4).

This time, I came here with the same symptoms (*jit-jai-mai-khoi-dee*). Maybe I will always have to be hanging around here and there. It is like I have lost my moral support and I don't want to struggle through my life anymore. That is why I came here to see the psychiatrist again (27.1.1.13-15).

It is concerned with my mind. It was a discouraged mind (*jai-kho-mai-khoi-dee*). Moreover, I kept forgetting about everything easily, even the things that I really should not forget. When I went out to buy something, then I couldn't remember what it was I wanted to buy. I had become completely absent-minded. It was such a pity! (23.1.6.196-199).

Signs and symptoms indicated that something was wrong in the participants' lives. As one participant said, there is no word in the Thai language for these signs and symptoms:

My mind is still palpitating. I do not know whether it is just called 'feeling lonely.' Sometime I felt that my mind was still palpitating even when I slept alone. Anyway, after having pills, I felt better. My mind was fine and I felt so relaxed... Like this ... I do not know what this symptom should be called (27.1.14.479-481).

Phase II: Access to Health Care Services

When they accessed health care services, the meaning of depression changed over time and through the interactions with an environment that was continually changing. However, no participants were told that they had a depressive illness. Some participants were told that the doctors had announced that they had depressive illness. Moreover, they accepted that their symptoms were similar to those described in the text they had read. Every participant could clearly differentiate the symptoms of depression as opposed to stress. However, the majority of the participants said that

they had stress, but they did not say that they had a depressive illness. When the participants were treated by health care providers, meanings of depression changed with three turning points in the process of the interaction with the course of the illness and the environment. These turning points are 'Beginning a mental illness,' 'Understanding the cause of the illness,' and '(Re) Identity of one's self.' The meanings for some participants were not defined in that particular order. They may be defined by skipping some meanings or some meanings may overlap in the three phases.

When participants accessed health care services, they started to be seen as mental patients, and depressive illness was perceived as a stigmatizing illness, as 'a disease of the insane,' 'a disease of a loser,' or 'as a tacit disease.'

A Disease of the Insane. Depression was perceived as 'a disease of the insane' from the time that the symptoms had clearly appeared until the time when the participants could not go on alone and had to seek help from a specialty unit for mental illnesses. The participants recognized that they might have a deviance from normal life. They must do something to help themselves to get better. They made choices by accessing the psychiatric unit. Some participants went to the general health care service before and after they were recommended to seek help at the psychiatric unit. The patients that were treated by the psychiatric unit were most likely to be labeled as mad by society, even though they did not perceive that they had a mental problem or a neurosis. For example, three participants thought that they had a physical illness and accessed a general hospital or clinic. When they received treatment from

the psychiatric unit in the general hospital, they immediately perceived their problems as the 'disease of the insane.'

One day, the doctor suggested that I should go to see a psychiatrist. I argued with him that I was not insane. The doctor said he did not mean that I was insane, but that he just wanted me to have the proper pills to cure depression. The depression symptoms required the appropriate depression-relieving pills, not gastritis pills. I asked him where I should go since a mental hospital was rare. I know only the Somdej Chaophraya and the Srithunya Mental Hospital. I told him that I would not go there as people would think that I was really insane and no one would want to be a friend with me. The doctor said it was not like I thought it was (11.2.11.305-314).

The first time, the symptom seemed to be similar to gastritis and then the physician said I had a mental illness and it suddenly struck me what had happened. Then he recommended that I see a psychiatrist. At first I did not understand anything about psychiatry. I thought it was only for insane people (08.2.11.349-352).

Although the participants did not perceive their illness as the disease of the insane, some participants still believed that society viewed the illness as the disease of the insane. This stigma impacted on their credibility, trust, and relationships in the workplace. The participants could not disclose the information related to the mental illness in order to protect themselves from being unfairly labeled:

Since my career is relevant to the field of communication, I would not feel embarrassed if I had to work in other jobs. As a teacher, if I reported it to my office and it was accidentally broadcast all over the office, no one would let their children study with me. At the moment, many people still misunderstood what psychiatry was. These days when I apply for reimbursement for the medical fee from my office, I still have to erase the word "psychiatry" from the receipt. I think that I am not an insane person or anything profoundly abnormal (08.2.11-12.383-390).

As a result of the word "insane," no one wanted to know me. If they knew that I had seen a psychiatrist, they would have thought that I was mad. They might think that they could not communicate with me and then no one would trust me. As a result, my career would be

badly affected. I would lose my self-confidence and be unable to talk to others. It would ruin so many things (11.2.19.560-566).

As a result of the depressive illness being perceived as a disease of the insane, the depressive illness was viewed as the beginning of madness in a person. Some participants spoke of sufferings with the depressive symptoms. For example, they could not control themselves and they took action all the time to move away from the suffering. Moreover, some participants had hallucinations and delusions:

They might think that I was rather eccentric (giggly). Even though I started having this kind of symptom, I did not dare to tell anybody as I might have felt embarrassed or afraid that others would think that I was crazy. So that I thought that I had better not consult them or go and see them or talk to them (23.2.2.27-29).

A Disease of a Loser. The depressive illness was perceived as the disease of a loser. In other words, only a strong person did not have a mental illness. They could confront their problems and cope well. When the participants were told by a doctor that they had a mental illness, they perceived that they were a loser or were defeated. Moreover, they thought that others viewed them as a loser, too. Thus, they experienced shame, a feeling of valuelessness, and loss of self-worth.

This definition is based on the explanation from the psychological perspective. Stress and coping theory views depression as the outcome of maladaptation or ineffective coping. The participants understood this explanation as judging them as people who were maladjusted or had ineffective coping.

For example, a participant who first announced she was from a psychiatric unit could not accept that she was mentally ill because the situation seemed to label her as a loser with a failure in life:

When I first came here to see the psychiatrist, it was an extremely miserable day for me. I used to be a tough woman who led my family. I had supported my parents and cousins, but even so I ended up at this place. That day I went home and drank a lot until my child begged me not to drink again. I asked her about this later since I could not remember about it even how I lost my purse and I have no idea who gave me a lift. After that I realized that I drank a lot because I could not accept that I was in this situation. I used to be a tough working woman who organized meetings with my customers. I used to contact my customers directly, but now I could not talk to them on the phone as they could no longer listen to my words, just me. So that was the end of my job (20.2.6.177-185).

In another example, a participant who was fully recovered from depression said that depression was a disease that happened to a person lacking problem-solving skills:

These days I do not want to be a mentally ill patient again. Now that I have recovered from that illness, I feel like I hate myself because other people who are in much worse situations than me can deal with them successfully (16.1.8.270-272). Anyway, I feel glad that the illness was gone because I am an educated woman. However, it has nothing to do with education at all. I thought that I should have a better way of thinking as I am an optimist usually. Anyway, at that time everything was so serious (16.1.15.497-498).

The meaning of depression as a disease of a loser and as a disease of the insane implies that a person and the disease are viewed as the same thing. The person and disease are not separated. In contrast with the person who has a physical illness such as diabetic disease or hypertension, the disease and the person are viewed separately. The person is referred to as a person who has a disease. On the other hand, a person who has a mental illness is viewed as 'the disease.' It is as if the whole world has put on a pair of warped glasses that blinds them to the person and leaves them seeing the patient as an illness itself. Possibly, the mental illness is an unseen disease or intangible disease. The source of the problem cannot be seen. In the following section, the meaning of the unseen disease is presented.

A Tacit Disease. Depression was perceived as a mental illness that had no physical appearance, was intangible, and was unseen. The expression of the depressive symptoms was subjective feelings. The majority of the participants tried to express their dramatic sufferings with their symptoms, but the listeners could not understand them. Sometimes they did not have the language to communicate the symptoms. Thus, they had to cope with the symptoms all by themselves:

I felt stressed because of my eldest child. Then everything happened to me at the same time. I did not have an headache but heartache. I was agitated but could not explain what I felt. In other words, I was so agitated that I could not sit but had to keep walking backwards and forwards. Sometime I kept on jumping because I needed to get rid of the feeling inside me. If other people saw me, they must have thought that I was so insane. But I was not the insane. I had to take actions to get rid of the symptoms. Sometimes the symptoms disappeared. I could not sleep or eat anything. After a while, I told my mother that it came back again, then she and my cousins had to hold me tight, and my mother applied balm on me, too. If they had not held me, I would have started walking again. I could not stop it as it came from my mind. Anyway, I perceived that I was not insane, but that the symptoms recurred from time to time (12.1.2.53-61).

Since then, it has become worse. My heart is always shaking. Before my heart was vibrating, my hands were shaking. Before my hands started shaking, they were white and then began to shake. My legs and internal organs were also shaking. After the problem started, my heart started having vibrating even though I tried to have a rest but that did not work. When it vibrated, I felt startled. I had this symptom for half a month. I went to see doctors at [name]....clinic but the doctor could not diagnose the problem. They gave me heart disease pills which I took. During the first four hours, everything was okay, but after another four hours I had the symptoms again. Then, I called my sister and she said I had a mental illness (04.1.4.92-107).

Other people might not understand the illness of depression. What is it? Even if you read about it in a text book, you would not interpret its meaning properly – only those who have had it can understand it. It is not a normal illness that gives you a temperature or wounds, but, instead, we would often hear about people who feel bored and could not eat their meals (08.2.12.415-421).

A tacit disease is a life threatening disease. Those who have never had this illness cannot understand the experiences of the person who has the symptoms. Moreover, it is hard to see that the ill person needs help or that he/she is suffering:

We were the only one who knew that we were having pills. No one else knew as they saw we still had lively faces. This illness did not show any outward symptoms like having a cold or a high temperature, measles, or chicken-pox. Some people regularly made a joke if I told them that I had insomnia and they recommended that I should get married (17.1.8.248-252).

I had never thought that it could happen to human beings or that it could exist in this world. When I had it, I realized then what it was like. It seemed like I was telling a lie, but it was the illness. I thought that this illness was so severe because it threatened my life. I might have committed suicide. It was so severe. Whenever it happened to me, I felt tortured because no one understood that I had a mental illness. While I was admitted at the hospital, I did not have any moral support to do anything. This illness was serious just as much as other illnesses, and I felt so scared (05.1.16.582-596).

Then I just realized the way insane people are. The ones cruel on their mind must feel tortured. It is not easy to explain but I can say that the ones who are ill with this illness are so unfortunate. Physical illness probably would be better for them as it could be cured easily, whereas the psychological illness is such a torture. They feel so tortured while their appearance does not show anything. If we could read their minds, we would know that they are feeling tortured and restless. I thought about the song of one singer, "The Love Fire." It said that love fire could burn life cruelly. Ohhh... I had an experience which I will never forget (25.1.11.350-356).

Phase III: Understanding the Cause of Depression

The participants had depression for a range of time. As a result of the interactions with the health care providers and seeking for information, the meaning of depression was changed. They considered the cause of the depression and judged that

the depression was the result of obsessive thinking of a stressed person, or love deprivation in the young.

A Disease of an Obsessive or Stressed Person. Depression was perceived as the cause of an illness. The participants contemplated themselves and began to realize that depression was the outcome of obsessive thinking or stress. After the accumulation of stress for a long time, many problems that happened simultaneously and being mentally abused were also perceived as causes of the depression. The participants that gave these meanings were considering physical symptoms such as stomachache, insomnia, and decreased appetite. Moreover, some participants had symptoms related to thinking such as negative thinking and non-stop thinking:

At first I felt so embarrassed, but these days I dare to tell people that I went to see a psychiatrist because I had stress illness. I could still do my job, and I was not insane (11.2.18.552-554).

I felt sick and pain in my stomach. I felt stressed until I could not eat proper food. When I ate rice I would vomit. I had no appetite. I was so anxious, so I regularly ate "somtam" (papaya salad) instead of rice. While I ate it more and more, I thought that I had both gastritis and stress (22.2.1-2.21-26). At first, I did not think that I was abnormal. I thought that I got sick and went to see a doctor. I was afraid of cancer. The doctor who was on the first floor sent me here, so I came here. When I came in this department, I thought that I had an over thoughtful disease (22.2.3.83-85).

Some people had depression, but other people thought that he or she had some kind of psychosis. I do not think that it was because they were just too worried (21.1.9.303-304).

On my past, when I abandoned anything, I think it was because I was a worried person from since I was young and did not live with my parents. Therefore, I thought that I accumulated this thing internally until it exploded when I grew up. When I was young, the symptoms rarely happened, but when I started working, I also started thinking too much about both personal issues and career. Suddenly, when it accumulated too much, it exploded and I had both vomiting and diarrhea (11.1.1.5-9).

One participant viewed external factors as the cause of her illness. Depression was perceived as the consequence of her obsessive thinking or her stress. She could discriminate between stress and madness:

I told my sister and did not feel embarrassed because I thought that I was not mad. My sister said I was mad, but I still insisted that I was not. Being mad, you would want to bash people or pick up the rubbish from the street. I did not think that my illness was as serious as madness. I was not embarrassed, but I thought that I was hurt by this one person... I hate him because I was hurt so much by this guy. I still did not think that it was madness, but society perceived that it was (25.1.12.390-399).

A Disease of the Love Deprived Person. Depression was perceived as an outcome of love deprivation and lack of a close relationship with a significant person since the time when the participants were children. They were aware that their deprived feelings could not be assuaged by anything. Additionally, the traumatic feelings were embedded in their mind.

I was stressed and lonely as a result of the lack of being loved. I extremely need a person who loves me. There is not anything instead of it (01.1.19.649-651).

Since I was young, I have never stayed with my parents. My parents were Chinese, and they gave me to my adoptive parents without my being registered. My adoptive mother had only sons and they knew that I was not their real sister and so they did not love me as a sister. So, I have been anxious since then. Also, I thought that my parents did not love me, so when I grew up the symptoms started showing clearly (11.1.12-19).

Phase IV: Recovering from Depression

In Phase IV, the participants tried to heal themselves by accepting the illness. The meanings emerged by considering themselves after they received therapy for a

time. The meaning of depression changed from explaining the cause to accepting the illness that happened to them. They were given the reasons for explaining the illness. Depression was perceived as a part of life, a phase of life, or just as a common problem everyone undergoes. For the last meaning, depression was viewed in terms of success in dealing with the stigma.

After the participants had been treated for a time, some participants fully recovered from their depressive symptoms, while others remained to live with depressive symptoms. In addition, the trajectory of the symptoms for some changes was according to the relative stress of their lives or the events that affected them. One person perceived that the depressive symptoms decreased; nevertheless, she did not see herself as actually being well. In Phase Four, the meaning of depression was categorized into three meanings as follows:

As a Part of Life. The participants perceived that depression was an untreatable disease because the depression had been embedded in their mind since they were young. The participants accepted the illness as a part of life and learned to live with depression. Furthermore, they tried to keep healthy by protecting and monitoring themselves:

I was stressed and lonely. I have had a love deprived disease. I really needed love ... I needed it so muchhhhhhh...(drags out her words). It would not disappear because I did not have anything to contribute. I thought that my neurosis and depression would be cured successfully. In the depth of my mind, I know that the need for love will continue forever if I cannot get rid of this feeling (01.1.19.649-656).

I do not think that this illness will disappear from me. Anyway, it can happen to anyone. Plenty of people would not know that they had it and would not even accept it if they had it. (08.2.11.380-381).

As a Phase of Life. The participants who had fully recovered from the depressive symptoms thought that depression occurred because they could not cope with the crisis in their life. Thus, depression was viewed as a treatable disease. The depressive patients could eventually overcome the illness:

It's strange that when the problem came to you, you could not handle it, but instead you fell down. Whenever you concentrate more and empower your mind and then come to see a psychiatrist, then you can stand back up again (05.2.1.14-16).

Just a Common Problem Everyone Undergoes. After the participants explained the cause of the depression in order to accept their own illness, they viewed depression as just as a common problem everyone undergoes. In order to deal with the stigma, the abilities of the participants themselves were compared with others. They found that they were not less able than others; furthermore, they were even more able than some normal people. Nevertheless, the participants still complied with their treatment by using medication continually. Moreover, they were aware of the possible relapse into depression if they forgot their medication. These participants did not view themselves as relying on others. Thus, this meaning ensured that the participants could overcome the stigma of being labeled:

I felt confident that I could work. I could calculate and do other things. I could do the work like others, maybe even better than them. My character is always to be. You could see that straight away if you saw my house. Not even someone who was not ill like me could not take care of their house properly like I could. It has helped me to feel confident. I was not mad and, so I did not have to feel embarrassed. These days, society realizes more and more that many people have a depressive illness (11.2.20.605-610). These days many people suffer from this illness, so I do not feel embarrassed at all. I told other people that I had had it long ago before others did. It is old-fashioned, but it is not a problem. I am still being treated for the symptoms still. Others have asked me why I did not feel better. I said it is because the illness is chronic, and, if it were not, I would have

been better long ago ... it has accumulated within me since I was young. No one would want to have this illness (11.2.18-19.552-560).

This illness is quite common. Everybody has a depressive illness if they do not have a neurosis. But we can change it if we do things that we like. It could be cured because it is not a neurosis, I think (06.1.18.626-636).

The process of recovering from depression was influenced by the meaning of depression. Participants who perceived depression as a disease of the insane, a disease of a loser, or as a tacit disease may have delayed or evaded access to specific psychiatric health care services. However, those who were treated at the psychiatric units became labeled as a mentally ill person. They may have delayed access to psychiatric units until they had severe symptoms or were so damaged that they could not control themselves and could not be responsible for themselves. Many perceived depression as a life-threatening disease, a suffering disease, or a severe disease that was a major experience in a phase of their life. They tried and intended to change themselves in order to fully recover from depression. Additionally, they prevented the recurrence of depression by monitoring themselves. Those who perceived others as not knowing about depression or how they suffered did not tell their story to others. They thought that the others did not understand them or that depressive symptoms were a subjective experience that was too difficult to understand. Those who thought that society gave the meaning of depression as the disease of the insane did not reveal their story to others, because the disease might cause them to lose credibility, trust, and faith. Furthermore, it might have an impact on their social relationships, efficiency evaluation, and others in the workplace. Thus, they were only able to tell their story to the doctors and close relatives.

In brief, the meaning of depression changes with the person, time, and experience of the interaction. The meaning at any particular time indicates the thought and action of the person in the process of recovering from depression. This will be presented in the next section.

Overview of “Theory of Self-Regaining from Loss of Self-Worth of Depressive Middle-Aged Thai Women”

As stated in Chapter I, the purpose of this study was to discover how middle-aged Thai women experience and manage the problems in their lives and move from depression towards recovery. A substantive theory explaining a basic social psychological process with middle-aged Thai women recovering from depression was generated, which was entitled the ‘Theory of Self-regaining from Loss of Self-Worth of Depressive Middle-Aged Thai Women,’ as shown in Figure I. This section provides an overview of the study findings.

The phenomenon of this study was ‘recovering from depression.’ The ‘core category’ emerging from this analysis was that of the “Process of regaining a sense of self-worth.” To develop a theory, various categories and subcategories were linked together and to the ‘core category’ based on the set of relationships denoting ‘causal conditions,’ ‘phenomenon,’ ‘intervening conditions,’ ‘action/interaction strategies,’ and ‘consequences’ (See Table 5). ‘The Center of My Life,’ ‘Negative Appraisal of the Center of My Life’s Reactions,’ ‘Loss of Self-Worth,’ ‘Symptoms of Depression,’ and ‘Recognition of Depression’ are identified as the ‘causal conditions,’ leading to

the 'phenomenon' of recovering from depression. A participant who would attempt to regain her self only if she could eliminate depressive symptoms was aware of the impact of placing the center of her life on external factors and discovered value in herself.

'Intervening conditions' are those that mitigate or otherwise alter the impact of causal conditions on phenomena (Strauss & Corbin, 1998: 131). Depression Self-Management,' 'Help Seeking,' and 'Contemplation about My Self' were identified as the 'intervening conditions.' The participants attempted to discriminate between or alleviate the depressive symptoms by self-management and seeking help. In addition, they tried to find out the cause of the depression. With contemplation about their self --self-awareness-- the participants could understand and admit that their pattern of thinking and problem solving contributed to depression. Moreover, the impact others had on them when they had the others as the center of their life was also realized. Then, they reappraised the center of their life's reactions/actions.

'Action/interaction strategies' for regaining one's self were as follows: 'Discovering My Self,' 'Redefining My Self and Relation with Others,' and 'Restarting My Self.' The positive 'consequence' of recovering from depression was 'Self-Growth.'

The theoretical finding from grounded theory analysis is the "Theory of Self-Regaining from Loss of Self-Worth of Depressive Middle-Aged Thai Women." This theory is divided into three phases. The first phase went from 'Causal condition of depression,' through 'The Center of My Life' to 'Recognizing Self-Deviance.' The second phase, 'Learning about Depression,' consisted of 'Depression Self-

Management,’ ‘Help Seeking,’ and ‘Contemplation about Myself.’ The last Phase, Recovering from depression, consisted of ‘Untying the Knot’ and ‘Self-Growth,’ consequence of the theory. All of the constructs and concepts in this theory are summarized in Table 6.



Table 5: Initial Study Findings from Grounded Theory Analysis

Type of Relationship	Categories	Subcategories	Properties	Dimension
Causal Conditions	The Center of My Life	Perceiving the Center of My Life	A person or a group of people who were important and of great value for the participants, as well as being their source of pride. The participants' perception of 'The Center of My Life' was based on Thai social values.	Children/ Husband/ Other people
	Negative Appraisal of the Center of My Life's Reactions	Being Treated as an Unvalued Person	Appraisal of the disrespectful behavior, abusive behavior, neglectful behavior and deceitful behavior which came from the husband, children, and friends.	High intensity/ Low intensity
		Having Overloaded Burdens	Appraisal of the demand for caring for illness, unexpected care demands and long-term care demands which came from husband, children and relatives.	High intensity/ Low intensity
		Having Sense of Loss	Appraisal of loss of expectations of the 'Center of My Life,' source of support, being accepted and trusted, security, wealth and freedom which could all result from other people's behavior or the participants' behavior.	High intensity/ Low intensity
	Perceived Loss of Self-worth	Perceived Loss of Self-Worth	The perception of the participants who considered that they were treated as unvalued people, had overloaded burdens and/ or had a sense of loss resulting from the actions/reactions of the center of life.	High intensity / Low intensity

Table 5: Initial Study Findings from Grounded Theory Analysis (cont.)

Type of Relationship	Categories	Subcategories	Properties	Dimension
Causal condition	Symptoms of Depression	Devastated Self	The response to the perceived loss of self-worth which occurred as a vicious cycle starting from negative thinking and loss of focus followed by desperate feeling, less sleep and loss of appetite, desire to be alone and abnormal perception.	High severity/ Low Severity
	Recognition of Depression	Recognizing Self Deviance	The awareness that they are different from what they once were. Their mean of recognition could vary depending on signs, degree of intensity, knowledge of depression, and ability to assess their thinking, feelings, and emotions	Recognized / Unrecognized
Intervening Conditions	Depression Self-Management	<i>Tamjai</i> (Accepting Situation)	Acceptance of circumstances by managing one's thoughts and feelings through reasoning, hoping, and self-reminding. When one realizes one's self, realization of the negative effect that could result is a process composed of intention, action, and evaluation for further action.	Taking actions effectively / Ineffectively
		Diverting My Self	The intention to divert one's thoughts and feelings in order to reduce or eliminate depression and the torture accompanying it. Activities that are used are leaving the environment, meditating, praying, having hobbies, exercising, using vitamins and caffeine, keeping busy with work, finding something new in life, and using drugs.	Taking actions in effective / Ineffective

Table 5: Initial Study Findings from Grounded Theory Analysis (cont.)

Type of Relationship	Categories	Subcategories	Properties	Dimension
Intervening conditions	Help Seeking	Seeking Informal Help	Seeking help that has no definite format or pattern, but is natural, composed of processes to determine the source of help, weighing advantages and disadvantages of seeking help and choosing information that can be revealed, and evaluated and repeated.	Taking actions effectively / Ineffectively
		Seeking Professional Help	Seeking help with a definite purpose from general health care providers and psychiatric health care providers. This is a multi-stage process composed of processes to determine the source of help, weighing the advantages and disadvantages of seeking help and choosing information that can be revealed, and evaluated and repeated when necessary	Taking actions effectively / Ineffectively
	Contemplation about My Self	Self-Awareness	Realization about oneself and some issues related to depressive symptoms. The contents of self-awareness including the good and the bad about one's self, depression comes from the ineffective coping pattern, the impact of placing the center of life on external factors, and the way to solve depressive symptoms must start from my self.	Effective consideration / Ineffective consideration
		Reappraisal Reactions /Actions of Those Who were the Center of My Life.	Reconsidering and reevaluating the reactions/ actions of those who were the center of one's life. These include behavior as continual change; other people behaviors may have an impact only when it is valued, and other people's behaviors might be a response to one's behaviors.	Effective consideration / Ineffective consideration

Table 5: Initial Study Findings from Grounded Theory Analysis (cont.)

Type of Relationship	Categories	Subcategories	Properties	Dimension
Action/ interaction strategies	Untying the Knot	Discovering My Self	The process of self-worth recognition from one's internal development. This process lead to the setting up of one's life-goals and the action-plan for achieving the goals.	Discovering their Self-worth/ Denial
		Redefined Myself and Relation with Other People	A process of the modification of life skills by explaining and defining events around oneself and re-establishing relationships with other people. For redefining oneself, the utilized approaches include: living with the present, being more flexible, seeking alternative thoughts and self-reliance. For the redefining of relationships with other people, the participants' approaches include: helping other people as they can but not with all they have, understanding other people as they are and not imposing expectations on them, helping without expecting anything in return, and relying on each other.	Redefined/ Denial
Consequence	Self-Growth	Restarting My Self	The process of taking various actions that proceeds gradually without exerting one's self and it results in self-worth for the person and other people. This process consists of restarting activity, reconnecting with the society, being productive, and devoting time and effort for community service.	Taking action / Denial
		Regaining a New Person	The state in which women perceived themselves as the center of their life, were able to control themselves, had internal motivation, and could generate mental happiness and peace.	Success/ Failure to regain one's self

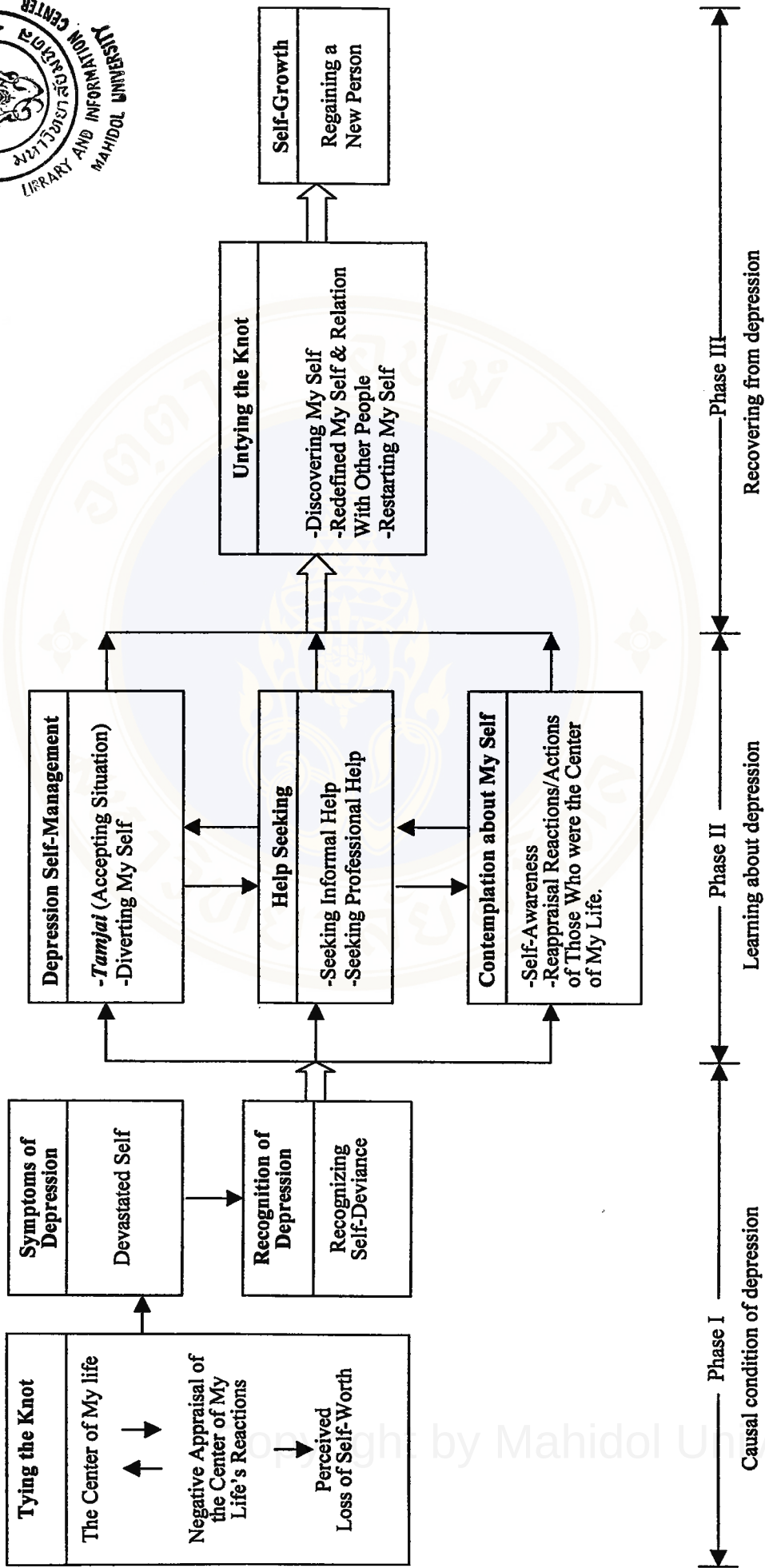


Figure 1: The Substantive Theory of Self-Regaining from Loss of Self-Worth of Depressive Middle-Aged Thai Women.

CHAPTER V

PHASE I: CAUSAL CONDITION OF DEPRESSION

This chapter presents the first phase in the “Theory of Self-Regaining from the Loss of Self-Worth of Depressive Middle-Aged Thai Women.” This phase explains how the participants lost their self-worth until they recognized the deviance of their life. This phase consists of three constructs including ‘Tying the Knot,’ ‘Symptoms of Depression,’ and ‘Recognition of Depression.’ ‘Tying the Knot’ is a construct that explains how the middle-aged Thai female participants in the study had their lives tied in a knot until they perceived loss of self-worth. ‘Symptoms of Depression’ is the response to ‘Perceived Loss of Self-Worth,’ and ‘Recognition of Depression’ is the turning point which the participants came to and from where they were able to manage their self-deviance.

Tying the Knot

‘Tying the knot’ is the process in which the participants had tied a knot in their lives by tying their self-worth and the sense of being important to the persons who are the ‘Center of My Life,’ for example, children, husbands, friends, or colleagues. Hence, the participants developed the sense of loss of self-worth when these people's actions did not meet their expectations. In other words, before having a depressive disorder, the middle-aged women judged their sense of self-worth from the

actions and the outcomes of the others who were important in their life. Whenever these people's actions were consistent with their expectation, or met their wishes, the participants would be able to maintain their sense of self-worth or have the feeling that their self-worth had increased. When people who were the 'Center of My Life' did not act as the participants expected them to or when they did not achieve the expected outcome, the participants would lose their sense of self-worth. 'Tying the Knot' explains the process of losing the sense of self-worth in these middle-aged Thai women, a process in which it seems as if their lives were tied in knots. This could be explained by the interaction between the 'Center of My Life' and 'Negative Appraisal of the Center of My Life's Reaction.'

1. The Center of My Life

The participants had socialized with various forms of behavior and had been taught how to behave since they were young by their families, schools, society, and religion. They were required to have a nice and polite character as defined by the opinions of senior people. Moreover, their behavior had to conform with the status and role they enacted. For instance, firstly, being women, they had to preserve their virginity, have a polite character and not go out at night. Secondly, being daughters, they had to follow, respect, and obey their parents' words. Thirdly, being wives, they had to do housework patiently as well as take care of everybody in the family and keep them happy. They also had to serve their husbands' sexual pleasure. Fourthly, being mothers, they had to take care of and teach their children to be good people and to be successful in their lives. Next, being bosses or subordinates, they had to be fully responsible for their duties and follow their organization's rules strictly. Lastly, being

daughters-in-law, they had to obey their mothers-in-law and make them feel content and satisfied with their own behavior. Therefore, the meaning and self-worth of their lives nearly always depended on satisfying other people. With recent changes in society, women have become much more involved in their families' economic domains; however, they still have to be responsible for housework and have to fulfill the same roles as before. Social changes have caused the self-definition of women to move from depending on others to depending on themselves much more. Therefore, the self of women depends on where the women locate their center of life.

Society has socialized women to believe their center of life depends on external factors. Society has assigned them the duty of taking care of their families from the time when they were young girls to the time when they become grandmothers. In comparing the genders, society always expects women to take care of their aged parents much more than it does men. The participants learnt this as a result of observing their mothers' and ancestor's duties. As one participant stated: *"...Because I had stayed with my parents, when I got married then I took care of my husband like my mother took care of my father and I don't think that is wrong...(27.1.10.328.330)."* Besides, participants also learned about being a woman from school lessons and media both directly and indirectly; examples of this include reinforcing the participants' required identity through the medium of actresses on radio programs, television broadcasts, in folk songs, and through playing games and novels. Therefore, middle-aged women's center of life has been socialized by Thai beliefs and values. The participants' centers of life, determined from the raw data, can be classified by three dimensions of children, husband, and other people.

1.1 Children as the Center of My Life

Value, meaning in life, and the pride of the participants depended on the achievements and happiness of their children. The children's success and happiness were the same as the participants' success and happiness. They tried to do everything for the achievement of their children or to make their children achieve their life goals, although they were extremely troublesome. Moreover, they still expected the children and/or nieces and nephews to show appropriate behavior and to be good people in order to achieve success in their lives.

The participants had motives to improve themselves. They could change themselves to do more, to be more patient, and to work harder. Moreover, they tried to increase the family's income to make their children happy in the present and accumulate money for the future of the children:

Since I have had children, everything in my life has totally changed. From being a person who was scared of ghosts, who was a coward and who did not use my brain in doing anything from one day to the next to be the one who can do everything, I have changed myself...(20.1.3.66-68)...Moreover, my children are my heart, I would die for them, and whatever might happen to them, I wish it would happen to me instead (20.1.2.59-62).

After having one child, I have changed myself from being a reticent woman and who used her brain only as a well-behaved woman is supposed to become a person who can do anything to earn more money for my child. I bought a car as I could not let my child go here and there by open-air bus. It was so hot. I felt sorry for them. I concentrated on working even on weekends. While I was working in my office, there were customers from five or six companies who I had to work with, at the same time; I also had to take care of my child whereas my husband did nothing with our kid while he was working. But I took care of both my child and of my job. After finishing work each day, I came back home then played with our child, and put the kid to bed at 11 o'clock. I went to bed and woke

up at 3 o'clock then worked until dawn and went out to my office (20.2.11.360-367).

At the moment, actually, my life should be happy already. I sent some money to my mother to build a new house in a big area. I have had bronchial asthma and I thought I might not live long so I send lots of money to my mother as my child is staying with her. My mother has now got a twenty-room commercial building. If I die, my child would not have any trouble, I think (09.1.8.249-253).

When the children were unsuccessful or had a problem, the participants were very displeased as if the actual problem was theirs:

Everything is for my child. If something goes wrong with my child, it seems as if I had the problem too and it was hard to endure when, for example, my child failed the university entrance examination, so I was down for such a long time. But if it happens to other people who are around me, I would not feel worried as much. Maybe I thought that the problem was at a distance from me (05.2.2.60-64).

In contrast, if the children were taking appropriate actions, or performing in a good way, the participants were likely to be encouraged:

My only moral support is that my child concentrates on learning properly (21.2.5.162).

The children's life was the life of the participants. In a clear example, a participant who had financial problems tried to commit suicide in order to provide financial insurance for her children. She stated:

There were so many problems for me to think about that it made me decide I wanted to die. So, I decided to commit suicide while I was working because I thought that I could get benefit from my group life insurance, which was quite a lot of money - around 24 times my highest salary. Moreover, I also had another two life insurance policies, so if I died, the amount of two million Baht would be paid to my children. I thought only about that at that time (13.1.395-100).

On the other hand, as a result of their recognition of their children, two participants changed their intention from committing suicide or killing others to going on to live for their children. As they stated:

My decision was making a wish. But if I could not overcome the problems, I would go into the water and then I would die. So, at that time, I went into the water at 11 o'clock at night. It was so cold. At the same time, I hit the wall with my hands and head and stayed in the water around 45 minutes. The water was getting colder and colder, I did not intend to swim as I went down there with all my clothes on. I gradually went down deeper and deeper. Suddenly, I thought of my children and it pulled me back. My mind was still, calm. I did not cry any more but walked back home to get changed then lay down on the sofa (24.1.5.142-149).

These days, I still do not want to stay in this world, the world of old, bad thinking about my family; thinking about my husband who did bad things to me and thinking about killing him and his mistress. I don't need to think about it anymore. I want to do everything for my children's future. They still need me. I have had a good life and a contented mind because of my children. If I didn't have that, I would kill everyone I could if I had enough money and energy. Because of my children, then, I have changed my mind (20.1.2.51-57).

1.2 Husband as the Center of My Life

Value, meaning in the lives, and selves of the participants depended on the achievement of their husbands and being respected as their wife. The participants did everything in order to give their husbands happiness, occupational success, and respect in society:

I was too sensitive when I saw my husband coming back home with a depressed face. I always asked him about what was wrong in his office and insisted on knowing what was up. When he did not enjoy eating, I bought some pills or vitamins for him. I mean I did everything for him (20.1.6.170-172).

Being loved and respected by their husbands was an important thing for every participant. The symbol of being loved and respected as the only wife was very important. The participants were not able to accept the idea that their husbands had more than one wife.

I'm hurt because I've put up with him all the time. Ever since I've been with him, I put up all the time. He'd like to go out, go...I can't complain. The last time was the worst. He chased me away, saying, 'Get out, Go wherever you want.' We got mad and had a big fight. I left and came back home. He was not nice to me, still. So I took drug to commit suicide (10.1.3.83-85).

Whenever there was a problem, I tried to be patient. I could not stand it when I knew that he had other women. I accepted that I would take care of my two children by myself but still I doubted that I would be able to do it. I started thinking that I had made some mistake as I thought that I sacrificed myself to him, but I did not get anything back compared to what I gave. I felt hurt (*noijai,jebjai*) and wanted to commit suicide, but I then I thought that if I died, who would take care of my children? So, I decided to live (23.1.2.30-35).

1.3 Other People as the Center of My Life

In addition to husbands and children, the participants were taught and cultivated to give love, help, and care to their relatives. The relatives were important people that the participants were obliged to love, help, and care for when they were in trouble or when they needed it. Moreover, society rewards the women who give respect, care, and help to parents and relatives. When comparing women and men, the women gain greater respect from both society and family for playing this supportive role. Therefore, when their relatives needed help, although participants were in terrible trouble themselves, they tried to give help to them. They felt proud when they gave

something to them. In contrast, if they refused to give help to them, they were likely to feel extremely uneasy and guilty.

For example, a participant was satisfied to help her relative even though she was struggling with her economic situation:

I got married with my husband when we had nothing. My parents didn't give me any inheritance. I have taken care of my parents and cousins until my husband felt discouraged because I love them too much. I have nothing, not even my own house. I'm staying in a rental house actually, whereas my brothers and sisters all have their own houses already. My husband told me that I was too generous a person. When someone asked for something from me, I gave it to them immediately. But I told him that it was my business, and I was happy to do it, so please let me continue doing it (30.1.5.91-135).

This single participant would sacrifice herself even though it might have gotten her into trouble. She gave the money to her sister although she had a low income and it made her struggle with her expenses. This was because she thought that if she refused to help other people, she would be unhappy and unable to accept the event as she stated:

Personally, I am not a selfish person who doesn't want to make merit. But I would feel uncomfortable when other people come and ask for help. Anyway, if someone asked for help from me but I didn't give them everything I could, I would feel frustrated. For instance, if I had money and someone came to borrow the money, even if I already knew that I would not get it back shortly, I would still want to give them the money anyway. It would be better if I were a person who knew how to say no to people. Helping other people sometimes made me uncomfortable so that I lost myself. However, I would be angry with myself if I did not help my cousins whenever they had problems. I also helped needy students and donated my old clothes to poor people since the time I had not put on weight like this. I am a kind and helpful person (16.1.14.465-477).

For others, 'the center of my life' was expanded to include the children of relatives. For instance, as a result of being the eldest daughter in the family, one

participant had the greatest family responsibility. She took care of her nephew herself, even though she had her own children and worked hard because she could not watch her nephew be neglected by his own mother:

My mother raised my younger sister without teaching her to do anything. I also loved her in the wrong way. I washed her clothes and took care of everything in my house, whereas she was not responsible for anything. After I got married, she then turned up to me as a totally irresponsible person, although she got married and had a child who had to be taken care of properly, she still did not care about her child. I felt sympathetic then, and so I took the kid home to stay with me. Anyway, my sister's child still needed her mother, not me. When the kid went to bed or talked to me, it made me frustrated as I wanted to take care of the kid properly but I still did not realize that the child needed its real mother. I do not know why my sister does not change. I wonder, in the future, what will happen when she does not have any brothers and sisters to take care of the child. This reason made me stressed. My sister knows that I have medical treatment like this, but she still does not think about my feelings. She is just a taker, not a giver like me (20.2.1.28-41).

Sometimes, there were others who took a place at 'the center of my life' that would take advantage from the woman. Being a person who was important to the parents, relatives, and others became the light that made her go on living. Moreover, it might also make her feel valuable as a person:

R: These days, who do you think you live for?

P: I am concerned about my children who have not finished studying. And my elderly mother - if something happened to me she would be sad. If my brothers and sisters had any problem, they would not have anybody to consult. Anyway, I am not so important for anybody (21.2.3.72-75).

In addition, the participants' parents, relatives, friends and significant others in society were perceived as the center of their life in different contexts and times. For instance, an unmarried participant who lived with her friends had a friend as the center of her life. She saw herself as being kind. If anyone asked her for anything, she gave

her/him all she had. If anyone needed any help, she was always sincere and faithful in helping them:

I am the one who always definitely helps people 100%, no matter what they ask for. So, I do not have any room to spare to be upset... (11.2.2.54-55)...I am the one who always feels sympathetic to other people...(11.2.3.71).

Being accepted by significant others as a good person, and never doing anything wrong in their life, leads to a feeling of self-worth. The participants usually compared themselves to the standards of normality and most likely were concerned about others' opinions especially in important matters. Consequently, they were most likely to choose to do things in a way that made them look good in others' eyes. For example, a participant still decided to get married even though she knew that her future husband had a wife and children. As a result, she was concerned about her relatives' opinion of her, and in significant others' eyes she was seen only as a close girlfriend, rather than as his wife, for a long time. This could make her life terrible:

I got married just to deceive my seniors and everybody else. I would not let them know what really happens in my family life (17.1.11.364-365).

If I could choose, I would not have got married. At that time, if I told my aunts that my husband had got married already ... but I felt concern for my aunts and other things. I am so stupid because I have let him cheat on me for seven or eight years so far ... (17.1.4.104-106).

These days, women can obtain more education and hold a wider range of jobs. The meaning and self-worth of their life have now become linked to external factors, especially to the identity of society, rather than just to their families. Therefore, the center of life for women who are working depends on social acceptance, especially job achievement, and having their own income. For example,

there were two participants who used to be successful in their jobs and earned a large sum of money. But after they resigned from their jobs, their self-worth and self-esteem disappeared:

I used to work in M&S. At that time, it was a transitional working period for me. I had been assigned to work in an import position rather than an export one. Therefore, I had to spend time on working more and concentrate on it a lot so that I did not have time for studying. Because I could not accept it if I did not do my job as well as I wanted, I restricted myself through self-discipline. Then I decided to work first, and whenever I had time later on, I would go back to studying again. Thus, I had been working there for five and a half years...(24.1.2.52-57)... After I quit my job, I suddenly felt that I lost money. I could not stay in my rented condominium. I was nervous. I thought that I should get a part time job and so I applied to be a life insurance salesperson and this Tuesday I will start my new job straight away (24.1.4.97-100).

I used to work in a private company. My former bosses were foreigners. I worked as a secretary who earned a salary of around 30,000 baht or more. As soon as I resigned, my social life disappeared immediately... But if someone were to ask me if I were upset or not...I would say that, at that time, I had a proper reason to resign (13.1.1.25-28).

Job achievement and revenue often come together but sometimes having the former can give self-worth without having the latter. This participant was happy with her job achievement in the past even though she has now retired from her job, explaining:

If we talk about working, I would recover. Even when my children and I were talking in the car while we were driving back home, it made me so happy (her voice broke here) ... like being in heaven. I am very happy whenever I am talking about working (09.1.10.350-353).

The center of the women's lives, as mentioned above, was important as it give self-worth to the participants in terms of earning money, and having good high-status jobs and job achievement. These participants perceived their identity through

other people's eyes and would feel self-worth when they perceived that their identity in other people's eyes was exemplary. On the other hand, whenever they perceived that the identity was not exemplary in other people's eyes, then they would lose their self-worth regardless of whether the perception was true or not.

For example, there was a participant who thought that her perception in other people's eyes should be perfect. She should be perceived as being a good and responsible person. Whatever she did, it must be a perfect job. If she appeared imperfect in other people's eyes, she would blame herself, thinking that it was a result of her own inefficiency. As she said:

I do not really want to be a good woman. But I do not want others to criticize me...I am not really a perfect woman but when I make a mistake, I don't want anybody to criticize me. I should be the only one to know that I did the wrong thing (16.1.1.168).

Maintaining the center of life depended on social acceptance. Participants realized their self-worth through their role and status in their job and job achievement. Whenever they felt that they were being criticized for their mistakes or for work by others, it would have an impact on their self-worth. In other words, they would feel that they had lost their worth and could not accept being criticized. These kinds of participants would be the ones who were afraid of being criticized, or of being looked down on, and they lost face even when their social identity was most probably engendered as a result of an imagination that had been socialized in that way in the past.

Children, husbands, and other people, who were the centers of women's lives, were prioritized by the participants differently. In general, married housewife

participants would prioritize their children first and their husbands would be second. On the other hand, single working participants preferred to prioritize job achievement and social acceptance much more than married working participants. However, participants tried to balance the different centers. Single mothers would change the center from their non-existent, divorced, or deserting husbands to their children, sometimes to too much of an extent. It was as if moving the center that made them feel they had lower self-worth to another center could enhance that sense of self-worth. For example, one participant's account revealed that she felt less self-worth when her husband was unfaithful and so she turned her attention to her children's success instead:

I still have worth for myself and my children and also I do have to be the core pillar for them. At that time, I thought that if I were to die, then who would take care of my two kids? I had never expected that their father could do that or even my cousins. No one could do that but me. This was the reason stopping me and I did struggle with it until every bad thing was over. It reminds me that even though now I don't have a husband I can still take care of my children properly. I feel that I have beaten him and so I am proud of myself. He used to look down on me that my children must be stupid and could not break through any trouble if they stayed with me. It is like a drive that pushes me to fight to make my kids successful in their life (23.2.7.228-236).

In conclusion, the centers of these women's lives were not static and could be changed by places, times, and events which occurred in their lives. At the same time, the persons who were the centers could come from many sources, depending on which ones were considered more important than the others. Therefore, **'The Center of My Life'** in this study is defined as a person or a group of people who were important and of great value for the participants, as well as being their source of pride. The

participants' perception of 'The Center of My Life' was based on Thai social values. The person or the group might be their children, husbands, or other people. Having the sense of self-worth could encourage the participants to happily live in the society and the world. Self-worth itself also influenced the women's perception of themselves as being valuable or worthless.

2. Negative Appraisal of the Center of My Life's Reactions

Participants sacrificed their energy, ideas, and intelligence to their centers of life according to the social beliefs and values to which they had been socialized. At the same time, the participants also expected to obtain proper reactions from the centers according to those beliefs and values. For example, they expected that their husbands would be faithful, give them respect, take care of them when they were sick and also function as the head of the family. Whenever the centers' reactions were not in line with what the participants anticipated and needed, the participants would appraise the reactions in a negative way. From the data, the appraisal of reactions can be classified into three groups, i.e. being treated as an unvalued person, having an overloaded burden, and having a sense of loss.

2.1 Being Treated as an Unvalued Person

Participants had the assumption in their minds that if they gave worth to the centers, then the centers would realize this and give it back to them as well. If not, the participants would lose their self-worth. Those who were the centers were their children, husbands, cousins, and other people who were important to the participants.

The behaviors that were considered to be the sign of being treated as an unvalued person were disrespectful behavior, abusive behavior, neglectful behavior, and deceitful behavior.

2.1.1. Disrespectful Behavior

In traditional Thai society, the man has to give respect to his wife as the woman with whom he has sexual intercourse. Further, the legal wife has to be given the highest respect as “the woman of the house” who would have to take care of everybody in the family including her husband. By contrast, the other minor wives would have their own houses and lower status than the first wife.

Later, as a result of western influence, the structuring of Thai society was changed from the polygamous family system to the monogamous one. Nevertheless, most men are still accustomed to the traditional Thai values and do not think that having many wives at the same time is wrong. Some men may be concerned about modern values in society and their wives’ feelings and needs but probably they still have secret mistresses. In this study, the participants wanted their husbands to have only one wife. However, if their husband still had mistresses, they may not feel worried as long as the husband did not give respect, dignity, and rights to the others equal to what they were used to receiving. On the other hand, if the husband gave those things to the others equally, they would feel that the man did not value them and consequently their self-worth would diminish.

When the husband gave respect and acceptance to other women as his wives and allowed other people to know of this arrangement, the participants felt that they

were devalued, and became less important. They were also afraid of being stigmatized so that society would consider that it was their mistake which led to this situation. This would cause depression in the participants. If the husband just had a temporary sexual relationship with another woman without giving any respect to her, the participants would not feel devalued or less important. This is illustrated by the words of these two participants whose husbands gave respect to other women as much as their wives:

The problem with my husband came from having the other women. Before that we had no problems and we lived together for nearly 20 years. Then, my husband got a better job and started to earn more money, and so there were more women with whom he had affairs. This current woman knows where we live and really want to stay here too. My husband also want her too, but I cannot stand it. Therefore, the problem springs from this situation (27.1.34.99-102).

Having another woman, I just could not accept it. I had an inkling that my husband had another woman who he really wanted to live with seriously. I really could not accept that. Then I told him that if this continued, we should get a divorce. I cannot stand it and separation is better...(23.2.6.191-194). ... If anybody has not had this kind of experience, they would not understand it. It is difficult to explain that I am not worth enough for him. If he has someone else to take care of him and can stay with him happily, then I will let him go. I can live like this (23.2.6.203-205).

There were limited solutions for the participants whose husbands had mistresses. If they still lived with their husbands, they had to face the feeling of being unable to stand their husbands' behavior. But if they wanted to get divorced, they had to face the feeling of being stigmatized by society as being bad and imperfect wives. Therefore, no matter which way they chose, it would bring mental suffering.

For instance, there was a participant who was faced with the feeling of being stigmatized by society after getting divorced from her husband. Thus, she tried to conceal her divorce from everyone. According to the participant's thinking, society

always viewed the broken families and husbands having other women as being the result of deficiency on the part of the first wives who could not maintain their husbands' love for them and keep staying with them. This idea was socialized by our ancestors in Thai culture; therefore, the woman whose husband was unfaithful and who made the decision to get a divorce would feel that she was stigmatized by society. It would result in her mental suffering which was hard to overcome even though she might not think it is really her fault:

Being worried is the other problem. Getting a divorced always results in the woman being blamed that it is her fault. Therefore, it makes me afraid of revealing this to other people. Mostly, the situation is considered to result from the woman's deficiency. This is a very important point. These days I still do not want others to know about it. I thought that I did a good thing and what others think is their own business. I do not know how my former husband thinks about me. But I think he cannot blame me for anything as I know that I did not behave badly. Now my two kids have finished studying and I also have a better house than the house where we lived together. Everything I have now comes from my two hands. Anyway, I still wonder whether he blames me or not (23.2.11.355-364).

Another participant still lived with her unfaithful husband and has concealed her hurt feelings about his having another illegitimate wife from anyone. This is because she was afraid of being stigmatized as a deficient wife. Her words are as follows:

I did not tell anyone about my husband's behavior. I felt so embarrassed that my husband was unfaithful to me. I asked myself what I had done wrong. I thought that I treated him well, rather too well than not well enough. Because of the word "mistress," it makes me feel embarrassed both of myself and in front of others. They might think that I am a bad woman so that my husband had to have someone else (21.1.10.310-320).

As well as the husband, being disrespected might also result from the appraisal of the mother-in-law who did not accept or respect the participant as her son's first wife or in the role of big sister-in-law. In some situations, participants were not respected properly by their husbands. An example is a Chinese participant who lived with her husband's family. She had helped her husband's family business and did everything in the house. Her husband was a drug addict and fond of going out at night. He also had many mistresses. However, her mother-in-law had given respect to her as she accepted that the participant helped her family's business. Anyway, the participant perceived that now the respect had disappeared since and this had led to her suffering from a mental illness. Her own words were as follows:

My heart did not beat properly. I knew that something wrong had happened. After I finished my job and arrived home, my mother-in-law swore at me badly. I apologized and asked for forgiveness from her. I spent such a long time talking to her and she stopped having a good relationship with me. Then, I went to my bedroom. Since then my heart has beat improperly, and my hands are always shaking (04.1.3-4.90-95).

In conclusion, the participants perceived that disrespectful behavior was a reaction reflecting lack of recognition of their worthiness. Her husband having mistresses both openly and secretly and being disrespected in the role of first wife by her mother-in-law brought about the feeling of losing their self-worth and eventually resulted in clinical depression.

2.1.2 Abusive Behavior

Domestic violence was inflicted on the middle-aged women in this study both since they had been married and sometimes after a specific event had occurred. Most domestic violence was psychological domestic violence. For example, one husband tried to bring an illegitimate wife to live in the same house with the first wife. However, physical domestic violence was also inflicted both by the husband himself and by the husband's cousins. The reasons why those participants were still living with oppressive relationships like these was that they had to be patient to protect their children from the new wife and to protect their husbands' reputation. Moreover, they had to be patient as they could not rely on themselves. However, this part will concentrate only on the physical and sexual domestic violence as the psychological domestic violence has already been mentioned with other forms of behavior.

Domestic violence often happened in the cases of the participants who lived with their husbands and their husband's cousins. Those husbands and cousins thought that the participants had less power and lower status than them. Although the participants could earn their own money or could work in the business of their husbands' families, they were still looked down upon by their husbands' families. One Chinese participant who had to rely on her husband's family said:

Since I got married, I did not know how I could be patient living with my husband in the house as he had plenty of mistresses, around five or six women, and he also took drugs. He never took care of me but just swore at me. But I thought that I was lucky as I could be patient until he died. Anyway, I had to be patient at that time, not because I had to work hard but because I had to listen to bad words from my husband. My heart was hurt when he was drinking whisky and he swore at me while I was working there. I had to work and he kept yelling at me until I finished and then walked away. I do not

want to think about it as I feel so sick... (04.1.17.384-393). ...I helped them in their shop and it was quite a difficult and busy job as they forced me to work hard. Not only was my husband a bad person but my mother-in-law was also a bad person. When I made even a tiny mistake, she immediately told her son, my husband, and then, within half an hour, he came and swore at me badly. It made my heart hurt (04.1.1.2-6).

The reason why this participant still lived in the house was because she wanted to protect her children. She was afraid that if she walked away, no one would take care of them:

I really wanted to get a divorce but my husband said that he would let me take my eldest son but my second daughter must stay with him. So, I refused as I thought that no one would protect her from his mistresses if I moved out. Therefore, I had to be patient and let them oppress me further until I came here to see the doctor. I had consulted the doctor for one year and then my husband died (04.1.2.58-64).

Domestic violence always happened when the wife asked for her right and proper role as an equal to her husband such as by asking him to stop gambling and trying to prevent him from bringing an illegitimate wife into the house. This participant's action was an action intended for the family's happiness, but it was also to strike back at the husband for not being concerned about her self-worth and rights. The results made the participant totally frustrated and depressed, in the same way as it did for two participants who made the decision to commit suicide and then ran away from home instead.

The first participant, who had been patient with her husband's gambling for ages, suffered domestic violence when she recommended that he should stop gambling:

I was so stressed. I hated his behavior. I could not complain about anything and I did not try to, but instead I became a patient woman. Sometimes I was such an extremely patient woman that even his cousins felt sympathetic. I had to be patient until I was nearly mad, until I exploded and said everything to him. And then he slapped me. I was so hurt (*noi jai*) and always asked myself why I was not like other people (10.1.9.295-316).

Domestic violence was the reaction of the husband when the wife asked for the proper rights of a legal wife and told him she did not want to stay in the same house with a mistress. A participant wanted to ask for her rights and then did not allow her husband to sleep with her after he brought a mistress to stay in the same house. Then she was hit and raped by her husband. Moreover, he also hit their children just to make the participant hurt more. Asking for her rights was wrongly considered to be bad behavior by her husband and his cousins. Incidences of domestic violence happened so many times that she could not stay with her family any more:

The problem started when my husband had another woman which I could not accept. So, I did not allow him to make love to me and I moved into another bedroom on my own. I am a woman, so I can live without having sex, but he could not. Even though he had other women outside, he still wanted to sleep with me. And it was a serious problem. He really needed sex until he had to force me. I could not stand that and moved out eventually (27.1.3.4.99-117).

Domestic violence, as it was inflicted upon this participant, also happened to her children. This was because the husband wanted to make the participant even more hurt. This behavior increasingly encouraged the participant to appraise her husband's reaction as a disrespectful reaction to her worth. She also perceived that her husband gave respect to other women much more than to her children and herself. Another participant, whose husband also hit her children to make her feel hurt, said:

R : How often did he hit your children?

P : ...Often...not only once...the last time was the worst as he hit my youngest child. When he hit the child, I had to stop him. But he hit me too. Actually, he really wanted to get me, not my children. But he knew that hitting my children was my weak point, and then he did it...(cried)... (27.1.4.125-129).

This domestic violence, which the participant understood to be a disrespectful reaction to her worth, was the physical, psychological, and sexual domestic violence inflicted by the husband and/or the husband's cousins who looked down on her as a person who not only was of lower economic status but also had less personal status because she was the wife. Moreover, they did not realize that domestic violence was wrong, and it made the participant depressed. In addition, domestic violence always happened at the same time as neglectful behavior and deceitful behavior which will be discussed next.

2.1.3 Neglectful Behaviors

Typically responsive behaviors of husbands, to whom participants had given respect, were unkindness and inattention. This was especially the case when the woman became sick and needed attention, but the husband did not take care of her properly. Eventually the participant appraised the reaction as the treatment of an unvalued person. For example, there were two participants who became so depressed when their husbands did not take care of them properly when they got sick:

He has never paid attention to me. When I had my leg operation, I was so stressed as he never visited me at the Praram 9 Hospital. I was admitted for four days, but he never came to see me. Next, when I had my tonsil operation, he did not visit me at all either. I have been keeping this desperate feeling inside me but I have to cry alone. I asked myself why my life had to be like this (10.1.9.301-305).

R: When did you know that there was something wrong with your mental health?

P: ...After I had the cancer operation. I cried when I was in the hospital as my husband never visited me. The patient next to me had her husband's subordinate, a soldier, who visited her with a bunch of flowers. The woman asked me about my husband's job. I felt so embarrassed then told her that he was just a non-commissioned officer. I did not dare to tell her, but cried until the doctor wondered what was wrong and asked me whether the wound was very painful... (29.2.11.243-249).

2.1.4 Deceitful Behaviors

The reactions of the center of women's life might be opposite to the way it was expected to be. The participants already had given trust and faith to them, but they deceived the participant by being deceitful about wealth and telling lies about being faithful. This situation recurred so many times that the participant felt hurt, confused, and mistrusted. The participant considered that it was a result of the treatment given to a person who was not valued and whose good behavior was completely ignored:

I recovered here...the doctor called and asked me... but I did not want to talk or reply to him. I thought that no one was sincere with me. Even my husband who used to be such a nice man to me was not sincere to me, so I did not think that others would be sincere to me either. I shut my mouth as I thought that I would not talk to or get along with anybody any more. I really wanted to live alone but I could not; my heart, my hands and my whole body shook as I was scared of everything. The first time I came here, I was so scared. I was afraid of being deceived and left again. I was panic-stricken. My friends and others tried to help me, but I did not believe them (19.1.6.199-205). ...I felt that everybody in the world deceived me, and I felt furious with all those people. I became sick of this situation and I wanted to die, so that then everything would be finished. He should not have deceived me, but he did it for many months. His behavior was opposite to his words. He had never been a playboy before, but he changed to be a flirt and an adulterous man instead (19.1.6.207-210).

Some participants were deceived in many things such as being told lies about money by their husbands. One participant said:

Even though I knew that he did not have any money, he still deceived me for an amount of 400,000 – 500,000 Baht. Before that, around one and a half years ago, he cheated me out of 300,000 Baht. And I gave him again more than 100,000 Baht two months ago, too. He made me trust his words and then I gave him the money. He told lies about everything, but I could not hate him. I am still in love with him. We have lived together so long for more than 20 years. He was dishonest and told me lies about everything (21.1.6.184-198).

As well as the husband's behavior, the deceitfulness of one participant's neighbor, whom she trusted, also inspired mental illness in one participant, a participant reported:

I got into a huge debt but it did not mean that I took the money for gambling because I had no interest in that kind of thing. I was cheated. I played money sharing which meant that 3,000 Baht had to be paid for one share. I spent 50,000 Baht, but the money was gone. I had nothing left. Since then I have been depressed as I expected to use the money for paying off my debt. My husband said I was so stupid because I had lost around 300,000 Baht. Unbelievable, I did not think that they could deceive me as they were my neighbors. Anyway, whatever they did to me, I would not mind. I can stay alive but still feel depressed as I have to pay my debts. I was worried a lot and I really wanted to pay everything. If I wanted to cheat them, I would not be like this. When the due date came, I was so worried. I had no idea how I could explain this to the creditor (30.1.3.60-76).

The appraisal of being treated as an unvalued person by the center of women's life, i.e. husband, husband's cousins, and friends, is associated with domestic violence, being disrespected, being neglected, and facing with deceitful behavior.

2.2 Having Overloaded Burdens

Participants judged that they had overloaded burdens from the demands of those who were the center of their life. These demands might be excessive; hence, the

participants could not manage them by themselves. The participants might be asked for help that eventually led them to trouble. The assessment of an overloaded burden was at different levels of intensity ranging from low to extremely high. The participants might have one burden at a time or several burdens might simultaneously fall onto them. The burdens can be categorized into three types: caring for illness demands, unexpected care demands, and long-term care demands.

2.2.1 Caring for Illness Demands

This demand is considered to be the most intense overloaded burden. This may be due to fact that the demand covers both physical and psychological care as well as financial expenses.

The participants might encounter caring for illness demands from many people who were the centers of their life, at the same time and in many aspects. They had to respond to the demand, and were unable to avoid the situation. Additionally, there was nobody offering help to them, as well as nobody that they could ask for help; hence, they believed that they had to handle the burdens alone. As a result, they were discouraged and felt a lack of energy. For example, a 40-year-old participant felt extremely depressed and upset with her destiny because her husband had schizophrenia to the extent that he could not work and, additionally, her daughter and son were mentally ill and needed to visit the doctors regularly. She, working as a maid in a company, was the only wage earner in the family. She said that:

(Crying while speaking...finding it difficult to speak out)...I was born to be in trouble. My husband and children all have their own problems. Sometime they argue with each other and I have to be the middle person to deal with all of them. I had to

explain to my eldest daughter that her father had a mental illness and asked her to try to understand him. I said “please don’t be angry with your father, if “Joy” (her daughter’s name) does not like him please leave for a while then I will talk to him later.” My youngest son, who is nearly eight years old, also has something wrong. Once the doctor said he suffered from anxiety. I was so worried as I thought he might be like his father... (15.1.1.9-18) ...I had to handle all these burdens alone. When I first took my son to the hospital, I could afford the medical fee. At that time I still had some money. I paid 5,000 Baht for the first time and 2-3 thousands respectively for later visits. After that, I had to spend more and more, a fortnight a time or once a week (15.1.1.23-25).

2.2.2 Unexpected Caring Demand

This demand occurred with participants who had never had any burdens before. For example, participants’ husbands were always the ones who handled every burden, especially financial burdens. Suddenly, they had a serious illness or they died, and so the participants had to handle those burdens instead of their husbands without having any prior warning. As a result, the participants felt that they were overloaded with burdens and also appraised the situation in a negative way, which had considerable negative impacts on their mental health. To be specific, there were two participants of this type. The first one was a 52-year-old woman whose husband had been the one in charge of handling the financial burden. One day he was diagnosed with chronic obstructive pulmonary disease. He could not take care of himself and needed close attention from her. She also had to take care of her young children and to handle all expenses. She said that:

I had to take care of my husband. His sickness was so serious that he could not walk. I had to carry him or let him use a wheelchair. I did everything for him such as giving him a shower. My children also

had to go to school, and I was alone without any money (03.1.2.51-53).

The second participant had to get a divorce without having any preparation. She had to handle every burden such as earning money, doing housework, and taking care of her children. Previously, financial burdens and other burdens had been her husband's duty. She said that:

It should not affect my family like this. During the last five or six months, my former husband never paid any alimony. After my children have finished their education, they can get jobs. Anyway, at that time, we had so many expenses, and everything was my responsibility. It made me stressed a lot, and the stress is still there. Sometimes I could consult other people, and sometimes I could not. Outsiders might think that I was happy. After he moved out, he drank and came back home once a month and gave me around 1,000 Baht or 2,000 Baht. I could not live with that amount of money (02.1.3.65-70). ...I felt that I should not have to endure this kind of thing. I felt so tired alone. My children's father is now an outsider after our divorce (02.1.5.151-153).

2.2.3 Long-Term Care Demand

This demand was also considered to be an overloaded burden. The participants had to take the burden for a long time without knowing when their task would be finished. At present, women have roles both outside and inside the family and they have to struggle with their life in order to complete their responsibilities. These are long-term tasks, starting from delivering the children until they become adults. This particularly affected participants who had now achieved role and status. One participant who had to perform the roles of mother, wife, and office worker without having other people's help said:

I've been so stressed all the time. It is like something has already accumulated inside me. When my children were young, I had to wake them up very early as my job would start at 7.00 o'clock. But it was difficult to wake them up. They moved very slowly and were so annoyed as kids. We argued with each other every day along the way to school. It happened again and again and made me extremely angry daily. Normally, I lost temper very easily. I was angry with my children, and I hit them, too. I got them dressed up and then dragged them to the bus to school. After that I hurried back to work. It was a routine situation that happened for ages. It was not related to my children's behavior, but it was like something had accumulated inside me for six or seven years. I felt a headache deep inside my head (09.1.2.40-48).

The caring demand, which was more than the participant could accept, could influence her to commit suicide, as could be seen in the following sentiment of a divorced participant:

I went to ask for forgiveness from my daughter-in-law's parents. Then when my grandchild was born, not only did I have to work hard, but also I had to take care of my children and daughter-in-law including my grandchild... (01.1.12.385-387). ...I had to handle every burden, taking care of my grandchild, my children - both the eldest son and the youngest one. They all relied on me. I nearly committed suicide, so I decided to come to see the doctor (01.1.12.396-399).

Moreover, long-term caring demands could cause depression in participants, especially when the money aspect was concerned. They did not have their own time for rest. As one of the two participants who were requested to handle financial burdens for their parents and cousins stated:

After I have finished...well...my parents were so poor. My salary was 850 Baht which was not enough for three of us (my father, my mother, and I). My mother also had some debts then on our land, and so we had to move into a small rental room. After I graduated only one day, I kept looking after patients. I probably had only a day off in around three days. After my certification ceremony, I had looked after patients for ten nights continuously. At that time, I was still young, so I could work hard. I was a hard working woman. While my friends went out for trips, I just kept working. Some years I did

not have any holidays. Every weekend I had overtime work, so that I could have enough money. Mostly, each week, I would look after patients for many days. I could only sleep just two nights a week (09.1.1.7-20).

I was the head of my family. I did not want to handle all the burdens, but I had no choice. I did not prepare myself before. Since my mother became old, I had to take care of her. Moreover, I had to support my nephew to go to school. My health was not good either, but I was the only one who could earn money for my medical treatment and others. It seemed like an oppressive situation which I could not avoid. I worked in the teaching business and tried to do extra teaching just to have enough money. I kept working while everyone else around me had problems (08.1.1.17-24).

In addition, one participant also appraised the situation of being relied on to shoulder a financial burden by her husband, cousins and children, which was too much for her to undertake, as an overloaded burden. In particular, she thought that she did not create or gain any benefit from the situation, but she still had to handle the burden instead of others.

Some participants had to repay their husbands' debts even though they were divorced. Additionally, the participants had to struggle with finances and worked hard to earn family income. For example, there was a participant whose soldier husband always pushed the financial burden of paying debt onto her. She said that:

My husband always had debts. The creditor wanted me to pay for the bouncing check signed by my husband. They all sympathized with me and wondered how I could afford it. I had tried so hard to pay them even though I did not have money left for myself. When I could not pay the capital, I then paid just the interests and capital installment. I tried to pay the interests as I did not want to be a debtor in the next life. The creditors asked why I did not tell them it was not me who had the financial problem and who spent the money borrowed from them. Sometimes it was 100,000 Baht and sometimes 50,000 Baht (29.2.20.462-471).



In Thai society, there is a value that demands that whenever brothers or sisters get into trouble, they have to be helped. It was the reason why some participants had to always lose money to help their cousins even though this would bring them some problems. Therefore, cousins were also the ones who always asked for financial support from the participants. There were two participants who had this problem, and no one repaid the money back to them. As a result, they had to handle the overloaded burden until they felt depressed. They said:

My sister wanted to buy a car, and she asked me to take out a loan from the Co-op. But when I did, she did not repay me the money at all. I had to repay the money without getting anything back. At that time, I had only a little money. My salary was a little bit more than 10,000 Baht, but I did have to pay installments of 6,000 Baht monthly, then I had only around 6,000 Baht to spend for myself. I was an out-going woman, and I used to spend my money on buying clothes for myself. But I had to save money for repaying the loan. I did not think it was a big problem, but it made me unhappy. I had to isolate myself from social activities as I had less money left (16.1.4-5.131-138).

My younger brother was laid off, and he asked me to support him by paying for his children's tuition fees. Sometime he asked for 300 baht. These day he is working again, but he has still borrowed 50,000 baht from me and has not paid me back so far. Sometimes he told his kids to come and ask for money from me for their extra tuition fees. It was an annoyance because I was not a rich person. Anyway, I could not deny helping him as he was my brother. I was so stressed, I came and consulted the doctor here. He told me to relax, and if I had money then just give it to them and, if not, I should tell them straight away. Moreover, my second brother had taken out a loan from the Co-op in my name. And then he said that he had no money to repay the loan and he refused to pay it. Eventually, I was the one who had to repay the money. I spent around half of my salary each month on paying the installments. I had tried not to think about it but at that time I felt so furious and I told him that I would be admitted again if he behaved so badly again in the future (12.1.8.270-278).

In conclusion, having overloaded burdens in this study refers to a result of appraising demands for caring which can unexpectedly arise from different sources and which may be continuous, as well as the appraisal of the demand for financial support from the centers of life. The participants would appraise those burdens as being overloaded burdens which had various degrees of intensity. In other words, overloaded burdens could result from many causes and many centers together, either at the same time or one after another.

2.3 Having the Sense of Loss

Having a sense of loss in this study refers to the participants' appraisal of disappointment in the actions/reactions of those who were the center of their life including children, other people, as well as their own self. Moreover, it was also the appraisal of losing supporters, acceptance, faith, financial security, and life freedom. This is discussed in the following section.

2.3.1 Loss of Expectation of the Center of My Life

Thai participants considered the meaning and value of happiness and success to be that if success was achieved by their family members, that was the same as achieving their own success. Those participants who had tried to control or supervise their family members' success as well as their own success had expected that success to be achieved. Whenever their children and husbands were not successful, then they would feel disappointed. Some single participants, who had high expectations for their job achievement, would feel very disappointed whenever they were unable to meet those expectations. They would feel extremely depressed and felt

they had lost their self-worth as they thought that plenty of problems had emerged and they had no one in their offices to support them.

The expectations of the middle-aged participants might be derived from various sources: their selves, their children or other people. Whenever expectations were not achieved, then they considered the result to be a loss. The degree of having a sense of loss differed, depending on how much the participants valued the expectation. The following part will discuss this sense of loss and with some examples provided.

2.3.1.1 Loss of Expectation of Children

The majority of middle-aged married participants had teenagers or working children. They all expected that their children should be good people and be successful in their lives. If their children, especially their daughters, did not follow Thai values, this could affect the participants' feelings to an extreme degree. Failure to follow values could include becoming a drug addict, going out at night, or having sex before marriage.

Deep disappointment happened most strongly with the participants who were infertile and desperately wanted to have offspring or who were single mothers who also expected more from their children.

I got married when I was 25 years old and had my child when I was 30 years old. After four years of marriage, I had to have medical treatments until I conceived my child. I love the child so much. I had my child when I was 30 years old, you know! (12.1.2.32-33).

In addition, children's behaviors that made the participants disappointed in them were the types of behavior that society believed would make the children fail in their later lives such as sneaking out at night, having sex before the right time, and failing in their education. It was never expected that their children would behave like this. For example, one whose daughter was a drug addict stated:

I never thought that my daughter would be like this. I only thought that we are a good family and that my child would not do bad things... (12.1.2.34) ...Before I got sick, I was so furious when she did not come back home. I followed her to her friend's house and found that they were only girls hanging around together. They did not have any boyfriends yet but only wanted to be hanging out in the pub and then go back home to have another drink. When I found out, I went mad and hit her with a big bat. Since then, my health has not been good any more (12.1.4.103-108).

The children's behavior which was most antipathetic to Thai values was that of having sex before the right time, leading to failure in education. This behavior was the one which the participants simply could not accept more than any other, and made the participants extremely disappointed with their children, as one participant said:

I am just so stressed. When I found out about my daughter's bad behavior, I was bent over and could not even walk properly. I was so hurt, really hurt. This should not have happened (18.1.4.121-125).

R: Can you please tell me, which problems were the ones that hurt you the most?

P: It was having a boyfriend. My daughter was able to pass the entrance exam to get into (name) a university. Then she had a sexual affair with the boy and skipped school. It was nearly the exam period and I followed her to make sure she went back to school to attend the exam. Anyway it was too late as she had been absent so much that the University would not allow her to have the exam. This was the behavior which made me hurt so much (18.1.5.164-169).

The daughter's behavior of sneaking out at night not only forced her mother to lose her expectations but also caused the mother to blame herself for not raising her daughter to be a good woman. One participant said:

I felt hurt. I thought that I had failed. At that time, my eldest daughter was still studying at high school, Mor. 5. She was smart. I expected her to be a good girl. I found out that she sneaked out at night when it was the second school term. I could not stand her behavior and kept asking myself why this had happened. I tried to pull her back, but I failed. Anyway, she still had high scores and now she has completed school and has started to work. However, I could not accept the behavior and it was the reason why I had to come here. I eventually told her that she was the cause of my mental illness, but I did not tell her definitely that it was her fault as she might think that I did not love her. Now, she still goes out at night like before but I am not worried as much as when she was still at school. While she was at school, at that time, I was so worried I could not sleep. I tried to follow her every step but it was impossible. I felt fed up with her as I was afraid that she might not finish the school. Anyway, she did pass it (23.1.369-81).

Having serious arguments and showing disrespect to their mother also caused the participants to lose their expectations for their children though they had sacrificed their love and moral support, as well as her energy to their children, without the desired outcome. One participant said:

Before seeing the doctor around one to two years ago, my daughter had been causing me stress a lot until, one day, she lost her temper with me. It hurt me as I had tried to do everything to make her happy. I even allowed her to spend time with her boyfriend. But when she said bad things to me, it hurt me so much that I had to have sleeping pills. I did not mean to commit suicide but really I just wanted to sleep as long as I could (02.1.3.75-78).

Loss of expectations from children occurred when the children did not behave properly or failed in something in which their mother had expected them to succeed.

Two participants stated:

When my child failed the entrance exam, I cried when I saw my child crying. I knew that my child was really hurt much more than I was. Even though I thought that I was deeply hurt the same as she was, she must have been hurt more than me certainly (07.1.4.120-124).

I was the one who supported her studying with money. Therefore, I felt depressed. At that time, I might have expected too much from my nephew and been too demanding of him because I really wanted him to succeed in his life (08.1.5.150-151).

The career and educational achievement of children seemed to them to be a function of the efficiency of their mothers or guardians. Good performance in these respects could earn respect from society as well as greater well-being to those who achieved a lot. On the other hand, if their children behaved in the opposite way to their mothers' expectations, then the mothers felt that this was a critical situation which affected their self-worth and ego. They would feel devalued even though other people might not think that the behaviors were that serious.

2.3.1.2 Loss of Expectation of Other People

Other people in this case were cousins, colleagues, and other people in society. Participants always prioritized someone whom they believed to be even more important to them than their bosses and their friends. They would sacrifice themselves, both physically and spirit. At the same time, they would expect those people to react similarly by responding to their effort, too. Whenever the reaction was not what the participants had expected, they would consider that they had lost their expectations of those people. This was the case with one participant who sacrificed herself to her organization and her bosses, but when her reputation was ruined, her bosses just ignored her and did not give her any attention. Therefore, she felt that she had lost her self-worth. This feeling affected her mind profoundly:

I felt very upset when my director did not fix the situation and just ignored it even though his wife was one of the witnesses to the event. Another teacher tried to clear up the situation and I was worried that it might turn out to be an even more serious problem. The other side was so furious, but I tried to keep calm as I could not explain anything, and I did not want to either... (05.1.7) ...The cause of the argument was that she accused me of being too close to my director's wife. Other people might think that she loved me until I got a double-level reward. Actually, no one knew that she exploited me a lot; I had to work until 2-3 a.m. for her. I should have got ten levels of rewards instead, I think. My health has been poor since then, and I have not cared about anything (05.1.8.265-271).

2.3.1.3 Loss of Self-Expectation

Participants linked their self-worth to their job achievement and their families' success. If the results of their actions were not the same as their expectations, they became disappointed and depressed. The expectations toward themselves were expectations of themselves as an ideal, the perceived ideal of being a perfect person according to social values.

The achievement which the following participant expected was a perfect achievement. The sense of loss happened when the achievement was not as good as she expected, since that was probably beyond her capacity.

At first, I had some problems with my job and my family. But these problems faced me at the same time in one year. It made me discouraged. I did not perform well in my job. Maybe I might have expected too much of myself... (06.1.1.27). ...I did not want to do anything, and I felt bored with so many things, especially my job (16.1.2.50-51).

The expectation of one's self might result from substituting the experience of a sense of loss in the past. For example, there was a participant who did not live with her father when she was young and she knew that this had caused her problems, giving her an inferiority complex in her life. She had expected that she would have a perfect family and happiness. Unfortunately, she could not meet that expectation and that affected her feelings a lot. She said:

He accepted that the child is his child. I confess that I was upset more than at any other time in my life. He said he wanted to live with me, but he was lying about that. I asked him whether he knew what would happen to me when he behaved like this. I had to stay with him secretly. Wherever I went, I had to hide from his first wife's cousins. I was so worried about what would happen if her cousins saw me. I was so stressed because what happened to me was so cruel. When I was young, I lived with my single Mother who always hit me and swore at me, calling me a "bitch!" and other bad words. It accumulated inside my mind all my life. Therefore, I thought that if I had a husband, I would choose the one who was older than me and he could be my friend, my brother, my husband, and my father at the same time. I know that I was doing the wrong thing. So that if I was able to have a family, I would try to make it perfect. I would not let it become a broken family like mine was when I was born. If I had a baby, I would not let my child have to endure this kind of situation like I did. Unfortunately, I could not make it happen (crying). The first day of my married life was a Sunday. After our guests had left, he said he wanted me to stay alone as he had to go back home and that he would come back again on Monday (17.1.3.4.80-97).

In conclusion, loss of expectation was the consideration of children's and other people's and participant's behaviors or reactions to behaviors together with the understanding that the behaviors or reactions were not the same as the participant had expected. They affected the participant's sense of self-worth and caused them to be very upset.

2.3.2 Losing Source of Support

The loss of supporters who were the center of life and who provided money and moral support to participants was another thing that the participants appraised as causing a sense of loss. For the middle-aged participants, the second supporter was their husband who supported them as their parents did before. One participant said:

My husband took care of me like I was his daughter. I had less education than him and had never seen the outside world. When I stayed with my parents, I had to help them work in our own shop while my brothers had a chance to study. I had to stay at home as our shop was at home. When I got married, I still had to stay at home again. And now it was too late to change (22.1.8.266-269).

The loss of a supporter which was not anticipated, such as the death of the husband, affected the participants' way of life. Two participants said that:

When my husband died, I had no idea how to do anything as I had just been a housewife. I lost weight as I could not eat any food (22.1.1.18-19).

The reason for having a mental illness was, at first, because I was frightened by his death. My hands shook so much that I could not write. Before I came here, I often had a headache (18.1.1.3-5). At that time, I was so scared of everything. I wondered how I could stay alive. I lost self-confidence (18.1.3.101-103).

Not only the death of husband but the continued living with the husband also was appraised to be a cause of a sense of loss. As a participant said that:

R.: When did you feel that you became deeply depressed?.

P: When I resigned from my husband's company. I was afraid of being left as my husband was a playboy. Whenever I could not see him, I felt so tortured. This feeling was such a torture to me. Then I realized that there was a hell in the real world (25.1.9.306-309). At

that time, I felt that I was crazy. I felt that I could not stand it. It seemed like there was a fire inside my heart (25.1.10.323-326).

Moreover, the loss of being loved also led to a sense of loss. For instance, for the husband to have an affair with another women was considered to be a loss by the participants as well, as another person said:

When I found out that he was unfaithful, I felt that I had lost him. He had been lying to me all the time (21.1.5.186-187). I did not trust him, but deeply in my heart, I still loved him and did not want to let him go. I did not know why. Sometimes I thought that since he did bad things to me, I should not be good to him. As a result, it helped me feel better from time to time. Anyway, I still could not accept the loss, and I really wanted him to stay with me (21.1.6.172-176).

2.3.3 Loss of Being Accepted and Trusted

The loss of being accepted and trusted by the center of life was considered a loss. Those who influenced the participants' feelings most were children, important people in the participants' lives, and other people. The behaviors which led to the feeling of loss of being accepted and trusted might be expressed in several ways as is discussed below:

2.3.3.1 Loss of Being Accepted and Trusted by Children

The middle-aged participants regarded their children as their first priority in their life. So, the loss of being accepted and trusted by their children brought about the ultimate loss to them. It seemed to them that they could not perform a mother's duty properly. The ways in which children revealed this behavior depended on the level of development of the children. Older ones, for example, would show their feelings through words:

My child was angry with me because I left her with my mother. She ran wild and cried. She also said that I should not have her as I could not raise her, but left her with my mother. It made me stressed until I had to come and see the doctor here. (09.1.7.211-213). Because she was so angry with me, she told me that she would try to make me hurt whenever she had a chance because I left her with my mother (09.1.7.230-1).

Instead, young children would show nonverbal reactions, as in the following example of a participant who perceived that her child did not realize the importance of her as a mother:

I often had to go overseas to work until I had no time for my child. I started feeling envious of my child's nanny as she was so close to my child, much more so than I was. I felt insecure when my child called my husband "mama." After two weeks of traveling overseas, my child kept distance from me. She screamed when I touched her at night until I had to let my husband carry her instead. Therefore, I decided to resign from my job just to stay with her (24.1.2.65-69).

2.3.3.2 Loss of Being Accepted and Trusted by Significant Persons

The participants who did not have enough love and care from the time they were born always prioritized the ones who supported and came close to them much more than any other. This was because they gave them a sense of self-worth. Whenever the relationship was finished, they would consider that to be a loss which would eventually affect their self-worth:

He transferred an amount of 500,000 Baht to me. He also sent me a letter to tell me that the money was like an exchange for the opal that I gave him. Actually, I did not expect anything. I felt shocked and so upset. I could not even read the letter again because I could not accept what he had said. I thought it would be better for me to die. I could not stand it that I had made him feel so bad (01.2.1.9-13).

2.3.3.3 Loss of Being Accepted and Trusted by Other People in the Society

The self-worth which came from being accepted and trusted by other people in the society was related to honor, dignity, and reputation in society and in one's career. The loss of being accepted and trusted by other people could affect the women's self-worth and made them unhappy, as one participant said:

When I arrived at the school, the student's mother rushed to me and swore at me and then accused me that I had a bias against her child. She said her child handed in her homework everyday. I tried to open my mouth, but she did not give me a chance. She said she would tell a newspaper reporter to publicize my behavior. I was so sorry because I treated the student as my own child. Why did she think that I was her enemy? (05.1.8.226-232).

2.3.4 The Loss of Security, Wealth, and Freedom

The loss or expected loss of security, wealth, and freedom came from losing a job, income or assets.

Losing a job was related to losing income and freedom of decision or having fewer choices for life. Long-term unemployment could affect self-worth and self-confidence and trust, especially in the context of losing a supporter. Two participants, who were used to having achieved high ranks in their organizations, said that:

Because at the moment I am unemployed, I feel so stressed. I have tried to stay at home as there would be expenses if I went out. I feel uncomfortable as I have no more income. I had been working for a long time and then, suddenly, one day I did not have my job any more. I seemed like I had no worth and meaning (13.1.1.5-9). When I decided to resign from my job, it was like going through a massive change. No social activity, no money, they are all gone from me (13.1.2.42-44).

When I quit from my job, I felt like I was going to lose my income. I could not live in a rental condominium any more. I was so nervous. Then I applied for a part time job as a life insurance sales person which will start this Tuesday (24.1.3.97-99).

Losing of a lot of money can affect the security and freedom of spending and of life. It can also affect the self-worth of the participant, especially if it came as a result of her mistaken decision. As she said:

P: I lost so many millions of Baht. Before that I had plenty of money to spend, but now I have so much less. I felt hurt because I made the wrong decision.

R: What did you think when you lost your money?

P: It was a pity that I made the wrong decision. Sometimes I really want to help my brothers and sisters, but I cannot do that any more.

R: Why did you lose your money?

P: ...I was cheated. I lost more than a million Baht. Moreover, I brought my brothers and sisters' money, around 10 million Baht, into that business. I trusted my younger brother too much and tried to be too considerate to other people... (21.1.1.123-127).

The consideration of loss may be just a forecast of what could occur in the future. The following participant, who was so worried that she might lose her wealth that it had a negative impact on her mental health, said:

The second problem was that my husband has a new wife. I was so worried that he might not give me financial support any more. I was afraid that if he had new children, there would be more trouble. Everything is his property. Now I have bought a piece of land and I will have my house built on it soon. So, I will probably have to get a loan from the bank (02.1.1.4). I was so worried that if he had new children, then there would be more problems about the property. I have spent time working until I have been able to buy my own house, car, and land. I was afraid of more trouble if he did not support me anymore (02.1.1.3).

In conclusion, the sense of loss of expectations of the 'Center of My Life,' source of support, being accepted and trusted, security, wealth, and freedom could all result from other people's behavior or the participants' behavior. Moreover, if the sense of loss occurred without preparation and/or in combination with a guilty feeling, as well as a lack of support resources, the participants would feel the loss of self-worth, resulting in mental suffering.

The definition of the 'Negative Appraisal of the Center of My Life's Reactions' is the appraisal of participants who thought that they were treated as unvalued people, had overloaded burdens, and/or had sense of loss resulting from the behavior of the centers of life. The centers of life might be the husband, children, parents, cousins, and the people whom the participants trusted as well as other people such as co-workers.

3. Perceived Loss of Self-Worth

The self-worth of the middle-aged participants depended on the reactions of important people who were the centers of their lives. The meaning of self-worth of most participants depended on the appraisal of behaviors or reactions of the centers of life. If they were appraised in a negative way, it would lead to the perception of loss of self-worth which could be the cause of depression.

The pattern of the process of perception towards self-worth led to perceived loss of self-worth, then stimulating the mental, emotional and physical responses of participants. If they could not control the responses, then depression became unavoidable.

On the other hand, the participants who did not negatively appraise the reactions of the center of life would maintain their self-worth and could even improve it. One participant had her daughter as the center of her life. The appraisal of her daughter's reactions could help her maintain or to improve her self-worth. When her daughter obeyed her and behaved properly, the participant could then maintain her self-worth, as she said:

She was a good girl, since the time she was in kindergarten until university. She prefers to go out with her parents. Whenever she wants to see a movie, she would persuade us to accompany her. When her friends call, she refuses to answer the telephone as she thought that her friends might persuade her to have ice cream outside. She is a normal girl and obeys us (02.1.1.2.28-32).

When her daughter turned out as the participant had expected, it made her gain more self-worth. She said:

At her graduation ceremony, I sat next to her boyfriend while watching the closed circuit television. At that time, the Political Science Faculty was scheduled second. Then I saw her wearing her graduation gown and giving respect to Her Royal Highness Princess Mahachakri Sirithorn. I felt that my heart was overwhelmed (02.1.8.249-252).

Whenever the daughter behaved in the opposite way to what the participants had expected, it was unavoidable that the participants would lose their self-worth and it would affect their emotional balance:

My daughter loses her temper easily. I do not know how to change her. When she is in a good mood, she will obey me. Anyway, these days the problem has become so serious that it has made me so worried. If she could calm down more, I would feel better (021.4.121-123).

In conclusion, the 'Perceived Loss of Self-Worth' in this study refers to the perception of the participants who considered that they were treated as unvalued

people, had overloaded burdens and/or had the sense of loss resulting from the actions/reactions of the center of life. The response were present in the form of suffering from depression and the participants' need to regain themselves whenever they perceived their self-deviance, which is discussed in the next section.

2. Symptoms of Depression

'Symptoms of Depression' is the construct of 'Devastated Self.' 'Devastated Self' was a response of perceived loss of self-worth. The response was widespread in various features including the cognitive, emotion and feeling, physiological and perception features. The concept of 'Devastated Self' is described as follows:

Devastated Self

The response of perceived loss of self-worth occurred respectively in the vicious cycle. The range of the severity of the response depended on the intensity of the perceived loss of self-worth. The more intensity of the 'Perceived Loss of Self-Worth,' the more expression of 'Devastated Self.' The high intensity of the perceived loss of self-worth came from the negative appraisal reaction/action of the children and the husband, and the reaction/action that came from several persons who were the center of one's life. In other words, the husband and children were more focused as the center of one's life than the other persons, but if the negative appraisal of the reaction/action came simultaneously from many sources, they may be much devastated as well. In addition, the context that lacked resources was likely to contribute to more expression of the devastated self. The raw data showed that the

participants who were a single mother or/and who lacked resources were most likely to have highly devastated self as can be seen in the following statements:

At that time, I did not have much money to spend. My salary was about 10,00 Baht. About 6,000 was deducted, so I had about 6,000 left. I liked to buy clothes, so I spared part of my money for this. This was one point, but not a big point. I didn't think it was a big point, but a center point. I was not happy to go places. I was different. I isolated myself and did not socialize. My money was reduced. This is one point. I can't think of other points (16.1.4.134-139).

My husband [name] was stressed because his ex-wife had two children. His ex-wife didn't work. There were many things. Sometimes we didn't have money to spend. I used my money to buy food and to pay for household expenses. Many things. He wasn't responsible for many things in the house as he thought he already paid monthly payment for the house for me to live. It was because I didn't work (17.1.4.113-120).

I found an album of the year 1997. At that time I thought I was complete to a certain degree. It was so perfect. Everything was okay. After that, the economic was not so good, and my husband was laid off. There were more problems about household expenses. I was the only breadwinner. I pulled this and that, and there was economic problems, so it began to get worse about two years ago (13.1.5.167-171).

The devastated self was the change in oneself in destructive ways ranging from mild such as depression or gloomy feelings, desperation, fatigue, boredom, to severity conditions such as being unable to control their own self and having abnormal perceptions. Sometimes the participants avoided great suffering by attempting suicide. In this study, five participants had attempted to commit suicide more than one time but were not successful. Additionally, four of the participants desired to die, as they stated:

...it was because I didn't sleep much. I thought too much, and once I did that, I wanted to take the pills and sleep. Why did having the disease make me want to kill myself? But then I asked myself I

wanted to commit suicide to escape what? Just insomnia? I couldn't sleep until I became so thin (16.1.9.293-296).

Various responses reflected a continual cycle as can be seen from the following statements:

The first time it happened, I couldn't sleep for months. I didn't sleep at all some nights. When I was like this, I could not teach. When I went to school, I didn't want to talk to anybody. Sometimes, I had to have a canvas bed at school so that I could sleep when I didn't have to teach. I separated myself from others. I didn't want to talk. I didn't want to do anything. I was so upset. Whatever people tried to talk to me, it didn't help at all. It was all up to me (16.1.2.32-35).

The vicious cycle first started with the perceived loss of self-worth followed by negative thinking and loss of focus, desperate feeling, less sleep and loss of appetite, desire to be alone, and abnormal perception. The following is the findings of each of the responses:

2.1 Negative Thinking and Loss of Focus

2.1.1 Negative Thinking

After developing perceived loss of self-worth, the participants viewed themselves in the negative way. The negative contents of thought and the frequency of the thinking were increased gradually. The content was likely to be what was expected in the stressful life events that were happening with the children. As a result, the participants were not aware of their enormous expected negative events and perceived the events as the actual current happenings, so they suffered a great deal as they said:

I was stressed all the time. I was afraid of car crash. When my kids leaned on the car door while sitting in the car, I was afraid that my kids would fall out of the car. I was afraid the door would open and my kids would fall out. I was afraid of everything before I went to see the doctor. I didn't go anywhere. I stayed home all the time on weekends. I wouldn't bring my kids anywhere because I was worried they would get lost. I was worried my kids would fall into the water. I was worried about everything. But now I am okay. I have fear once in a while. I don't read newspapers. I don't watch TV, especially news about accidents or what happened to the child. I would throw the newspaper away. Simply put, I cut newspaper out of my life. I watch television sometimes. I would turn it off as soon as I see a program in which children are harmed. I have the feeling. Even today I still feel this. About the kids, I am okay when it comes to my family. I have recovered. But I do not recover when it comes to my kids. I can't stand it if I see news about suffering children. I would feel as if those children are my own kids. I am also afraid that what has happened to those children would happen to my own kids (20.1.7.202-216).

2.1.2 Loss of Focus

Loss of focus or loss of concentration was likely to occur simultaneously with negative thinking. The contents of the thought expanded to the stories over the possibility of the contents or unreasonable contents. Moreover, it was serious enough to lead to the sleeplessness or insomnia and loss of appetite. A participant spoke of the suffering as follows:

At night, I closed the bedroom door and tried to sleep. But I couldn't. The symptoms were so severe...I couldn't sleep until three or four in the morning. My thoughts ran wild. I tried to pray or others, but I couldn't. I was so confused. So many things came into my head and I couldn't cut them off. Even though I could sleep, it was only for a short period of time. My dreams were so confusing and nonsensical (23.1.6.171-175).

The severity of the enormous loss of focus might lead to an inability to control oneself. The participants tried to control the loss of focus, thinking, and

feeling of fear which were the consequences of the negative thinking by keeping doing activities all the time. Nevertheless, the activities did not help them achieve their aim. For example, they kept walking forward and backward all the time as they stated:

At that time I thought I was insane. I felt that I couldn't tolerate it anymore. It was like I had fire in my chest. My mind was a turmoil. I was restless. I couldn't be still. I had to walk back and forth aimlessly. I was not afraid even though it was a deserted area. I wasn't afraid of getting raped. I went to the north at that time, and it was an orchard—longan orchard. People said there were Burmese workers who came to this place to use amphetamines and rape the girl. But at that moment I couldn't be in one place. I felt I couldn't be there anymore, and I had to walk. I walked till the end of the orchard, but I didn't meet anybody. I walked back, and walked again—back and forth. I had to find something to do to prevent my mind from going wild. I couldn't even sit still. I had to rock myself all the time. Why? It felt better to rock myself. If I hadn't done it, I would have gone mad. I realized then what a mental sickness person was like (25.1.10.328-335).

2.2 Desperate Feeling

Desperate feeling in this study is an emotional response of the perceived loss of self-worth and negative thinking. The more perceived loss of self-worth and negative thinking, the more desperate feeling. There are various types of desperate feelings, and the feeling is unique for each person. These include distress, grief, pang, agony, anguish, pessimism, loneliness, isolation, stress, anxiety, and loss of the will to go on. Some female participants compared their life as vaporized water in a glass or a dried leaf. Regardless of how they felt, some participants were able to perceive the above feelings but never told anyone about the feelings they experienced. It was possible that Thai people do not like to reveal their feelings to others. Moreover, the

participants may not be aware of their actual feelings because they did not learn to capture or be sensitive toward their feelings.

Following are the raw data that expressed the emotional responses of the participants that were unique for each one of them:

It was kind of sad and quiet. I didn't want to talk to anybody. Everything was sad. I cried. I lied down and let the tears flow. I knew that my symptoms were acting up...It was severe around dusk. I would sit by myself quietly like that. There was nobody home. None had come back yet (23.2.3.82-85).

I was so disheartened. It was like my mental power was becoming weak. It was like I had no energy left to fight. I was inexplicably disheartened. My heart was trembling (27.1.12.407-408).

It was like what I had been before. I was drifting aimlessly. It was like I was stuck in a small world (08.1.5.136-137).

R: How did you feel before coming here?

P: I felt I had no energy left. I was so exhausted. I couldn't catch up with my breath. (21.1.2.39-40) ...At first it was not this severe. At first I was frustrated. I couldn't bear anything. I was so easily irritable. I hated my kids. I hated my first daughter because she lied...(21.1.8.270-273).

2.3 Sleeplessness and Loss of Appetite

As a result of the negative thinking and desperate feeling, the rhythm of life was disturbed. These included sleeplessness and loss of appetite. The prolonged sleeplessness and loss of appetite led to weight loss, as well as physical symptoms such as stomachache, headache, vomiting, and lack of energy:

I liked to cry by myself. I cried often and didn't eat. I could live for two or three days without eating anything. I drank only water. I didn't feel hungry. Sometimes if a friend asked me to eat something with them, I did. But it was periodical. When I was not hungry, I was not hungry at all. But at some other time, I could eat as if I was compensating. Thinking about it surprised me. Why wasn't I hungry at all? How could I live for days drinking only water? Before this I was so thin and had darkened complexion. My weight was only 47 kg. (15.1.7.213-216)

Loss of appetite was likely to co-occur with insomnia. They could take place continuously for a month. The participants coped with the situation by keeping busy:

At that time I went to Santiasoke. I helped them cook, cutting up chili or onions or others. I didn't want to be unoccupied. I couldn't live. And I couldn't sleep. I got up. No matter what I did, I couldn't sleep. I walked back and forth until dawn. I couldn't sleep for months. If you asked me whether I was sleepy, I would say no. I didn't have sleepy feeling at all. I didn't want to eat. I couldn't eat. I wasn't hungry. It was strange. No food went to my stomach, but I wasn't hungry. I didn't even want to drink, except when I couldn't go on without drinking anymore. I didn't eat, but I could live. At that time I was so thin. My weight was reduced to only 45. After that I felt happier, so I could eat everything. I could sleep. I was happy. I have passed my crisis—a whole year of sufferings (27.1.10.340-347).

As a result of loss of focus and nonstop thinking, prolonged insomnia or sleeplessness occurred with the participants. The following accumulated responses were illustrated as a chain which increased the devastated self, leading to the participants' desire to live alone:

The first time I couldn't sleep for months. Some nights it was like I didn't sleep at all. When I was like this, I couldn't teach. When I went to school, I didn't want to talk to anybody. I had to bring a canvas bed to school to sleep when I didn't have to teach. I didn't want to talk to anybody. I didn't want to do anything. I was so upset. No matter what people said, it didn't help (16.1.2.32-35).

2.4 Desire to be Alone

As a result of the above sufferings, the participants desired to close all the sensory perceptions. In other words, they did not want to receive and send any information. They lacked the interest in the surrounding. They shut in their sensory perception by not turning on the television, not reading the newspaper, and unplugging the telephone. These situations increased the preoccupation of their negative thinking and loss of focus:

I didn't want to watch television. I didn't want to listen to music. I didn't want to see anything. I wasn't a person who got bored with anything so easily. I didn't want to see anything at all. I could lie down and close my eyes for hours doing nothing. I didn't want to see anything, but my brain didn't stop. It ran wild (23.2.3.82-97).

I felt that I had no concentration. For example, during the school break I had three or four job offers, but I didn't do it. I didn't read newspaper, and I didn't watch television. Whatever activity which would make me sit still at one place made me mentally confused. I didn't want to do anything. I wanted to sit and let my thought run freely. I wanted to travel and change places one after another (05.1.1.3-6).

The participants as the sender were not likely to initiate the communication with anyone as they stated:

I didn't want to talk to anybody. I didn't want to do anything. I was so upset. No matter what people said, it didn't help (16.1.2.32-35).

2.5 Abnormal Perception

In some participants, the response was so severe that it led to chemical changes in the neurotransmitters, expressed in the form of hallucination. Two of the participants used to have hallucination—one had auditory hallucination and the other one had skin hallucination as they stated:

Once I ran into a centipede or something—the thing that would curl up when we touch it. I saw it, and in the evening when I came home, I felt as if it was crawling all over my body. I couldn't sleep. I had to use my hands on my arms and legs as if to ward it off. I felt as if it was crawling over me all night long, and I couldn't sleep the whole night (21.1.9.283-287).

I slept for a very short period during the day. I would get up when there was noise. I would be very startled. I thought somebody called me up. I had auditory hallucination that someone was calling out my name. I always called out 'wait a minute' and ran to the door. It happened to me again a few days ago. I heard somebody call me and I ran down to see who it was (23.1.6.179-182).

Devastated self refers to the response of the perceived loss of self-worth which occurred as a vicious cycle starting from negative thinking and loss of focus followed by desperate feeling, less sleep and loss of appetite, desire to be alone, and abnormal perception. The responses were reciprocal effect and continually accumulating effect in the context where there was lack of resources which could go on until the participants could no longer endure it and/or recognize self-deviance. However, each of the participants recognized the responses by different methods as could be seen in the following categories:

3. Recognition of Depression

‘Recognition of Depression’ is the construct of ‘Recognizing Self-Deviance’ concept.’ The detail of ‘Recognizing Self-Deviance’ is described as follows:

Recognizing Self-Deviance

As long as the causes of depression were not dealt with or the problems solved, depressive symptoms would increase until the participants wondered, asked themselves questions, and found out that they were different from what they once were. They would find out that they were different from normal people in many ways. Such deviation was subjective experience such as boredom, loss of desire to socialize, and gloom. Some participants, however, would not recognize such changes and continued living their lives until they realized their changes when they could no longer perform their work as they used to, or until the symptoms became so severe that they were life-threatening. There are many ways in which individuals could recognize their abnormalities—when there were only minor changes or when there were major changes. In this study, the participants’ recognition of self-deviances could be divided into six categories, each of which would be discussed in detail.

3.1 Recognition that They Perceived the World Differently from Others

This realization that they perceived the world in a different way from others made the participants believe there was something wrong with themselves. One participant lived with stress for 2-3 years after losing her husband and children. All through these years, she sought treatment for stomach ulcer. She only realized that she was deviated from others when she compared her perception of the world with that of

others in society and found that she was more sensitive and felt more sympathy for people who had hardships in life, as she said:

I felt sorry for everything. I got on a bus and felt sorry for the people on the bus. They had to suffer waiting at the bus stop. So, I wondered what was wrong with me. People had to struggle, and this was natural. Why would I feel sorry for them? (22.1.1.11-13).

In addition, their thinking content was different from that of normal people. For example, they wanted to die, and suicidal thought was a sign showing that the women realized something was wrong with them when compared to others in general. They realized they needed to do something to stop themselves while they were on their way to destruction:

At first, I felt indifferent. I was so blanked. I was aimless. I didn't have joy in life. And I felt I wanted to die. I wanted to walk into something to end it all. But then I realized normal people would not have such a thought for sure. Would there be people who think like this? Yes, there would be, else there wouldn't be headline news on newspapers (08.1.2.40-47).

3.2 They Discovered that They Cried Without a Good Reason

Participants realized the deviation that occurred to them as a natural thing in life, be it depression, sadness, desire to live alone, negative thinking, loss of focus, and abnormal perception. However, they realized that they were abnormal when they compared their expression of sadness to what they once were. The sign which told them they were abnormal was their crying. In the past, it was difficult for them to cry no matter how bad the situation was:

At first I thought it was normal. I could get up from sleep easily. When someone called or the phone rang, I would be startled. I didn't pay attention to it. I didn't think I was sick. But, why was it like this? I had the symptoms like this for a while, but I didn't realize it. I liked to be alone. I sat doing nothing. I didn't want to eat. I could eat, but I didn't want to. I felt that whatever I looked at, it was so sad. I wanted to cry, and I did cry. But I shouldn't have. So, I felt it was abnormal. The next day I went to see the doctor at Hua Chiew Hospital right away (23.1.1.13-19).

Normally it would be difficult for me to cry. I couldn't cry. But on that day I cried a lot. I was alone. I thought that I wanted to die. If I died, things would be all right. What if my kids died? I had a picture in my mind just like watching a television series. It would be like this and that. My friends would cry a lot and I would faint. Or I had to go to the Police Hospital and looked at each corpse in the morgue. Would I be able to deal with that if they disappeared from home? (23.1.4.105-114). There was no reason. Why would I cry without reason? Sometimes things were so serious, such as when my dad passed away. I didn't cry at all...not at all. Why would I cry without reason? What was wrong with me today? There was no reason except I didn't want to eat. I walked back and forth and then sat at a corner where I used to sit, and cried. I cried alone. Tears streamed down my face as if what was inside my body was getting out. I might have been suppressed. But it was strange because there was no serious issue. I had never had the symptom before. (23.1.5.153-158).

3.3 They Discovered Their Physical Symptoms

Physical symptoms were more dominant and easily noticeable. Participants recognized their deviation because they could specify their symptoms and their causes. For instance, they had a stomachache due to stomach ulcer. However, the physical symptoms they had came after their depression and lack of enthusiasm in life which had happened to them for a while. Some participants asked questions and were wondering what had happened to themselves, but they could find the answers. This was because it was suffering which happened to everyone, so they did not realize that

they were their self-deviances until there were physical changes with symptoms such as stomachache, vomiting, headache, and exhaustion. That was when they recognized their deviances. Even so, the participants did not realize that they had mental deviances, so they sought physical treatment instead. They had to wait until they received diagnosis from their physicians that they accepted their mental abnormality:

I didn't know what had happened to me. At first, I felt life was meaningless. I felt bored and lacked enthusiasm. I wanted to do nothing. I wanted to be quiet. Normally there would be sparkles in people's eyes. Not for me. I was indifferent. But I had awareness left enough to ask myself what was wrong with me. At first, I didn't know what these symptoms were. I didn't know and couldn't find answers. When I was like this for a while, physical symptoms followed. The more I was indifferent, the more it was like my thermometer dropped. I no longer liked the food I used to like. I didn't want to eat anything. I didn't want to do anything. I didn't want to meet anybody. I wanted to be alone in my room. Just like that. Then, there were physical symptoms. Most of the people would go to the doctor because of physical symptoms without realizing they were actually caused by mental problems. I was one of them (8.2.11.205-215).

The physical symptoms that occurred were perceived as severe. On the contrary, the mental symptoms that had been happening for a long time were thought of not as severe and did not require treatment. Instead, even when left untreated, natural recovery or rehabilitation would eventually result. There may be more than one physical symptom that occurred to these women such as stomachache, nausea, headache, or exhaustion. They were obvious to see and led the participants to recognition of self-deviances, finally resulting in their cry for help from the physician:

I took care of my niece and when she went back to the United States, I cried for half a year. It was sad every evening. After I came home from work, I looked after my niece and I did household chores at the same time. After work I went home and met my mom. When I saw my mom, I would cry right away. We both cried until we vomited.

My mom had the same symptom. That was the most serious (11.2.12.360-369). Before this, I didn't know it was stress. I thought I had stomach ulcer. I went to the doctor and took medicines for stomach ulcer. One day the physician told me to see a psychiatrist. I argued with him. I told him I wasn't insane. The doctor said it wasn't the case. He said I thought too much since I was a child. He had seen me come for one injection after another. When I was exhausted or something, I would come to him for glucose so that I would have energy. Or I would have saline solution. My coworkers knew that in one year I would be hospitalized three or four times. At first I didn't know it was stress until the doctor told me to go see a psychiatrist (11.2.10-11.300-316).

3.4 They Realized They Could Not Work

Participants saw their changes as they could no longer perform the roles they had or they could not perform their roles as effectively as they used to. This resulted from loss of energy, loss of concentration, or extended loss of sleep. This did not affect the income of the participants who worked for daily wages or those who were laborers. However, it affected the economic status of those who worked outside in the middle socioeconomic level or higher.

Inability to work or ineffective work resulted when the body could not control the function of the automatic nerve impulse. The symptoms included fast heartbeat, trembling hands, and trembling heart. Such symptoms affected daily living activity and work, as the participants stated:

From then on, it wasn't okay. It didn't work. My heart beat very fast. My heart was trembling. My hands were also trembling. The hands would become pale first, and they would tremble. At first, it started with the hands. My heart was all right. But my legs and my flesh inside were. Then, when it happened, my heart beat very fast and it wouldn't stop. No matter how I tried to rest, it wouldn't stop. When my heartbeat was like that, I panicked. I panicked. It was like

this for half a month. Until now I could work. I could sell my merchandise, and I could work everything (04.1.1-5.92-99,135).

I couldn't even sit when it was acting up. I couldn't sit. I had to get up. I had to take off everything on me. Sometimes I wore only a wrap-around sarong and walked with a stick. I walked. I knew what I was doing, but when I did it, I felt better. But people thought I was crazy. I suffered greatly. It didn't hurt or wasn't painful, but it was suffering deep in my heart. I couldn't sit. I was so restless. It was inexplicable. I was so afraid of it. It was scarier than undergoing an operation. The symptoms occurred with my mind (12.1.1.21-27).

Inability to work due to exhaustion was the first signal of the participants who worked using their labor. They felt that they did not have enough energy left to work. Before that, they never thought or doubted that they had an abnormality. The inability to work affected family income, so the participants had to seek health from healthcare providers. One participant who worked doing laundry for others and who was the main breadwinner of the family as her husband was stricken with emphysema and had school-aged children described her condition as follows:

No matter what the doctor tried to treat me, I still lacked energy. Then, the doctor told me to see a psychiatrist. My hands and feet were cold. So cold. And I didn't have energy to work at all. I couldn't sleep. I couldn't (03.1.1.16-17).

Inability to work due to loss of concentration was another change these women saw in themselves, especially those who needed to use their thinking and concentration in their line of work such as those who were teachers. It did not affect their income, but it did have an impact on the quality of their responsibility, as one said:

I felt that I didn't have concentration. For example, during the school break I had three or four things to do. I haven't done it until now. I didn't read newspapers. I didn't watch television. Whatever



activity that would make me confused, I wouldn't do it. I just wanted to sit and do nothing. I wanted to let my thought run aimlessly. I wanted to travel from one place to another. I felt that it was like in the beginning. I felt that way (05.1.1.3-6).

It was difficult to explain. I didn't have concentration to do anything. I wouldn't do any work which required concentration. In the past I liked to watch television. But now after a few words of news, I felt like getting up. I didn't want to listen to it. I wanted to sit still. When my boyfriend turned on the radio in the car, I felt anxious. It was so torturing. It wasn't what I liked. And I didn't know what I liked. We wanted something, but this was not what I wanted. It was so confusing. I was frustrated. It was like this. I didn't want to do anything at all. I walked back and forth. Sometimes I had a half day free, so I walked back and forth for half the day. I walked to this corner, and I turned back and walked to another corner. In the end, I felt exhausted, so I turned back and sat. Then, I knew I could work, and I did. But, sometimes I still couldn't work, and I had to sit and think aimlessly. I may be asked whether I wanted to watch TV, and I didn't want to do anything (05.1.3.65-75).

Inability to work due to extended sleeplessness was another deviation these participants saw in themselves. Extended periods of sleeplessness or inadequate sleep could affect their work as the quality of their work could considerably be reduced:

The first time it happened, I couldn't sleep for months. I didn't sleep at all some nights. When I was like this, I could not teach. When I went to school, I didn't want to talk to anybody. Sometimes, I had to have a canvas bed at school so that I could sleep when I didn't have to teach. I isolated myself from others. I didn't want to talk. I didn't want to do anything. I was so upset. Whatever people tried to talk to me, it didn't help at all. It was all up to me (16.1.2.32-35).

Inability to work was another sign which told the participants that they were different from what they once were. However, before the participants came to this realization, they had to live with stress for a long period of time without realizing it. Then, they had severe symptoms which would require medical treatment lasting a long

time. Some participants still had chronic symptoms which made them unable to stop the medication.

3.5 They Believed Their Nightmares Would Come True

Repeated nightmares led to fear that they would come true in real life. It was so threatening to the participants that they could no longer live their life as they used to. Then, participants would realize their deviances and sought help. Before this, when the participants did not have much deviation or when they had other responses such as worry or obsession, their daily life was not affected much. Thus, these symptoms were overlooked. Even when close persons tried to point out to them that there was something wrong, they were still unable to detect such changes. They began to realize them when they had become life threatening. For instance, one participant realized that something was wrong with her when she was afraid that her nightmares would come true. In other words, she was afraid that she would be like what she was in her nightmares. Her friends used to tell her to go to a psychiatrist, but she did not listen because she felt that she was all right. However, after the nightmares occurred repeatedly, she felt that she might not survive. She was afraid that she would not be able to control herself, and the nightmares would become real, as she explained:

I told her the same thing over and over again. I told the same stories. They were about my kids, their allergy. I was sick myself. I was the mother who faced the greatest difficulty. My friend said, "I think you should go see a psychiatrist. I have told you many times before, but you didn't listen to me." We were rather close. I could tell her things. She was older than me. So, I told her this time I would go for sure. What made sense was that I had a nightmare. If I didn't have it, I would be stubborn. I wouldn't go (05.2.7.143-146).

I dreamed that I went to see a pagoda situated on top of a mountain. Then it was time to come down. I looked down and I saw a deep valley. There were so many people down there. People walked up and down the mountain. I was so scared. I was making a decision for a while. I thought I had better not go down. I had to choose what to do. I thought for a while. Then I realized I was dreaming. There was no such thing in real life. In reality, there would be stairways which would be very convenient. They wouldn't torture people like this. So, this must be a dream. Then I jumped down, and nothing happened. I was all right. Then, on the next night, I had the same nightmare. I jumped again from a higher ground. It was just like what they had on the front page of a newspaper. I was afraid I would be like that (05.1.1.16-28).

One participant had realized her deviation when her responses were so serious that they were very life-threatening. This participant had never known that what had happened to her was deviance which required solution. In addition, she did not know that it could be treated:

I didn't know that there was such thing in the hospital. I didn't know that there were these kinds of people in the hospital. I didn't know there were these patients in the world. I had read a psychiatric column in magazines in which teenagers asked the psychiatrist trivial questions. I had never thought it was one disease of the hospital. So, it had to be treated. I didn't know that much. And I didn't know whether I should be embarrassed or not (05.2.7.150-155).

3.6 They Thought It was Abnormality of Close Persons

The participants were not aware that something was wrong with them. Instead, they thought that abnormalities occurred to their close persons. Some participants were obsessive-impulsive, anxious, pessimistic, and wanted to be alone. Nevertheless, they felt that there was nothing wrong with them. Some participants felt that there was something wrong with her children, so they sought treatment for her

kids. Not until they were confirmed by psychiatrists that they accepted they had a problem. Two participants stated that:

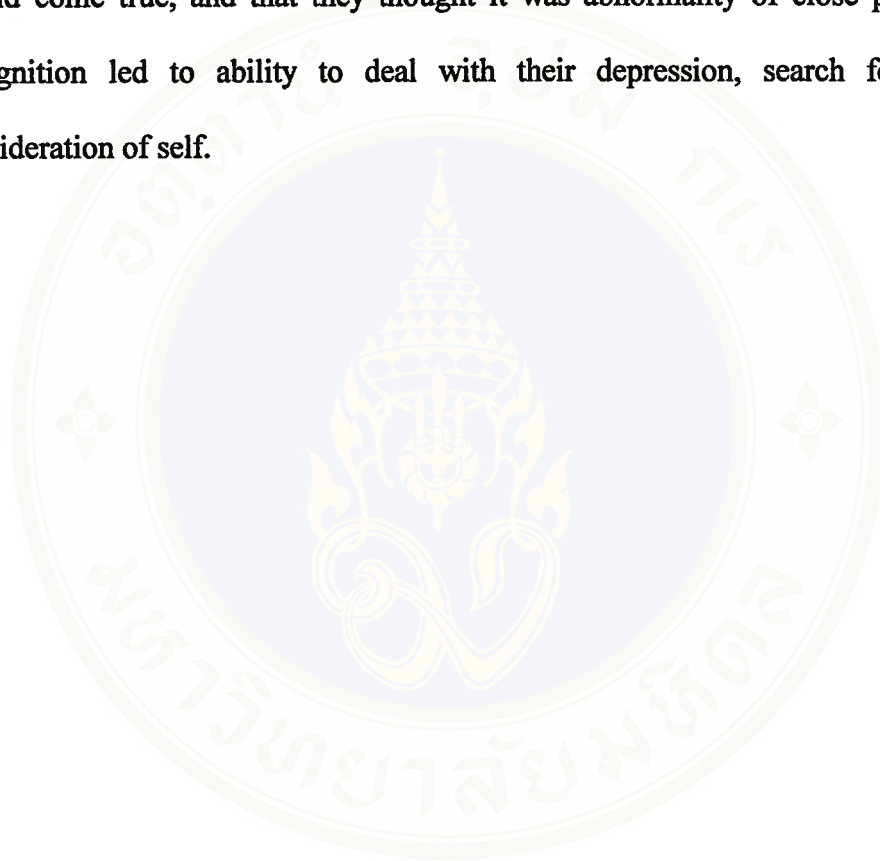
At first I didn't realize I had deviation. Before this, I was obsessive-impulsive. I wanted to be alone, quietly. I didn't want to hear loud noises like when the children are running around playing. It was nerve-breaking. I didn't read newspaper either. I was afraid what I had read about would happen to me. When I met my kids, I felt like something was wrong with my kids. My kids were so naughty. I couldn't stand it. I wanted to spank them hard. If they were not my kids, I would bang their head against the wall. So, I took them to the doctor to see whether they were hyperactive. After several examinations, the result showed that they were all right. But something was wrong with me instead, so I sought treatment (20.1.1.2-10).

I took my son to the doctor (at the mental health center). I talked to the psychiatrist, and after a while, the psychiatrist said that the mother herself had problems, not the son. He was so young then (21.1.3.68-70).

Physical responses were signals which made participants become aware of their condition. Emotional responses, perceptions, communication, and intuition were so slow. However, if participants observed their emotions and compared their emotions with those of others or their own emotions in the past, they might be able to be aware of their condition except when the condition was so severe that they were no longer able to control themselves. Thus, recognition of self-deviance consisted of the following properties: type of cue, degree of intensity, and personal characteristics which are knowledge of depression and ability to consider and become aware of their own emotion and feelings.

Recognition of self-deviances refers to these participants' awareness that they were different from what they once were. Their means of recognition could vary depending on signs, degree of intensity, knowledge of depression, and ability to assess

their thinking, feelings, and emotions. The road to recognition of self-deviances including recognition that they perceived the world differently from others, that they discovered that they cried without a good reason, that they discovered their physical symptoms, that they realized they could not work, that they believed their nightmares would come true, and that they thought it was abnormality of close persons. Such recognition led to ability to deal with their depression, search for help, and consideration of self.



Summary

This chapter explains how participants became to have depressive symptoms until they recognized the deviance of themselves. It is the phase one goes through in the process of recovering from depression. This phase consists of 3 constructs: 'Tying the Knot,' 'Symptoms of Depression,' and 'Recognition of Depression.' The first construct is a process that explains the interaction between the center of life and negative appraisal reactions of those who are the center of life. The consequence of the process is perceived loss of self-worth. The response of the perceived loss of self-worth is the devastated self. The perceived loss of self-worth in the context of lack of resource leads to the more devastated self. The devastated self is the self-change as a vicious cycle from negative thinking and loss of focus, followed by desperate feeling, sleeplessness and loss of appetite, desire to be alone, and abnormal perceptions. The devastated self is recognized as underpinning the condition of characteristics of the devastated self or the cue, the severity of the cue, and personal characteristics such as knowledge of depression and emotional considering skills. The physical symptoms are most likely to be recognized. However, the emotion, thinking, and perception features of devastated self are the least likely to be recognized. In this study, the participants recognized these features when the deviances were severe enough to threaten their life. The recognized self-deviance led to their search for strategies to eradicate depressive symptoms they were experiencing.

CHAPTER VI

PHASE II: LEARNING ABOUT DEPRESSION

Learning about depression is the second phase of the recovering process from depression. Learning about depression happened after the participants recognized the deviance of self. This recognition led to the condition that made the participants went to manage depressive symptoms. These strategies are categorized into three categories/abstracts concepts including 'Depression Self-Management,' 'Help Seeking,' and 'Contemplation about My Self.' Three concepts might occur simultaneously and/or consecutively in some participants that found that the previous strategy was not successful. In this phase, the participants learned to know more about depression in order to achieve full recovery from depression. However, some participants who were unable to fully recover they had learned to live with depressive symptoms. The three categories/abstracts concepts will be present in detail as follows:

1. Depression Self-Management

'Depression Self-Management' is an act to create peace and happiness to the mind temporarily or for a short period of time. It occurred after a participant had realized that he or she was not under a normal condition. 'Depression Self-Management' could occur before or at the same time as 'Help Seeking' and

‘Contemplation about My Self,’ which can be classified according to its time of occurrence into two patterns.

The first pattern of depression self-management occurred immediately when participants realized that something about them was not normal. For example, participants might realize that they had stress and insomnia, which had occurred prior to entering the health service system and they continued to experience them while being under the system along with medical treatment and contemplation about themselves. The reason why participants did not undergo the health service system after realizing that something was not normal was that they had never known that such condition was an illness, and they did not think that doctors could cure it. They would define a person seeking help from a psychiatrist as “mentally ill.” They looked at the changes as not so significant and that they were not a threat to their lives. There were also networks that they could find information and suggestions from. On the other hand, participants continued their self-management of depression while they were under the health service system because they realized that in order to be cured, they had to continue self-managment, contemplating about themselves, and receiving medical treatment. They also looked at the system as just a physical treatment that helped them to get to sleep, but the treatment of the mind had to be done on their own.

The other pattern began with self-management when entering the health service system without any prior experience with depression self-management. This was because they did not realize anything that was not normal until it became significant, and then they decided to enter the system. However, after realizing that something was not normal, they started self-management along with medical treatment

and contemplation about themselves. They perceived that medical treatment alone would not cure their illness and depression self-management would help reduce and shorten the medical treatment. Furthermore, they were afraid that without self-management the conditions might aggravate.

Depression self-management was an act intending to create the peace of mind and to avoid the negative effect. It occurred when participants realized their emotion and saw the negative result that could follow without self-management.

There were different types of depression self-management--those that were apparent to the outside and those that occurred from the inside. The act was a result of previous knowledge, inline with the way of lives, and might be a trial of something that was recommended.

Depression self-management in this study is defined as a process involving intention, action, evaluation of the action, and repetition of the action when the result is satisfactory. This process can be divided into two sub-categories, which are '*Tamjai*' (accepting the situation) and 'Diverting My Self.'

1.1 '*Tamjai*' (accepting the situation)

'*Tamjai*' was a method of dealing with one's own thought and feeling when facing unsatisfactory circumstances so that the person accepted what was happening, which led to temporary peace of mind.

'*Tamjai*' occurred when the participants realized their own emotions and feelings as well as the effect which could result if nothing was done about themselves,

as can be seen in the following quote “*Hau hoo after my husband has passed away. “Hau hoo Ama frequently trade abuses persons. I told to other person that if I endure at this time, I have to go to see a doctor and use the drug again. I have tried to ‘tamja’i... ‘tamjai’.*” *Tamjai* was a method derived from past experiences or from others’ suggestions followed by a successful practical result, which was repeated when faced with similar circumstances. *Tamjai* included three types of action, which were ‘Reasoning,’ ‘Looking Forward to Better Things,’ and ‘Reminding My Self.’

1.1.1 Reasoning

‘Reasoning’ was the use of reasons to explain the circumstance that had occurred so as to accept that circumstance. One participant used reasoning to eradicate her negative thinking:

Before, I sympathized with everything I saw such as a person getting on a bus. He had to wait for the bus. What’s happening to me? This is human nature, having to fight in life. Why do I have to cry? I’m not that old and why it seems like I’m very old. It’s human nature. Why do I feel sorry? So I think I don’t have to feel bad and try to *Tamjai* (accepting situation) (22.1.1.11-16).

1.1.2 Looking Forward to Better Things

‘Looking Forward to Better Things’ was *Tamjai* by managing one’s own thought and feeling so as to accept the circumstance that was going on and create the peace of mind. One participant hoped for positive changes in the future, so she had a will to do the best she could in the present:

Then I thought only that I had to do my best since I would go back to Thailand soon. I would leave him by himself in America (09.6.197-8).

Another participant hoped her life would be better in the future since her husband was having cancer and would not live for a long time, so she accepted the circumstance without any worry:

I would do everything for him since he is going away soon. **I tried to accept the situation (*Tamjai*) and told myself** to let him do anything. So he could scold me all he wanted, I didn't care. He would be gone soon and I would be better (04.1.7.194-196).

Hope could refer to hoping for a better life in the next life by giving alms or offering food to monk, which led to temporary feeling of contentment. One participant said:

R: How can giving alms help you?

P: Contentment. The day I gave alms and dedicated them to relatives who had passed away, I felt that I did something good. **I thought that next life wouldn't be difficult** like this life...Before, I used to feel unhappy and I would give alms frequently, and that made me feel better. **When I felt unhappy, I wanted to offer food to monks.** I did that frequently then and it made me feel better. All my life I had to tolerate with him, and now it was like this. It must be sin from the past life. I've dedicated and prayed, and I feel better. Now I'm not doing that as frequently. I'll go when I feel like it. When it was bad, I would go very frequently. I would constantly think about it. It must be sin from the past life...(10.2.9.289-305)

1.1.3 Reminding My Self

'Reminding My Self' was accepting the situation (*Tamjai*) by controlling one's own thought and feeling so that proper actions could result such as reminding one's self to be strong and to stop and think so as to accept the circumstance that had

occurred. *Tamjai* by self-reminding had the opposite meaning from letting one's self to do as wished for without any self-control and self-force. Two participants said that:

He's not like me. He's not controlling himself. I have to do the opposite. **I tell myself this is what I have to do. I can't do otherwise.** If I did otherwise, I would get used to it. Like your kids, if you let them have their ways, you would always have to let them (15.1.15.526-530).

When I think where he is and what he is doing, it will come into my thought. I couldn't stand that and wanted to act out something violent. **When I realize that it's becoming this way, I have to turn my thought somewhere else...**I have to get rid of it and stop thinking about it (21.1.7.237-241).

Controlling thoughts and feelings by avoiding unsatisfactory circumstances:

P: Yes. You gave me medications and sometimes I stopped taking them. I tried to control myself (*Tamjai*) and not take the medications.

R: What did you do to control yourself (*Tamjai*)?

P: When I didn't like it or weren't satisfied with it, I would walk away or stay by myself. Sometimes I would go out and come back in after a while.

Controlling thoughts and feelings by restraining from caring for another person was used when there was no way to make things better:

I didn't understand why he had changed so much. I tried to control myself. I didn't know what to do, he's like this. When I would have a family, I would tell him not to bother my family. I have a family and I have to stop thinking about him. The money is still with him, and he can use that whenever he wants. Just like my sister, I've stopped thinking about her (11.2.1.12-16).

Controlling thoughts and feelings by telling themselves to fight and encourage themselves to be strong was a strategy for one participant who reflected:

No matter where I turn to, I don't have anyone. It's only me. Sometimes I have to tell myself I have to be strong. I have to fight. I can't be weak (08.1.2.61-62).

In brief, *Tamjai* in this study refers to accepting the circumstances that occurred by managing one's thoughts and feelings through reasoning, looking forward to better things, and self-reminding. When participants realized their own self, realization of the negative effect that could result was a process composed of intention, action, and evaluation for further action.

1.2 Diverting My Self

'Diverting My Self' was an act to divert one's feeling and interest temporarily. This method was derived from past experiences and/or from following others' suggestions. It was repeated when positive effect was a result. This method was done intentionally to temporarily reduce or eliminate depression.

There were various types of 'Diverting My Self' including leaving the depressive environment, meditating, praying, having hobbies, exercising, using vitamins and caffeine, keeping busy with work, finding something new in life, and using drugs.

1.2.1 Leaving the depressive environment refers to reducing or eliminating depression intentionally by temporarily leaving the current environment.

Some participants used this method to eliminate depression according to the doctor's recommendations. When the results turned out to be good, they continued to use the method when depression within themselves was realized. The new target or

environment was the one that was in line with personal interests such as collecting antique items:

I felt depressed and didn't want to talk to anybody. Everything sounded so depressing to me. I cried, letting tears run down. I knew it was back again. Going outside would be better. I would forget it and be normal again. Don't go sit by the rivers. Go where there are a lot of people, like shopping centers. The doctor said it would make me feel better. It would be terrible around sunset. I would just sit by myself. There's absolutely nobody around. No one had come home yet. And I would be thinking about death. I shouldn't have thought about it. It was not me to get worried, so why should I think like that. So, I would leave the house (23.2.3.82-88). **I felt better and the depression was gone.** I got back home at close to 8 o'clock at night. It was time for a shower and watching television. The time to think about anything depressing was shortened. After watching television, I went to sleep. Everything felt much better. After leaving home, everything became better. No more depression. I would forget them all. When I saw anything, I just paid attention and didn't think about it. But when I got home and sat by myself, it would happen again. Say if I got back before seven, I would try to waste my time and try to get home around eight. OK, eight o'clock and I would take a shower, get upstairs, and watch TV. All the symptoms would be gone (23.2.6.178-182).

Then I didn't go out much, but I just stayed home. But after my husband died, I thought I had to go out. Staying home just gave me stress. Then I visited the doctor who recommended me to go out and see other things. So, I would go to shopping centers. I just sit there and look around (22.2.2.36-38).

Condition for leaving the current environment was the participants' goal of creating peace of mind by trying to find ways to eliminate depression out of something of interest. They continued it when the result was good:

First I didn't go to a hospital. **I tried to make myself normal.** I would go to shopping centers by myself. *Central Ladprao* was where I would usually go. I would find books to read and drink coffee everyday. After I had dropped the kids off at school, I would go there (29.2.19.459-461).

Another condition was to realize one's own self and the negative effects that could follow if they did not divert themselves. Two participants said that:

Now I begin to think I'm becoming more self-centered. When he's saying anything, I would not argue. I would just get up and leave. I would just leave him for a while. I would get back, and we would not talk until I feel better. Then I would talk to him. If I was in a bad mood, I would not talk to my husband or my kids. I was like that for many years. It was torturing, very torturing. I didn't know what to do to make it better (30.1.2.31-36). If I could do anything, I had to get out of there. I could not stay there. I had to go anywhere. I just had to go somewhere (30.2.4.129-130).

It would interfere with family problems. It would just come up. I would let it go on. I would turn the other way, but not to medicine. I would just get out of there, something like that. But I would not talk about it or take any medicine (27.1.2.43-45).

1.2.2 Meditating was a self-managing technique involving focusing on one thing temporarily, mostly on inhaling and exhaling. It was aimed to create temporary peace of mind. Participants that chose to meditate would read and listen to Dharma and learn how to meditate from studying Dharma. Meditating would be done when the mind was ready. Some participants said:

I did everything including Dharma. I did not take your medicine for a while. I would meditate, mostly, meditating and reading books about Dharma. But when I didn't read, I didn't at all. When I read, I would just read. I didn't go to temples, give alms, or offer food, not those (08.1.3.69-73).

While my mind was not in peace, I tried to get it out and tried not to think about it. I tried for a while, and my mind became peaceful. Going to temples made me feel better (11.1.3.89-92).

I would meditate every night before going to sleep. Sometimes, you know, I would read the Buddha Tasa's book, and he would tell us how to meditate. Meditating feels empty like there's nothing, like air. I would feel very happy, and I would meditate every night. I

would also take medicine, and I can let go of more things (09.1.8.244-246).

The other thing is meditating. You know, regulating your breathing. When you do that, you would hold your breath just a little and exhale calmly, and try to control the conscience. **It would feel better.** It could relieve the headache. I would go to a meditating room in the morning to pray and meditate for about 10 to 15 minutes. I could meditate longer and longer, from 5 to 10 to 15 minutes to half an hour. It would be longer, and it would feel better (13.2.8.256-292).

1.2.3 Praying

Praying was a way to divert one's self to create peace of mind. One participant said that by praying every night as recommended by a monk, the result she got was that she forgot the problems and felt better, explaining:

Then I was doing it for a while, and I memorized everything. First, I thought how I could memorize it. It was a lot. Afterward I could do it because I tried. I thought I could sing very easily, so why this was so hard. I tried and I could do it. Now I could still recall it as many times as my age. I had to memorize many pages before that. Sometimes I had to read the books along, whenever I got stuck. Then it would go on smoothly (15.1.14-15.470-496).

1.2.4 Having a Hobby

Some hobbies that were used to temporarily manage one's thoughts were playing jigsaw puzzles, doing cross-stitches and crochet, reading novels and magazines, and traveling. One participant said:

R: You've lived like this for two years, what do you do?

P: I stayed home doing some household chores. Then I would sit down, get some books to read, and tried not to think. If I could not

concentrate on reading, I would think. I found my own remedy--jigsaw puzzles. When I started the puzzle, my brain would stop thinking. I would just think which pieces would fit where. My house was full of the puzzles...(20.1.10.284-289)...OK, Jigsaw puzzles did help. Any night that I could not get to sleep and didn't want to think, I would just get up, and put together the puzzles until morning. I would turn on the radio for some light music. That also helped. But jigsaw puzzles helped me to concentrate the most. I would not think of anything else, just the puzzle...(20.1.10.310-313)...I would try to find my favorite things to do, like cross-stitches, jigsaw puzzles, and crochet. If I had time, I would sit down and do it. I would enjoy it, and when it came out nice, I would feel very glad...(20.2.9.290-293)

The next two participants read. One reads magazines, while the other reads novels. They said:

Sometimes I still could not sleep, still had some stress. But I didn't stay still. **I tried to find books to read**, and tried not to think about it except the good things. I would give more time to the kids. It would help (13.1.6.191-193).

I would do the household chores, reading, and other things. I have stacks of novels (laughing). I would lie down and read. Sometimes I couldn't sleep and kept on reading. Sometimes it took a while to go to sleep. Sometimes I didn't sleep at all, and I would get sleepy in the day (laughing) (12.1.7.214-215).

Another participant traveled to make herself feel better:

When I was under a lot of stress, I would travel to places. I went to temples and other places, just to make myself feel better (12.1.6.182-183).

1.2.5 Exercising

Exercises that participants used to eliminate depression were aerobics and light exercises at home. Two participants said that:

Another way is to do aerobics. I would do it for a month and stop for two months (laughing) because I was busy traveling down south.

I had an annual membership, so I could go whenever I wanted to. I wasn't relying only on medicine (08.1.3.78-81).

I tried to make myself feel better. I tried to adapt, trying to exercise or something...I would shake my hands or sometimes dance. I would keep on stepping or jumping up and down by myself like a crazy person (30.2.3.77-81).

1.2.6 Using Vitamins and Caffeine

Some vitamins and coffee helped manage depression temporarily. Two participants explained:

I tried to take evening primrose and vitamin B complex. I tried to find help from many ways. I happened to be a Christian so I would pray or having many things to hold on to. If you ask whether there's a problem, every month before my period I will get into conflicts with my husband and other things (24.1.3.74-77).

I have observed many times. This is a good suggestion for others. A cup of coffee, hot coffee, after breakfast, will help clear your mind. But it must be during the morning and only one cup, no more than that. You would feel you could see things clearer. The sky is clearer. I have observed many times. Probably it's the caffeine in the coffee that makes me feel better, but not for long, only a while (13.2.9.311-317).

1.2.7 Keeping Busy with Work

Doing nothing would cause a lot of thinking that led to feeling bad. Participants tried to keep busy like finding someone to talk to such as neighbors or relatives over the phone, or watched television. Three participants said that:

Try not to get deeply involved with your thoughts. Try to do something to get rid of it. Don't stay around and do nothing. You will think about it. When you have nothing to do, try to find something enjoying to do...Find a friend to talk to. Talk to various people. Don't stay by yourself. If you do, you will come back and think about it. You can't say that you don't think about it. If you have nothing to do, you would think (10.1.8.225-262).

But when I felt bad, I didn't want to do anything. **I did something just to get my mind at peace** so that my mind didn't go wandering around. It still did, but it's better than just lying still (25.1.15.497).

Now I'm beginning to have stress again, and I feel depressed again. So, I try to do something else like watering plants. If I just lie down, it will come back again. I try to pray so I can get to sleep or try to watch TV like comedies or call my kids (07.1.1.15-19).

1.2.8 Finding Something New in Life

Changing one's self and the surroundings could help stimulate changes to the mind. One participant said:

If only I found something new in life to make it more fun, I would have to think about it. I thought about what to do to make life better. I tried everything--buying flowers, decorating the room, changing curtains to blinds. I bought a spinning waterfall and put it in the room. I bought a TV, but not a stereo, not yet. I tried to change everything. I changed my dress style. I used to wear short skirts, and I changed to long ones. I used to have short hair and would change to long hair, something like that. I tried to make myself a new person. Some people got surprised and they would say that I was becoming fashionable, changing these and those, changing my hairstyle and all. It was getting to the worst, and I had to find something new that I was interested in. I bought musical dolls. I'm trying, not that I'm not. I just don't have close friends. That's all (08.1.4.106-120).

1.2.9 Using Drugs

Using drugs to cure one's mind was using drugs that could be obtained from drugstores without consulting a doctor. The participants asked for advice from relatives and those that knew about health. Using drugs by themselves was intended for physical symptoms such as insomnia and stress. Four participants said the following:

I couldn't stand it, so I came. I took some drugs for a while, but it was still the same. I'm a nurse, so I could get sleeping pills. You

could get them in Thailand, these pills. Sometimes I couldn't find any, and I would take dramamine and sleep. It helped a bit. Then I came and see a doctor, and he gave me some drugs. I've been taking them for months, and I feel better (09.1.7.240-242).

I began taking stress pills like valium. I bought them myself. My niece's husband is a doctor, graduating from here. He told me when a surgeon is under stress, he would take valium, but only one tablet. From 2 milligrams, I increased to 5 and 10 milligrams, and I don't feel anything now. My body is used to that (29.2.15.375-377).

If I could not go to sleep on any day. I know that taking drugs without consulting a doctor must have a negative effect or something. How can I do it? So, I bought stress pills from stores that had a pharmacist. But I will not take it regularly except when I'm under a lot of stress and could not go to sleep for 2 or 3 days. If I had to take it everyday, I wouldn't...(20.1.10.284-293).

I went to a drugstore and bought some drugs. The store didn't want to sell them, sleeping pills and those for heart failure. They were not allowed to sell them. But I asked to buy them and kept on taking them until my older sister took me here (04.1.7.211-214).

Thus, using self-prescribed drugs was a way to get rid of those bad feelings resulting from depression that could be noticed through physical symptoms such as headache, insomnia, and stress. Drugs were used temporarily, not regularly, to control the symptoms without consulting a doctor. Drug use was a result of consulting with pharmacists at drugstores and relatives that knew about health.

In brief, 'Diverting My Self' is defined as the intention to divert one's thoughts and feelings to reduce or eliminate depression and the torture accompanying it. Activities that were used included leaving the environment, meditating, praying, having hobbies, exercising, using vitamins and caffeine, keeping busy with work, finding something new in life, and using drugs.

In conclusion, 'Depression Self-Management' refers to the intention in trying to manage one's thoughts and feelings to get through the torture of

temporary depression after realizing that one was becoming not normal by accepting the situation and performing self-diversion. Various conditions that each participant used to self-manage depression were skills and interests, advice, and various supports such as money, places, and persons.

2. Help Seeking

‘Help Seeking’ is one choice arising after participants found that something was not normal or after they had applied self-management with those abnormal without success. So, they would want to seek information and methods to make them feel good as before. Most participants seeking help would also be under self-managing and contemplating about one’s self, but this could vary from person to person on the order of occurrence.

‘Help Seeking’ was a process composed of considering sources of help to see whether which source worked, weighing between advantages and disadvantages of seeking help, selecting information that would tell which source would reveal how much of personal information, and evaluating and repeating it when necessary. Two participants said that:

Brothers, sisters, and children are not like a staff that understands me. I can’t tell everything like how bad my husband is to my brothers or sisters. I can’t tell my children everything either, things like sex. But with a staff, I can tell them everything on my mind. Afterward when I get home, I feel a lot better...I feel good every time I talk with a staff because I don’t have to hide anything. But with friends, I talk to them and they might talk about it somewhere else (10.2.8.274-281).

Sometimes there can be a disagreement with the monk. When I want to do anything, I can go ask for advice and the monk will teach me. Lately, if I have anything, I would go to a temple, not that I will go only if I have problems. If I have time, I will go to a temple (11.1.4.130-133).

‘Help Seeking’ can be categorized into two sub-categories—‘Seeking Informal Help’ and ‘Seeking Professional Help.’

2.1 Seeking Informal Help

‘Seeking Informal Help’ is a way of seeking help with no definite format or pattern. It depended on the need of the participants seeking help, the readiness of the person providing help, circumstance, and time. It can be divided into four properties, that is, the source for informal help, characteristics of the informal help support that participants received, characteristics of persons providing informal help, and the period during which informal help was being supported.

2.1.1 The Source for Informal Help

The source providing support for informal help could be very close to participants as well as gradually getting further away from participants. This included members of the family such as husband, children, father, mother, and relatives; friends such as colleagues, neighbors, classmates; and social institutes such as monks or priests; and media and information.

2.1.1.1 Members of the Family

Members of the family was a source of help that was closest to participants and was the first source that participants considered seeking for help when

realizing that something about them was not normal, unless the cause of depression was from the husband or other close members of the family. Members of the family would provide support when the family was loving, warm, and understanding. Members of the family that provided help had to be patient and a good listener since participants spent most of their time with the family. Furthermore, they had to repeat providing the support with full understanding on a regular basis. One participant said:

Again with the depression. I was in bed trying not to get my husband to talk with [Normally I would call on the husband to talk to until going to sleep]. I couldn't, and rushed him over to tell various things (05.2.4.90-94).

For participants that were married and had moved out, their father, mother, and relatives were still a good and close family network that could obtain help from during critical time. One participant found that something was not normal and failed using simple managing ways. She sought new alternatives by consulting her relatives:

...Since I've become paranoia, I've been jumpy for about half a month now. I went to a doctor at a clinic [name], and he couldn't find anything. I went to a clinic, like [name] clinic, and they gave me some drugs for the heart. After I had taken it for only as little as 4 hours, my pulse was not normal again. So, I called my older sister, but I didn't know my relatives came over here. I didn't know that. My older sister came, my youngest sister came, and my other 4 sisters also came. I called my older sister, and she told me to be calm saying that it was near Chinese New Year. And on the third, there was an appointment with the doctor. She told me she would take me to the doctor at Rama and that the doctor was great. She told me being mentally ill with heart problem was OK and told me to be patient (4.1.4.97-108).

In particular, if the relatives had some knowledge in health care, they could be a good first source that participants could consult and seek further help from. Two participants said the following:

I began consulting a psychiatrist 2 years ago, close to 3 years, because of my older sister who was a nurse here at Rama, and now she's in Nakhon Pathom. She thought that she couldn't help or condole me as well as a psychiatrist. The husband and other relatives in the family did not know, and they did not understand me well enough to persuade or condole me to help me be in a proper condition. So, my sister recommended me to go to Niti Chittawaeth (24.1.1.9-14).

My older sister is a nurse at a hospital (in a province). She saw me like this and knew that there were also some psychiatrists at the hospital, but they would prescribe some drugs, and the patient would be unconscious, not joyful, something like this. It was her fellow nurse that told her to take me to this clinic in Nontaburi area. I forgot the name. I went and I didn't get better (16.1.2.57-62).

Participants who did not realize their condition would not seek help or would not raise any doubt about themselves until relatives or other people noticed the abnormality and extended a helping hand by taking them to a doctor to confirm the condition. One participant said:

First my older brother, his wife and my younger sister said that I was mentally ill. I told them that I wasn't. I wasn't. It was not possible. If I were, I would have realized that. They kept saying I was and took me to a doctor. They gave me some drugs to take. The first time I argued with the doctor that I wasn't mentally ill, and the doctor said okay I wasn't. Then she started talking and observed my behavior. She saw I was moving back and forth, side to side, so she gave me some drugs. After taking it for a while, I was becoming better (25.1.11.357-369).

Seeking help from relatives would only be during a critical time and when it was necessary such as staying overnight when the problem caused the person to leave her home, encouraging, caring for and taking care of them in a critical time, and giving money to them once in a while.

2.1.1.2 Friends

Classmates, colleagues, and neighbors could provide support when participants asked for help or sometimes provided help when seeing the opportunity to be of help. And sometimes the help could be coincidental. The characteristic of the help would be depending on each other or could be a person that the participants had helped before, as reflected in sayings "*Talking to each other*"(29.2.25.590) and "*Condoling each other*"(04.1.18.435). Participants would consider the person to ask for help from various characteristics that would be discussed later. The help would be temporary, but would be frequent during a critical time or when participants had to really let it out by talking to someone. Other help could be offered from supporters such as asking to get involved in activities, traveling, shopping, looking for other source of help, encouraging, and giving confidence. This would be very effective when participants were getting better or during the problem solving phase.

2.1.1.3 Monks and Priests

Participants did not give the meaning to the depressive symptoms as being only medical problems, but also being problems in life. Therefore, they tried to seek ways to solve the problems. They would ask for advice in living their lives and learn good conducts that would lead to happiness from religious figures that they had faith in. One participant tried to find a method that had never been done before by staying overnight at a temple and learned how to meditate, as well as facts about human nature:

I thought I would go to the temple and see what I would get from there. Maybe it could change my life (11.1.4.125-127). The monk

there earned high respect. If it was not for this, I couldn't have made up my mind. **He would teach me how to meditate.** You can see bad things in the temple, like jealousy. He taught me to take only the good things with me and to leave the bad things at the temple **since everything would not go smoothly. There would always be obstacles whether you are inside or outside the temple** (11.1.3.70-73).

Some participants sought help from Buddhist monks by taking advice from the monks that was given to groups of people seeking help. When participants followed the advice, they felt better. This was one type of spiritual support. Other than this, participants also prayed, which was a method of indirectly managing their suffering. One participant said:

Then, when my daughter ran away, I liked to go to the countryside. My mother lived in Ayuttaya. When I visited her, I would go to Ampawan Temple in Singburi. We would eat there and then meet the abbot. I would write and seal the envelope. The abbot said that it didn't matter how much. I put as much as I wanted to, 100 baht. I wrote that my son was ill like that and had to go to a hospital like this. The abbot would take every envelope. But before he took the envelopes, **he would start to speak, like preaching, but he would be telling us to do this and that, to read Dharma books.** He would teach many things and then rest. He was not very well. **I did borrow a book to read and memorize certain verses that the abbot said. I read every character in that book.** A person with this symptom would be cured, doing what the abbot said. You have to cite this verse before going to sleep, repeating it as many times as your age. I used to do this for a while. Now, I don't do that because the kids must sleep and get up to go to school, so I can't turn on the light since the room is so small...When I was doing it then, I could recite everything (15.1.14-15.470-490).

Some participants also sought help from Roman Catholic priests when realizing that they were in a critical condition such as thinking of committing suicide.

One participant said:

I went to a priest. I thought about suicide, and I went to talk with the priest. He asked me why I came, and I said I thought about suicide. I told him the problems, and he told me to (heavy sigh) control

myself and that committing suicide is a sin. But it was hard for me not to do it. Whenever I got angry, I wanted to do it, only to commit suicide. I didn't know why I only wanted to die, I didn't want to live (30.2.7.214-219).

2.1.1.4 Media and Information

This included medical printouts about depression that hospitals put in the waiting room prior to seeing doctors such as leaflets, books about mental health, and facts about diseases, as well as books about religious teachings that were good sources of help for participants. Participants tried to seek information from these sources. A good place for participants to reach the information conveniently was a hospital while waiting to be examined. Three participants said the following:

I tried to read on my way out. There were leaflets at the front. I always read them. Then I realized what to improve, and it got better. I would read it every time I came here, continuously. I get better and have strong will (16.1.1.8-11).

P: I'm like this and I read a lot. I found this type of story I tried to read.

R: Reading? What kind of books?

P: If I happened to come across depression, I would read...(16.1.11.355-357).

I tried to read Dharma books. **When I come to the hospital, I will read the books that you have. I read and I feel better** (22.2.3.61-62).

Programs about mental health on TV were also a good source for persons that had doubt whether they were abnormal or not. Participants accepting that they had the condition would try to search, understand, and adjust the advice given to make it better suit themselves.

This participant, after learning from a TV media, reassured herself that she was mentally abnormal and tried to find ways to improve her condition from health professionals. At the same time, she was trying to cure her mind through other methods. She said:

I'm like this. Sometimes I felt so confused from something. **When I listened, I thought that I was like that, so I went and saw a doctor.** The doctor asked me to go there 3 or 4 times. He gave me some drugs, and I felt better. But it was confusing. It would interfere with problems in the family. It got there. Sometimes I just let it go, let it go on. I wanted to go elsewhere, not to rely on drugs. I wanted to go far away, away from here, something like this. But I didn't come here to talk about this, and I didn't come here to take any drugs (27.1.2.41-48).

Seeking help from TV media went on continuously even if participants were recovering from depression. One participant said:

Mostly, I would listen to programs on TV about advice from psychiatrists. There's a seminar on TV, and I would listen to how it was then, about the progression in problem solving that would be advised. Sometimes, in a short program, exercising can reduce stress. Don't stay by yourself but find someone to talk to. That's what I got. The advice would be short, about psychiatrists or mental health or something like that... You get the knowledge, this and that, and I remember some of it since it's on TV now (11.2.21.630-638).

Other than this, it was also possible to seek help from experiences of persons with the same illness or those that had mental illness. One participant said:

I had asked others that were having the same illness like me how they were. She came back and she was overactive. She worked in everything. I sneaked a question without her knowing that I was suffering from the same illness. She was from a different school, but I asked her during a meeting what it was like. She would do every work there was. When I listened, I was afraid I would be like that. But I hadn't got that worse, not that active (16.1.14.489-493).

2.1.2 Characteristics of Informal Help that Participants Receive refers to the action of taking care of and helping in various aspects as well as encouraging with words and other gestures to make participants feel that they had obtained support. When participants realized that they were being supported for help, their morale would be boosted. The characteristics of informal help that participants received from other loved ones and acquaintances are divided into seven types, which will subsequently be discussed.

2.1.2.1 *Plorp-Jai* (Comforting) refers to directing with explanation or redefinition about the circumstance that was occurring that could lead from depression into something else that caused positive feelings. The following example illustrates '*Plorp-Jai*' (comforting) by directing the redefinition of the occurring circumstances as an assumption:

The old lady said that I didn't have to be worried. **They were acting out a drama for us to see.** I watched some and I believed her. But we were just **comforting each other (*plorpjai*)**, taking turn when the other felt bad. We talked and we could stay like this. I could stay like this. I still think about myself how I could stay like this (04.1.18.432-436).

Other than this, there was also comforting by directing the redefinition of the circumstance as being positive. One participant said:

...Because that day was really bad. But I didn't cry. I came to my friends and cried. My friends tried to **comfort me (*plorpjai*)**, telling me that it's better than having to stay with him forever (11.1.8.275-276).

2.1.2.2 Showing Understanding refers to expressing the feelings of understanding the impact of depression with which supporters had to respond in line

with the needs and had to have forgiveness for any mistakes made as in the following two examples:

She said if I were sleepy, go ahead and sleep. If it wasn't time to teach, it was my free time. But in my mind I still thought that there were lots of works on my desk. But she kept saying go ahead and sleep "if you are sleepy, go to sleep and don't care about other things" (05.1.12.425-427).

I told him that the marks were incorrect and asked him to tell the director. The director knew and asked whether I felt any better. I told him I felt better...and told him that I made mistakes that the grades were messed up. He said not to worry. The mistakes could be corrected. That was what he said (05.1.12.432-435).

2.1.2.3 Giving encouragement refers to giving confidence that whatever was being done was great and to keep on doing it.

And she encouraged me that it was good. Or she was just comforting me, I didn't know. From what I'd seen and talked with her, my senior, she said I had total consciousness. But she didn't know that I was feeling restless. I had to keep that within me. But she said it was good, and she kept encouraging me (05.1.12.425-430).

Giving encouragement was expressing gestures that indicated the acceptance of the participants' behavior when suffering from depression without any sign of boredom, including other tangible supports without being asked for:

...very much. And he would **encourage by not showing any sign of boredom**. He would talk about Dharma and those things. Sometimes like the topic of having sex, I didn't think it was. There were many factors. I was like this too, and I was having menopause, something like that. Sometimes I got worried about him. He was a man right. He told me not to worry about him. He understood and didn't want much. These days he's been into Dharma and tried to keep things to himself. He understood and **tried to take care of me like driving me around**, something like that. He would say don't go by yourself, and he would drive. If the kids weren't with me, he would drive. **Even when I got to sleep, he wouldn't let anybody**

bother me, something like this. And he would **do all household chores himself**, like that (07.1.8.256-274).

Giving encouragement was showing care for participants, responding to needs, and helping those loved ones in their everyday lives. One participant who had a very loving, understanding, and encouraging husband said:

He would understand when it would be like and what he would do for me. Like this morning, he dropped me off, and he told me to go talk to the doctor and tell him that I was still looking for work with no good sign. Prior to the day appointed with the doctor, he would keep asking me what time I made an appointment for. He knew I didn't want to do anything, but he tried to help. He would ask what time? Was it Thursday? It made me feel that he still cared. And those minor things he did for me, I felt that I was well encouraged now. He's still a good husband for better or for worse (13.2.3.72-78).

Another participant had a husband who had never shown her that he cared, but she had had relatives who cared for her. She said:

I have my own relatives...She would call and ask how I was, whether I could get any sleep. I told her that I was asleep. I couldn't before, but now I could...I told her I felt much better and she said she was glad to hear that. She told me not to think of anything, so I said I wasn't. She was afraid I would go back and think about it. I said I would not...(10.1.6.177-184).

2.1.2.4 Giving Confidence refers to saying things to assure the participant's being such as giving her confidence that she was under a normal mental condition:

I would go under the staircase and cry for about 2 or 3 hours. She asked why I had to cry. **I was better, so why did I have to cry?** Others said this to me. We just talked back and forth, and laughed. There was nothing (04.1.19.445-447).

Support can also be given by saying things to give participants' assurance and confidence in their capability, a pushing force for them to stand up and fight to go back to the society again. One participant said:

My friends said they regretted losing me, not close friends. And another set of friends said they regretted I was very talented. That's all they said and I started to think. My friends could be praising or encouraging. I didn't know. I decided to fight and I got better. These are factors and encouragement. After that day, someone saw me worthy, not that anyone had said that I wasn't good, I just looked at myself as not capable, not good. When my friends said that, it was like a tonic that helped pick me up (16.1.11.356-360).

2.1.2.5 Giving Opinion and Helping to Decide

Making decision in an important matter in life while participants were suffering from depression could lead to regrets in the future. If there were people who helped support and gave opinion, it would help participants went through the process of recovering from depression. The following is an example of one participant's support from her husband and children:

My husband said if I quit, I would be lonesome. That's what he said. And he understood that being a teacher was what I wanted. But sometimes if you didn't do that, you could be under stress. Sometimes he would say that I should keep on, and whenever I wanted to quit, I could quit. Both my husband and my children would tell me not to worry about compensation or anything since we were not in need of a lot of money. If the younger kid wanted to do a masters degree, she could help. She said we had money and told me not to worry about the compensation. She said if I got it, I would still be depressed. She said it was not worth it and told me to continue my job and told me I could quit whenever I wanted to. Even if this program was over, she told me not to pay attention. These were my children's and my husband's comment (07.1.8.256-266).

2.1.2.6 Motivating for Self-Motivation was suggesting participants

to improve themselves. One participant said:

P: ...and I had friends to help me, uh, another friend helped me. She brought me Dharma books to read and she told me not to get bored, uh, not to be depressed for long. I was ill for a long time so I tried to keep wandering around.

R: What do you mean by keep wandering around?

P: It means I just went on, something like that. And she tried to get me do things like this. I tried reading the Dharma books **and thought about what my friends said. It motivated me also...**(07.1.7.209-212).

2.1.2.7 Tangible Supports refers to supports which are materialistic, including labor support and financial support such as relieving the workload, providing convenience during traveling, giving advice and / or taking participants to other sources of help, and arranging the environment suitable for recovery. Two participants said the following:

Before this he was already a good person. And when I became like this, he paid even more attention. For example, he would take care of all my food. I didn't have to prepare food or wash the dishes. It's not that he just started. He'd been doing it for a long time. And he got me to the doctor (05.1.14.462-464).

Tried to take care of me like driving me around, something like that. He would tell me not to go by myself, and he would drive. If the kids weren't with me, he would drive. **Even when I got to sleep, he wouldn't let anybody bother me**, something like this. And he would do all household chores himself like that (07.1.8.270-274).

2.1.3 Characteristics of the Persons Providing Informal Help

Characteristics of the persons that participants chose to ask for help would be related to the type of help that participants needed such as when participants needed

advice and ways to make a decision, they would ask for help from persons with similar or related problems. Based on the data, characteristics of persons that participants would ask for informal help support can be divided into five patterns as follows:

2.1.3.1 Those That Were Used to Depend on Each Other mostly were classmates of the same institutes. Participants realized that friends, who were used to depend on each other in the past, were ready to provide help when asked for, considering they already knew the participants' background well enough and would not let them down. Furthermore, they could be trusted and were willing to do it for a friend:

She would be free on Sunday. When it was Sunday, she would take me out. At night, even when the next day was not a holiday, she would take me out. She would bring her husband along. She probably loved me too. She said she did. That's what she said. She probably knew how to care for people with this illness. I told her that I had this illness. She said that I just talk nonsense. In her eyes, I was not ill. That's what she said. She's Chinese. I also knew that she was caring for me. And there was this other friend that I would treat her meals when we went out. But this friend, Tuptim, treated me. But the other one, Morakot, I treated her. So when I had to reposition, she could help me fast because she was in the Department. And I would give her gifts like gold. She was good. She didn't do it for the gifts. She helped whoever asked, even when they gave her nothing. If she could help, she would. She's charming. I could tell them everything, whatever, just everything. I'm glad I have close friends in the countryside that I could talk with just about everything. Even there are only 2 or 3, I'm still fortunate to have close friends. Buddies, that's what I can call them. Even if I were dead, they would still be my buddies, real buddies. They said if I really have this illness, just go to them and don't go to the doctor, and I'd be cured. And I thought to myself how could they be better than the doctors. And they really did care for me, but it was only temporary, not permanent, or is it getting better? I don't know (05.1.16.540-557).

2.1.3.2 Those That Could Be Trusted would be especially considered among colleagues to prevent damage to the reputation or to maintain the

image of the participants. This was because some of the things said unconsciously at that time should be kept as a secret from others:

I had good friends who I could consult. They wouldn't tell others all the things I said when I was acting like mad. All the worries would be in what I said. I had to find someone to tell all these things over and over again. Because people like this have something on their mind, they can't sleep. A bit paranoia if there's something on their mind. Telling others all the things is good. Drugs also help somewhat (16.1.11.360-366).

2.1.3.3 Those That Were Always Considerate and Thoughtful

would be preferred by participants to trust and consult with:

R: How did you choose a person to tell these to?

P: At first we were not so close. Afterward, I found out that she was good-hearted. If there were people sick at work, she would take care of them until the final seconds. I saw with my own eyes that she was considerate and thoughtful, so I decided to befriend her. When we went out together, she would know how I behaved. Something like that (11.1.9.281-285).

2.1.3.4 Those That had Common Problems or Background

would make participants feel that they would understand the circumstances that the participants faced better than those without common experiences. For example, one participant met a classmate that had the same problem. Their husbands were both in the military and both had a mistress. The backgrounds of these two friends were also similar in that both quit school before they graduated. So, they became close friends and told each other things, which made them feel better:

I met this friend. She was looking for me. I loved her, but we hadn't met recently because she'd gone with her daughter to take care of her granddaughter. We agreed to see each other during the New Year. She would dress nicely. She said she was looking for me. Her husband was also younger, so we would talk to each other...I tried to go out with my friend. No one would believe me, thinking

that I went gambling. We would leave since 10 o'clock in the morning and would get back at almost 10 o'clock at night. Most of the time we would go to Chidlom. She had this gold card. We would buy things using her card, so she could get the shopping points. We would have fun shopping the whole five floors of the store. We would walk, have lunch, have a coffee break in a previously prepared room, have dinner, and then go home. It's like this every month (29.2.24-25.585-591).

2.1.3.5 Those That Understood Others, Were Good Listeners, Were Patient, and Were Willing to Sacrifice were those that participants realized they could get help from. People with these characters would help participants recover from depression. For example, one participant talked about a colleague that helped her:

Later when I would tell someone about this, I would talk until whoever was listening got bored. But this friend was very good. She listened to me and helped me all along. We were buddies. She taught home economics like me, so we knew the problems. When I felt it, I would tell her I didn't want to teach. I wanted to sleep. She would substitute teach for me since our rooms were close. I went to sleep. When it wasn't as bad, I would get through the periods, just letting time go. But when it was really bad, I would ask to go to sleep. I would say I have to go to sleep today (16.1.10.332-338).

2.1.4 The Period During Which Informal Help Was Being Given

Help would be effective only during a proper period. Various help or support would be effective for different periods of time. For example, when participants suffered from depression, they would want someone to understand, sympathize, be willing to listen, show ways to make a decision, and guide or lead them to the source for other supports as follows.

R: Why don't you tell this to Doctor R?

P: No, because my mind is getting better. But Doctor P knows everything. Every New Year I would go see her and give her

presents. She would ask about my husband, something like that. **Because when I was worried, I would talk to her.** Now it already passed that critical point. There was nothing. Then I **wanted to just let it out, let everything out, like everything from the bottom of my heart.** Now there was nothing, so I didn't tell it to Doctor R (25.1.7.231-235).

When participants were about to enter the problem solving point, their symptoms started to get better. They would understand and know themselves. They would also know the world and life. And they would know the cause of their depression. This was the period when participants would start to develop themselves gradually. Giving encouragement, confidence, and convenience in various things could be effective supports. This was the opposite when depression was very bad, when comforting and giving encouragement could be looked at as annoying. Also, asking them out when depression was severe could make participants feel uneasy and bored. One participant said that:

When it was bad, everything was bad. When you got to that point, you didn't look at anybody. They were willing though. Like my older sister, what ever she said, I would take it as bad intention because my mind wasn't well. Deep in my mind, I was not happy. I couldn't go to sleep or eat, and I was moody, when she said things like that. Afterward, I came to think that she loved me and that who why she was so persistent. She wanted me to be cured and took care of me. But I looked at it differently then. I was so annoyed with her, something like that. I wanted to be in silence (16.1.15.498-504).

In conclusion, **'Seeking Informal Help'** in this study refers to seeking help that had no definite format or pattern, but was natural, composed of processes to determine the source for help, to weigh between advantages and disadvantages of seeking help, to choose information that could be revealed, and to evaluate and repeat it. The sources for support were family members, friends, monks and priests, and media and information. Characteristics of the persons that participants sought

help from were trustful, reliable, having similar background, considerate and thoughtful, understanding. They were also good listeners, who were patient, and willing to sacrifice. Besides, Supports could be tangible or intangible, and had to be given in a timely and opportunistic manner for them to be effective.

2.2 Seeking Professional Help

Seeking professional help is seeking help with definite purpose and pattern from both general and psychiatric health care providers.

2.2.1 Seeking Help from General Health Care Providers

Thai people define illness as the abnormality of the body, whose cause can be observed clearly from each part and organ of the body. Depression is thought of as a physical illness having symptoms such as stomachache, vomiting, headache, fatigue, and inability to work. Thus, general health care providers would be the sources which participants sought help from. Many participants accepted that they did not know such illness existed, and they did not think doctors could treat mental symptoms. Medical doctors, then, would be the first source that participants sought help from. One participant said:

First I had high blood pressure, so I went to see a doctor at a clinic. They couldn't determine it. Then, I had a physical check-up, and the doctor said I had high cholesterol and high blood pressure. So, I was treated by the doctors downstairs, three of them, and I was not cured. The cholesterol was lowered as well as something else. That's true. The high blood pressure was still there, and it was high (03.1.1.2-7).

After seeking help from general health care providers for some time, ranging from one day to more than ten years, participants then decided to seek help from

psychiatric health care providers. They would seek specific help under the conditions that they received information from the doctor's evaluation related to their abnormality and from evaluating their own symptoms themselves.

Participants received feedback and evaluation from doctors that had been treating them that treatment in the past did not eliminate the causes of illnesses and that the actual illnesses were from the mind. The doctors then recommended participants to seek advice from psychiatrists. Three participants said the following:

No matter what type of treatment, I was still weak. So, the doctor recommended me to see this psychiatrist. And she would ask questions and give me some medication (03.1.1.8-9).

Before, I didn't know I had stress. I thought I had ulcer, so I went and saw a doctor regularly, only taking drugs for ulcer...And one day, the doctor recommend me to see a psychiatrist, so I argued. I told him I wasn't mad. He said I wasn't, and that he wanted me to consult a psychiatrist to see if I was under stress. Stress required different types of drugs. Taking drugs for ulcer wouldn't cure it (11.2.10.302-307).

There was headache, very severe headache. So, I went and saw a medical doctor who gave me some drugs to take. The headache was still there. So, the doctor sent me here and I got some drugs. I took them and I couldn't do anything, just slept (long voice), but it was gone. I was cured, but they still gave me controlling drugs, something for headache (12.1.2.47-50).

Another condition was that participants evaluated themselves that past treatment did not work in the aspect that they did not stop the symptoms permanently. They were also afraid that continued use of drugs could have negative effects on the body. Sometimes the symptoms got even worse when facing circumstances that caused stress, so they realized that the cause of their illness was from the mind. For example, this participant had received treatment from medical doctors for a long time for ulcer symptoms without having any sign that the treatment would work for her, so

she decided to go to a psychiatric health care provider, expecting that the treatment would be better:

The first time I received treatment in Chonburi from two doctors and I wasn't better. I felt I was becoming addicted to the drugs, the sleeping pills from a clinic in Chonburi. The doctor treating ulcer gave them to me. Then I came to Rama for orthopedics treatment, so I came to this department also... (10.1.1.14-15).

For the participants who continued to seek help from general health care providers even though they had doubts whether it could be mental, they viewed that seeking help from psychiatric health care providers would label them mentally ill, which was very shameful.

For participants receiving information in the first visited to the health professionals that their abnormality was a mental illness without expecting it, they responded with refusal and did not follow the treatment schemes until the symptoms aggravated and were more severe than before. Then, they would accept their illnesses and treatment. One participant said:

The symptoms kept coming without me realizing them. The day I came to the doctor, I liked being alone, just sitting still. I didn't want to eat. I could, but I didn't want to. And I felt that everything I looked at was sad. I wanted to cry and I did even though I shouldn't have. **This, I felt, was abnormal.** The next day I went to a doctor at Hua Chiao. I told the doctor about my symptoms. The doctor didn't ask much and **said that it was depression.** I didn't take that. So, the doctor gave me some drugs, and I skipped them for a while. I didn't see the doctor. I thought I wasn't ill, for sure. Afterward, the symptoms came back, just like before. So, I came here (23.1.1.15-22).



2.2.2 Seeking Help from Psychiatric Health Care Providers

Seeking help from a psychiatric health care provider was almost the last choice after other methods had failed. One participant said:

Actually it had been there for a long time, but I didn't think I would come here. Then I came to think I was at a dead end. I didn't know where to go (09.1.7.237-238).

This showed that the ways to use other methods were about to run out, or they thought that if they let it continue, the result could be their own life. Another participant said:

Before...(friend) recommended me, but I didn't go. But without the nightmares, I would still be stubborn. I wouldn't have gone there. But now I knew I had to go. If not, I could die (05.1.2.6-7).

The condition which caused participants to hesitate or delay seeing psychiatrists was the fear of being labeled lunatic or insane. The participants eventually decided to turn to see psychiatric health care provider because they could not view any other way out, as one participant said:

I wanted this for a long time, but I was afraid people would think I was mad, or something like that. I looked at it over and over again. I wanted to come for a long time. I thought that I had to take drugs. Then I argued with my husband, so I thought I shouldn't be ashamed anymore. If I didn't come now, it could be worse. I wasn't ashamed anymore. They could say I was mad, and I didn't care. The first time I came here I was afraid, afraid that they would say that a mad person came, so I was afraid to ask them. Then I argued with my husband, I was suffering. I couldn't sleep. Then I thought I shouldn't be ashamed to anyone. The doctor could help. They should have some good sleeping pills. So, I decided to come myself (10.2.10.318-331).

Another condition was that participants had never known before that the changes in them were illnesses that could be treated. This sentiment was reflected in the following:

I didn't know that a hospital would have this, would have this type of patients. I read about psychiatrists from different columns like when teenagers with minor problems asked for help. I wouldn't have thought that it was an illness in a hospital that must be treated. I didn't know that much (05.2.7.78-82).

Participants with prior experience as a mentally ill patient or participants who had learned about it or had already had knowledge of mental health would not hesitate to see psychiatrists when they realized something was wrong. They were afraid the symptoms could get worse. One participant said:

R: Did you stay for long?

P: Two or three days. I wouldn't let it continue as I could get worse. I had to. It could get worse and worse, so I hurried and came (14.1.4.102-5).

Receiving information from the media helped participants make up their mind to seek help from psychiatrists faster and when the symptoms were not so severe:

Before I didn't know. I knew from watching TV. It seemed like I was. I couldn't say for sure how it started. But I felt that I should go. I was like what the doctor said on the TV that people with these symptoms had some kind of mental illness. So I hurried and came to see a psychiatrist. We talked and I got some drugs to take. I felt I was better. I couldn't say for sure (27.1.2.33-37).

Seeking help from psychiatric health care providers had different characteristics from general health care providers, especially in the characteristics of help provided and its result. The details of which will later be discussed.

2.2.2.1 Characteristics of Help Provided by Psychiatric Health

Care Providers refers to the action of treating and taking care of the participants so that they were relieved or eliminated from depression. This included various methods including giving medication, listening to problems, giving advice, and showing new perspectives. These methods would be chosen, in line with the needs and necessities of each participant, by psychiatrists. The principal method that every participant received was the use of antidepressant drugs.

2.2.2.1.1 Giving Medication

What most participants expected from receiving help from specific psychiatric services was receiving medication that would help relieve the sufferings resulting from depression such as insomnia and fear. The result of antidepressant drugs caused participants to be more joyful. Three participants confirmed:

I switched over to here, and it got better. I didn't know it was better because of the drugs or because of time. I thought both. Drugs played a part. The fact that I got some sleep at night made me wake up fresh and active (16.1.2.42-44).

I got some drugs to take and I felt I got better. My mind didn't want to fight anymore, knowing I couldn't make it. I would rely on drugs. Before, if it weren't really bad, I wouldn't rely on drugs. Taking drugs made me feel better. I thought something was heavy on the mind, something like that. I got some drugs and I felt better. My body also got better (27.1.1.18-21).

These days I was very glad that I had come to the right person. And the psychiatrist said that it was hard to find a patient like me. I was treated after taking drugs once or twice. I was normal up to now. But nothing much happened. My lips were dry, and that was all...Until now I could sell things and survive. I could do anything. But I couldn't see a bed. If there was one, I had to lie down. Before

when I wasn't ill, I didn't sleep or lie down, never. But now I wanted to...(04.1.5.128-138).

2.2.2.1.2 Listening to Problems

Listening to problems was help that most participants did not expect. However, it was the kind of help that participants were satisfied with, and it could relieve depression dramatically. One participant shared her own story:

The first time I expected good drugs that could get me to sleep and I would be cured...But it was different. I let it out a lot. I let out all the sufferings, everything. If you can let out everything, you feel better than taking drugs (10.2.10.353-357).

2.2.2.1.3 Giving Advice

Giving advice such as advice on how to eliminate depression could help participants apply depression self-management when the symptoms aggravated. One participant explained:

I felt depressed and didn't want to talk to anybody. Everything sounded so depressing to me. I cried, letting tears run down. I knew it was back again. Going outside would be better. I would forget and be normal again. Don't go sit by the rivers. Go where there are a lot of people, like shopping centers. The doctor said it would make me feel better (23.2.3.82-88).

2.2.2.1.4 Suggesting New Perspectives

Some participants received help by being shown new thoughts and perspectives by a psychiatrist. An example can be seen in the following:

When I was down, sometimes I thought about it. But then I thought I'd better go to the doctor. I said I thought so much I wanted to commit suicide. The doctor asked if I had got that far and gave me reasons why he asked. He would tell me not to feel so bad. **There was someone worse than me. He told me to go look around**

ghettos. They didn't have anything to eat, and also the children. He said it was good enough where I was and that I should look at people who were even worse than I was. Sometimes I did look around where I worked. My friends didn't even have as much as I did. Some retired having nothing. I thought about it, and I felt proud. I was motivated...(11.2.14.429-436).

2.2.2.2 Result of Seeking Help from Psychiatric Health Care

Providers. The result of seeking help from specific psychiatric professionals was that participants became to see mentally ill patients as losers who were weak. They had to face the feeling of being labeled. One participant gave a definition of getting psychiatric therapy as failure and loss in life:

The day I came to the psychiatrist, the first day, was very sad. I was the head of the family and helped them all along, and I had to come for treatment like this. I couldn't live with it. I really couldn't live with the fact that I had to come here and get treatment. I had to meet customers. I used to talk to them myself. But now I couldn't. When I got a phone call from a customer, he would be lost. I didn't speak any sense. I understood what I said. That's the end of it (20.2.6.82-85).

Other than this, the interview with psychiatrists caused participants to think about their childhood. *"The doctor would talk about the past, about the childhood, about what I did then. What I did when I was with my family and how my brothers and sisters were..."*(20.1.2.72-73). This caused some participants to go back and think over to reflect on them later.

Ventilating the participants' feelings and telling their stories were the outcome of seeking psychiatric help that the participants did not expect before. The result of seeking psychiatric help for the first time led to the reason for following visits to psychiatrists which became more than the method of reducing depression by drugs. One participant who came to see a psychiatrist gave the meaning of the visit as being

able to tell everything and getting advice in return. This was different from participants who never came to see psychiatrists and regarding the visit as receiving medical treatment only. One participant said:

Sometimes the things I told the doctor were what **I might not want to tell others because they couldn't help**. So I had to come and tell the doctor. I recommended them, but they didn't believe me. They thought they would only get drugs to take. That's what they said. So I told them yes, **drug was a part of it. But your mind, if you listened to others' opinion, you might think of it differently**. It's not that others' opinions must be bad. You had to find a good and trusted one to consult like doctors. Who else could they tell your stories to? They would only know our past. You only tell them about the symptoms. It's better than thinking too much and being mad. That could not be treated (11.1.8.264-271).

Other than this, participants under therapy could ask for help when they felt like they did not want to live anymore, as one participant said:

Then I didn't take any drugs. I just thought and told the doctor I didn't want to live. The doctor told me to stay over in a hospital so that we could find a solution, something like that (13.1.4.118-119).

However, treatment with drugs was still an important point for seeking help from psychiatric health care providers. The following are examples from two participants who stopped getting treatment and came back for the reason of getting drugs:

Sometimes I had something on my mind, but I couldn't talk to anyone. So, I turned to drugs. It would get better. I would feel better (27.1.2.48).

R: Do you know why you came back?

P: To get some drugs to take. It used to happen, and I took some drugs (14.1.4.113).

The condition that made participants continue to seek help from psychiatric health care providers, even though they had been treated for a long time and become better, was the fear that the symptoms may aggravate due to the impact of severe depression. They had tried to stop taking drugs or had forgotten to take them and the symptoms would be readily apparent. So, they were willing to undergo continuous treatment.

What made participants stop seeking help from psychiatric health care providers resulted from denial of the fact that they were mentally ill. They thought the methods of help received were not in line with their needs and that their symptoms were better, yet they were afraid that they would be in medication for the rest of their lives.

Denial of the fact that they were mentally ill took place during the first visit. For some of the participants, they were taken to the hospital while they were unconscious. Some participants went to see doctors out of doubt whether mental illness had happened to them. After they had been diagnosed as having a mental illness, they refused to take the diagnostic and stop undergoing treatment. One participant said:

This, I felt, was abnormal. The next day I went to a doctor at Hua Chiao. I talked the doctor. The doctor didn't ask much and **said that it was depression. I didn't take that.** So the doctor gave me some drugs, and I skipped them for a while. I didn't see the doctor. I thought I wasn't ill, for sure. Afterward, the symptoms came back, just like before. So I came here (23.1.1.15-22).

Some methods of help received were not in line with the needs of some participants. One participant received help that was not what she needed, so she stopped seeking help from the place, saying:

When the doctor moved away, I met another doctor. He treated me differently from before, and he didn't listen to what I said...and told me to go listen to some tapes in another room, which I did. But I didn't get to ask the things that I wanted to be answered. Every week I would have questions to ask, but I wasn't treated like that. I was put in that room. After that, I stopped going. I stopped going after that (24.1.2.27-35).

Other than that, participants stopped seeking help when they saw that they were better and were afraid that they would become addicted to the drugs. They would have to be under medication or use the drugs for their whole lives. So, they stopped seeking help or sought help once in a while only when necessary, and turned to other methods to get themselves at peace. Other methods were depression self-management and contemplation about self. Two participants said the following:

The doctor told me to keep taking drugs. I did take them. Sometimes I didn't take them. I was afraid I would not be able to live without the drugs (15.1.3.83-84).

P: There was this period of resisting drugs. I didn't take them. Just didn't take them. Just like that. I tried to resist taking drugs on many occasions.

R: Why do you think you had to resist taking drugs?

P: I didn't want it to rule my life. I told you I didn't want to believe it. Believing it was hard enough. But I took them. I had to force myself to take them. And if you closed the clinic today, I didn't have to come. That's even better. I can stop taking them. If you leave a hole, I will just go away (31.2.10-11.343-349).

However, for participants who continued to seek help from psychiatric health care providers, when their depressive symptoms were not apparent, they turned to

considering and validating about themselves as the next step. They saw that medical treatment was only a part of it. It would not help them find real happiness:

Taking drugs made me feel better, more relieved. But it wasn't my priority. Drug was helpful only about 10%. The rest was for me to take care of myself. I had to create perspectives and thought for myself (13.1.8.267-269).

Lately I took Airdolic (drug), you know, given to me by Doctor (name) saying that it would help me adjust myself in society. And I thought this was it, this drug. Afterward, I found out the truth that it wasn't. It was me. The drug was controlling me. I found the truth. I found it myself, like when the Lords Buddha became enlightened. I got the idea. So I sat and thought about it. When it was gone, I realized that even the drug couldn't help if I couldn't stand by myself, something like that. Do you understand? It meant I had to rely on someone. It was not possible for it to be permanent. I'd better rely on myself, something like that. Before I used to rely on myself, but it wasn't enough. It wasn't like this... (31.2.8.252-260).

In conclusion, 'Seeking Professional Help' refers to seeking help with definite purposes from general health care providers and psychiatric health care providers. This was a multi-stage process composed of processes to determine the source for help, to weigh between advantages and disadvantages of seeking help, to choose information that could be revealed, and to evaluate and repeat it when necessary. The practice included giving medication, listening to problems, giving advice, and suggesting new thoughts and perspectives. Participants that had been ineffectively helped or denied the fact that they were mentally ill would stop seeking help and return to seeking help only when the symptoms became more severe. However, participants that had been helped effectively would continue to find other methods to fully recover, together with conducting depression self-management. They

saw that medical help using drugs had to be done concurrently with the attempt to try to change themselves.

3 Contemplation about My Self

Many participants did not know how depression occurred, when depression happened, or why they had depression. When they traveled to the point of time that the depressive symptoms, both the frequency and the severity, were decreased, the participants tried to answer the questions related to depressive symptoms. They thought about themselves and simultaneously sought information from various sources. They reflected and considered their interaction with other people from the past until they recognized and realized the reality of the situation, as a participant stated:

When I had recovered, I told myself that I should not be like this because my problem was not very serious. My illness made my cousins worried too and then they had to have pills ... Actually, if I could adjust myself and put something behind me...It was just I was not the kind of person that could leave things behind. When I could not...I saw them then, I hurt myself (16.1.10-11.347-354).

Referring to the above statement, the participant considered and contemplated about herself, or having self-reflection, until she realized and understood her weak point and her thinking pattern as a cause of depression. Therefore, she was able to view the previous problem or event with a new perspective and in a different way.

The process of 'Contemplation about My Self' that led them to self-awareness consisted of 'Restating,' 'Reflecting,' 'Considering,' 'Validating,' and 'Comparing.' These actions were based on the new information obtained from religious teaching, psychological books, books concerning life and quotable quotes of other people. Sometimes the participants might rethink about their past experiences. The process of 'Contemplation about My Self' that was uncovered from raw data is present in details as follows:

'Restating' is to rethink and review one's action in connection with its consequences from the past to present in a respective order:

It was like I had a textbook. Then I gradually opened the book from the first page on and then I understood the events that had happened to me (02.2.15.517-518).

Restating could take place at the same time as comparing and validating the information about oneself with the new information obtained from a psychological book or religious teaching, as stated in the following conversation:

R: After you started feeling better, what did you do?

P: I looked back into the past and asked myself why I did not think more positively like that before. At that time it was just the way it was. Anyway I do understand now that the situation happened like that at that time. I've got it from books...They said that in Dharma books to. I did not limit myself. I read Dharma books, too, not only psychological books. I read lots of Dharma books, even more than psychological books. Probably I mix them together (31.2.12.436-441).

'Reflecting' is reconsidering and reviewing both negative and positive information about the interactions with other people in the past and viewing the feeling that occurred toward the situation, as a participant stated:

I thought about people gossiping about me or looking down on me or something like that (31.2.3.85).

A positive comment from other people might validate one's competency and create the sense of self-worth. It is a useful contribution to reflecting and considering the past experience that made the participants recognize their competence and self-worth as can be seen in the following statement:

Before I was fully recovered, I felt better and better until I met one of my old friends at the school and I told her that I could not stand it anymore. I would resign after 25 years because I could get the pension then. She said that it would be a pity, and this was not my best friend. Another group of friends said it was a pity because I was good at work. After hearing that, I felt good. They might give me compliments or just tried to give me moral support. But after that, I was ready to fight again. I became better since then. It was partly because of that. I thought mental support helped. That day when a friend said so...when somebody thought I was good and nobody thought differently...Only me that thought I could not do it, I was bad, and I was incompetent...So when my friends said so, it was like a, potion that lifted my energy (16.1.11.358-366).

Other people had stigmatized me that I was lonely and needed care. But this woman said I had a strong mind. So, I remembered only the good things she said and that she admired me. And I wonder now why I did not listen more whenever others also said they admired me before. I thought it may be because I didn't give myself much compliments. But, later... gradually I realized... why... why I didn't take it when people gave me compliments (31.2.10.324-328).

In addition to positive comments, the reaction of other people was sometimes used as the information for reflection:

I might be lucky in that others told me some bad things which seemed to be the truth. Fortunately, people said such things but they did not come and swear and curse me, but they showed me that they felt disgusted or something like that. Anyway, I forgave them already (31.2.8.262-265).

'Contemplation about My Self' and the acceptance of the other people's suggestion are different. Regarding 'Contemplation about My Self,' the participants'

thoughts and beliefs based on the consideration of their beliefs and the reality of their circumstances without being influenced by information from various sources, as shown in a participant who received a graduate degree stated:

I had never used any terms that a psychiatrist used, like depression. I didn't use that... yes...I felt down, but I was not insane. I would say that I had some problems that made it difficult for me to have a social life. That was it. I never liked any sophisticated words. Even if they had a Ph.D., having all these terminology in medical textbooks. After reading for a while, I thought it was all rather exaggerated. I would stop and look for a new book. I didn't think I had to believe them all the time. Not that it was difficult to make me believe things. It was just...after I read doctors' books...about this illness...I did not believe them... I did not think that I had the illness. Why should I have this illness? I never thought so. But I analyzed myself, and I didn't know what was wrong...I felt down, quiet, and lacked enjoyment. Then someone took me to see a psychiatrist, and he ordered some pills for me ... Previously I blamed it on my fate. Well, may be it was my bad fate that brought me to having to take pills like this (31.2.10.333-341).

Revisiting childhood experiences while receiving psychiatric health care services led participants to a review of the past experience. The participants took the words of a psychiatrist to the process of reflecting, validating, and comparing, until they were aware of and understood themselves, as well as their thinking pattern and behavior pattern that led them to depressive symptoms, as in the following statement:

The psychiatrist asked me about my past, way back to my early life. How was my life with my family? How about my brothers and sisters? He said I put a thick frame, not only to myself but to my husband and children, too. Thinking about it, I agreed with him that the more I was rigid to myself, the more I was tired and stressed. Yes, he was right. ...(20.1.3.71-80) I knew that sometimes I did not do the right things. I was wrong. And I felt that I knew myself much better (20.1.4.100).

The consequences of the process of 'Contemplation about My Self' obtained from raw data in this study could be divided into two categories: 'Self- awareness' and

‘Reappraisal of Reaction/Action of Those Who Were the Center of My Life’ as discussed in below.

3.1 Self-Awareness

The participants were aware of something that they were not previously aware of. For example, they were aware that they were not flexible. Moreover, something that they were aware of in the present might be something that they did not consider as an important matter before. For instance, they were aware that they were responsible persons or they were sensitive persons. In the phase of self-awareness, the participants could connect their personality with the outcomes of their decision. For example, they were aware that depressive symptoms were the response of submissive negative feeling, the unassertiveness behavior, and the lack of ability to negotiate when they faced a problem. The subjects that the participants were aware of can be divided into four types as follows:

3.1.1 Awareness of the Good and the Bad of My Self

The bad personalities that participants were aware of and accepted after the contemplation about themselves and about the situation that led them to depressive symptoms included being a lonely person, a stressed person, a love- deprived and sensitive person, a perfectionist, and a thoughtful person. They were also aware that they needed someone who would understand and gave them an encouragement. While the participants were aware of their bad or weak personality, they were also aware of and accepted their good personality. The good personalities that they realized included being a responsible person, being patient, having a good manner, and being well-

disciplined. The participants perceived the good personalities as a source of encouragement and pride for them:

I really was not a good woman but I did not want others to blame me. ... when I did something wrong, I did not want anyone to blame me as I already knew myself what I had done (16.1.5.168-172).

I was a totally responsible woman. I was too good because I was faithful to my words and behavior. So that was what I was (12.2.3.69-72).

3.1.2 Awareness of the Coping and Thinking Pattern Leading to Depression

Coping and thinking patterns that the participants were aware of and accepted as a cause of their depressive symptoms were a submissive feeling and thinking, not expressing their feelings with other people, *'Sometimes a good thing does not win over a bad thing. Sometimes I did not speak so it was compressed inside me...'* (27.1.5.140-147).” The participants were also aware that they viewed themselves in a negative way and that was another factor that contributed to their depression:

When I did a good job, I didn't really think about it. I just thought about when I had made a mistake. It had a bad impact on my life. I hurt my life myself. It was not that I didn't do anything good at all. I really did do a good job sometimes, but I rarely gave myself a compliment. I always blamed myself. I did not do it well here. I could not do it there. That was me (16.1.7.242-245).

3.1.3 Awareness of the Impact of Placing the Center of their Life on External Factors

The participants' contemplation about their life by considering, restating, and comparing themselves with others led them an awareness that they placed the center of

their life on other people. Moreover, after connecting their present self with the one in the past, the participants found that having other people as the center of their life led them to be stressed and it had an impact on their brain functioning, as in the following statements:

I used to ask myself why I had to do this. Other people's siblings in other families were always concerned about their business. I thought that I had a mental illness because my father was a drinker and my mother always thought about herself. Whenever they met, they would argue in front of me and hit each other. I was their daughter and I felt sorry for my mother. When I grew up, I could not sleep when my father got drunk because no one could control him. I am the second child. My eldest brother ran away from the problem by moving out. Then I had to stay with my three sisters, my grandmother, and my mother. If my father was drunk and came back home, he might hurt somebody. I thought I should do something to protect them when my father was drunk ... This idea led to my mental illness (20.2.3.72-82).

Another thing was getting stress from working too hard. I was stressed because I had to work and had no time to sleep properly because I had to earn money for my child. I love my child like my own heart. I could buy expensive toys for my child as I love my child too much. I never thought that someday I'd get old and my health will run down. And I had never thought that having less time to sleep and eat would result in my coming to see a psychiatrist here. I only just realized that stressfulness could cause so many illnesses. If only I knew I would not have work that hard (20.2.17-570-275).

The following participant was aware that her mental suffering was the impact from having a nephew as a center of her life as she stated:

At that time, maybe I expected too much from my nephew. I expected him to achieve a lot in his education and his life. These days I stopped doing that and let it be (08.1.5.150-155).

3.1.4 Being Aware that Depression Solving Must Start from Own Self

The participants were aware of and accepted that their inappropriate behavior led them to depression. For example, they were aware that they had too high expectation toward their job. The participants then realized that elimination of depression needed to start from themselves, as one participant stated:

Don't expect too much. Whatever the result will be, we must handle it and try to improve ourselves. We must solve this problem. Otherwise we would become bored with the job. We have to solve it ourselves (16.1.8.249-250).

Now I could abandon everything and just accept what happens because no one could help me except myself. Other people might give me words but I have to adjust myself (11.1.1.2-4). Everything depends on our thoughts (11.1.7.233).

We had to start from ourselves first because moral support and confidence must come from our mind (13.2.1.1-2). Having pills can make our minds relaxed, but not mostly just for 10%. The rest must be ourselves. We must have our own views and ideas (13.1.267-269).

Everything surrounding us depends on our mind. When we meet bad bosses or bad work, it happens. It is up to us if we can handle it or not (11.2.15.465-467).

In conclusion, 'Self-Awareness' refers to the realization about oneself and some issues related to depression. The contents of awareness included: awareness of good and bad personality, awareness that depression comes from the ineffective coping pattern, awareness of the impact of placing the center of life on external factors, and awareness of solving depression by oneself first. After self-awareness, the participants clearly realized the various situations which led to 'Untying the Knot' in the next phase.

3.2 Reappraisal of Reaction/Action of Those Who Were the Center of My Life

In addition to the contemplation about themselves, the participants also considered and contemplated about the actions of those who were the center of their life. They developed a new perspective from reading psychological books or magazines, books about religious teaching, and the advice and suggestions from others. The new perspective was brought to consider the same problem. The participants would subsequently view the world differently due to their reappraisal of previous situation and other people's reaction, as these two participants stated:

After that, I started to concentrate on Phra Buddha That's words. There were so many tapes that had recorded his teaching. My stress symptoms were much better after I listened to his teaching. (09.6.187-189).

I adjusted myself, thinking to myself. The teaching taught me to abandon feelings, not to be angry and passionate, or selfish and learn to sacrifice. I thought that even if my husband did not give me any money, I could still take care of him because he resigned from his job to stay with me and had a hard time with me. I should not complain. So I had never argued with him about money. He was not a bad man and he did not go gambling (09.9.279-286).

A person or any subjects that were the 'Center of My Life' included the husband, children, as well as the acceptance from other people in the aspects of task achievement and property. The 'Reappraisal of Reaction/Action of Those Who Were the Center of My Life' simultaneously occurred with 'Self-Awareness' and 'Self-Acceptance.' For example, a participant accepted that she struggled to earn her income so much that she did not have time to sleep and felt stressed. It had an impact on the surrounding people and also made them feel stressed. Therefore, after the reappraisal of the action/reaction of other people, she thought the reaction was the response to her inappropriate behavior.

‘Reappraisal Reactions/Actions of Those Who were the Center of My Life’ was expressed in three ways and could be summed up in the following statements: ‘The behavior is dynamic,’ ‘The behavior of other will have an impact on me only when it is valued,’ and ‘The reaction of other people may be a response to my behavior,’ as detailed below:

3.2.1 The Behavior Is Dynamic. The behavior is not static, but it continuously changes. For the behavior of those who were the center of their life, those who participants used to perceive as important and appraised that they were treated as an unvalued person, the participants began to realize that they could not control the reaction of other people to be the same as they wanted. The action of other people was dynamic, not constant by static. The giving and the response were not like a bouncing ball. Therefore, the participants reappraised the reaction of those people as dynamic behavior that could not be controlled. For example, a participant reviewed her experience of having an interaction with her friends while practicing and learning Dharma. She then developed a new perspective, leading to an awareness and reappraisal of the reaction of her friend that it was not static, that it was uncontrollable, and that it did not always occur as her expectation. She said:

No matter how good my friends were, they also had their own burdens. They only gave me suggestions. Therefore, I should not be dependent on them. I could rely on myself only. The control of myself totally depended on me, while the pills were a partial help (11.1.5.155-158).

It depended on the circumstances. It was impossible to expect everything to be as I needed it to be. For example, today my friends may be good to me but perhaps tomorrow they would stupid things, many things (11.2.16.479-481).

Sometimes it flashed into my mind. But I did not care about him and just let it be instead. If I was too sensitive, I would have become mad. One more thing, I could not control him. I did not want to follow him wherever he went. I just wanted to go wherever I wanted to go, so I did not have any boyfriend now (20.2.3.67-69).

3.2.2 The Behavior of Other People Will Have an Impact Only When It Is Valued.

For the behavior of other people that the participants used to appraise as showing no recognition of their value as they expected, showing no acceptance and giving no treatment as a valued person, or expecting other people to react as they wanted to see, the participants started to realize the reality of the situation that other people's behavior would have an impact on their life only when they valued it as an important subject. Therefore, if they did not think that it was important or did not pay attention to such behavior, the meaning of such behavior would change. They also realized that they could not change the behavior of other people and even changing themselves was difficult enough:

...As he was the way he was, and so was I ... I could not change myself... How could I change him? I let it take its natural course. If we could get along with each other, then that was fine. If we could not, then let's finish it. That was how I felt... (08.1.6.188-190).

...(my child) was not talkative. It seemed like we were strangers just living together. As a result, it increased my level of stress. Anyway I did understand him, it was my fault to be concerned about him too much. At the time, and I gave up and I thought that nothing would be gained if I still kept being concerned about him, because it was the way he was (22.1.6.202-206).

3.2.3 The Reaction of Other People May Be a Response to Own Behavior

When the participants considered and contemplated about themselves and learned new perspectives until they viewed the world from a new angle, they recognized, understood, and accepted themselves. The participants, then, reappraised the reaction/action of other people that it might be a result of their inappropriate action. For example, a participant realized that she might be over stressed, and, as a result the surrounding people were also stressed, as she stated:

I think I started having stress for a long time but I didn't realize it. My life circumstances were not in balance. I was not happy, unlike other people. I struggled too much and did not try to abandon things, and I could not put things behind. So, I was stress, might have had it for a while but I didn't know. I didn't know I was sick. My husband was quite nice. When I had stressed, he felt stressed too. There's a small problem about him. He's a really jealous guy, likes genetic, He's very jealous and I was stressed so he became even more stressed. But I didn't know that. I thought I was always right and he thought he was right, too. So we argued quite often (09.1.3.74-80).

These days everything is OK. I partly forgave him as I was one of the reasons that made him act the way he did. Am I right? Anyway there's still something I did not forgive him. I thought it's his selfish and irresponsible character, because I was smarter than him and could handle everything on my own. Now, he is in trouble whereas my life is good (20.2.8.276-279).

Conditions for 'Contemplation about My Self'

Conditions that led to the successful 'Contemplation about My Self' and 'Reappraisal of Reaction of Those Who Are The Center of My Life' included having peace of mind, learning a new perspective, and having analytical thinking skill.

1) Peace of Mind refers to an awareness of one's self, being conscious of one's action and not losing the focus. Each participant tried to find strategies that helped her have peace of mind. These strategies were different depending on the individual characteristics. For example, some participants used meditation and

praying to gain mental peace. Other participants concentrated on an image of the Lord Buddha. Generating peace of mind required training with different duration of time for each individual. When an individual had peace of mind, they internally analyzed themselves in order to understand: who I am and what I need. The participants needed to give themselves sometime for considering and practicing, and they needed not to allow themselves to an inappropriate subject. For example, a participant recognized that she wanted other people to respond as she expected and when the response was not consistent with her expectation, she felt disappointed and suffered:

The first thing was that we had to calm down and try to concentrate on ourselves. And we asked ourselves who we were and what we needed. If we only requested this kind of thing from others such as our husbands or children, it would finally lead to unhappiness. But if we thought that we would be the ones who should give, then happiness would come back to us. Anyway, my previous problems recurred at that time and they were very serious. I could not concentrate or be calm. I was still staying with other people in the world of chaos. It was so difficult. The most important thing was that we had to give time to ourselves and we should not think that we were the ones who were always right. We had to follow the middle way (02.2.22-23.750-770).

2) Learning To View the World With a New Perspective

Learning to view the world with a new perspective occurred at the time when the participants did not have depressive symptoms. They considered information obtained from reading and listening about life and the nature of life. These new perspectives were developed from religious teaching and books about human life and mind. With the new perspectives, the participants viewed the world with understanding new. This condition made the women recognize, understand, and accept the former situations in the new way.

New perspectives were learned during the reduction of depressive symptoms or in an absence of the symptoms as mentioned below:

When I was taking the pills, I did not think too much about it. I made the decision that I should take care of myself by reading some old books such as Dharma texts or books about life and learning so that I could find a way out of my situation (01.2.5.147-149).

The same participant tried to learn new perspectives by practicing Dharma in order to retain peace of mind. She believed that it was the way of definite recovery from depression:

But I had to try hard, trying to read a lot of books. If I wanted to recover from the symptoms, then the first thing to do was to read the Dharma textbooks. The other thing was that I had then to behave according to the teaching in the books. It was the only way to go on as the serious problems had been sticking in my mind a lot ever since I was young (01.1.12.409-414).

Learning new perspective sometimes occurred from listening to suggestions from other people and thinking about them. For instance, a participant contemplated about past experience after failures in committing suicide and recalling her interaction with close relatives. She learned that suicide was not the way to solve the problem and changed her mind. After that, she was ready to restart her life as she shared her story:

I took some pills because I wanted to commit suicide. I did it twice, but finally it made me think about my brothers and sisters and that cheered me up a lot. Then I made the decision that I would not do it any more. Whatever my husband did, I would not care (10.2.3.80-83). I thought that I was alive now and so I would not think too much and that I should just not care about my husband anymore (10.1.3.97-103).

3) Analytical Thinking Skill

Another factor that contributed to an effective outcome of the ‘Contemplation about My Self’ was analytical thinking skill. This factor was influential in learning a new perspective. Each participant viewed the world differently, and they also interpreted and applied the perspective to their life in different ways. For example, a participant stated:

When I listened to the Dharma teaching from the tape, well, the monk did not know my private problems, but I applied the teaching to the resolution of my problem anyway. My mother-in-law also listened to the teaching but we did it separately, living in different areas. I didn’t know what she thought while she was listening to it. Anyway, I was able to obtain some good ideas from the teaching, but I did not care much about the life of the monk. Sometime he said he used to be a great monk in a past life or something like that. He said if the listeners were smart enough to see the light or the way out from their situation, that meant they were successful in this life (13.2.8.263-273).

In conclusion, the **‘Reappraisal of Reaction/Action of Those Who Were the Center of My Life’** refers to reconsideration and reevaluation of the reaction or the action of persons who were the center of the participants’ life. The reappraisal of those reactions could be summed up in the following sentences: **‘Behavior is dynamic,’ ‘Other people’s behaviors will have an impact only when it is valued,’ and ‘Other people’s behavior might be a response to my behavior.’** The success of going through the process of ‘Contemplation about My Self’ and ‘Reappraisal Reaction of Those who Were the Center of My life’ depended on having peace of mind, learning new perspectives, and having analytical thinking skill. If the participants did not have these components, they might not recognize or be aware of themselves, and they might not be able to reappraise the reaction of those who were the center of their life.

Summary

This chapter explains how participants managed depressive symptoms after recognizing self-deviance. This phase was consisted of three categories as follows: 'Depression Self-Management,' comprising '*Tumjai*' and 'Diverting Myself;' 'Help Seeking' which involved 'Seeking Informal Help' and 'Seeking Professional Help;' 'Contemplation about My Self' comprising 'self-awareness' and 'Reappraisal of Reaction/Action of Those Who Were the Center of My Life.' These three categories were reciprocal interaction and simultaneously or consecutively occurred. The participants who could self-manage more were likely to seek help less. On the contrary, the participants who could self-manage less tended to seek help more because of the severity of the depressive symptoms. On the other hand, the participants who sought help more would be able to self-manage depression more, as they received suggestions from health care providers and other informal helpers. Thus, the participants who could self-manage depression more were likely to contemplate about their self more. Similarly, the participants who contemplated about their self more were likely to be able to self-manage depression more. Additionally, the more seeking help, the more contemplation about one's self because the new perspective in viewing the world could be obtained. In contrast, the more contemplation about one's self, the less seeking help. The consequences of these three categories were the condition contributing to the process of recovery from depression discussed in the following Chapter. Therefore, this phase could be viewed as the intervening condition in the 'Theory of Self-Regaining from Loss of Self-Worth.'

CHAPTER VII

PHASE III: RECOVERING FROM DEPRESSION

‘Recovering from depression’ is the last phase in the ‘Theory of Self-Regaining from Loss of Self-Worth of Middle-Aged Thai Women.’ In this phase, participants began to discover their value from internal self instead of external self. It means their sense of self-worth was not tied to those who were the center of their life; on the other hand, the recognition of self-worth lied in their sense of success. The participants, then, emerged to reform themselves. This phase may be perceived as the second turning point in the process of recovering from depression. The participants reconstructed their thoughts and reconnected themselves to the world. As a result of the cognitive reconstruction, they refined themselves as well as their relationship with other people. All these changes were theorized under the category ‘Untying the knot’ which led to self-growth, which was a positive consequence in the ‘Theory of Self-Regaining from Loss of Self-Worth.’ The strategies used in the process of untying the knot and performance of self-growth are present below. This chapter also contains details about the participants who partially developed self-growth as well as those who were unable to recover from depression.

1. Untying the Knot

'Untying the knot' was the concurrence of the absence of depressive symptoms, self-awareness, and reappraising reaction/action of those who were the center of one's life. These components resulted from self-management of depression, help seeking, and contemplation about one's self. They automatically occurred to the participants' recognition at the same time, as stated by one of them:

And the doctor had been giving medications for a while. After taking the medications I felt better...better...and... **All of a sudden I thought I was like that because I was stressed...because of this and that. It was like the knot was untied, and I realized that I was really ill. But why when I was first ill I kept saying 'No...no I was not ill.'...So I knew all the causes now. All these thinking just came out autonomically, without anybody telling me.** I once had a talk with a friend... you know... It was like a ball of tangled wool and we untied it bit by bit. That friend said 'Yes... it's the same with me.' She learned to think, too. The first time we took medications we thought...no, we did not have depression. **When we recovered from the illness we felt the same. We realized that it was the knot that we needed to untie, to resolve, and then we would be relieved from the symptoms (25.1.11.362-369).**

The absence of depressive symptoms, self-awareness, and reappraising reaction/action of those who were the center of one's life led the participants to this point. The length of time taken by each participant was varied, from a couple of years to several years. However, some participants did not reach this point; hence, they just lived with the absence of symptoms. Nevertheless, the depressive symptoms could recur under stressful circumstances or when the participants encountered unexpected action/reaction of those who were the center of their life.

The process of untying the knot consisted of three approaches including: 'Discovering My Self,' 'Redefining My Self and the Relationship with Other People,' and 'Restarting My Self,' as discussed in details below.

1.1. Discovering My Self

'Discovering My Self' resulted from 'Contemplation about My Self' that subsequently occurred from 'Self-Awareness' which had an impact on the perception of external factors. 'Discovering My Self' in this study refers to the discovery of one's value. This value was the real self-worth because it emerged from the participants' internal components, not from the action or appraisal of those who were the center of the participants' life. The process of 'Discovery My Self' comprised 'perceiving self-worth,' 'setting goals for one's self,' and 'planning actions to achieve the goals,' as can be seen in one participant's sentiment:

...And now, I am fully recovered. I feel even better than the time before. It is really better. It's more like a discovery of myself. I have discovered what is good about myself— who I am – you may say. Who I am – who am I. So...it means I know who I am now...It's a discovery of myself. Fortunately, you've found or I've found that before I die. Er... life...life...life is really valuable. **This is my life that is valuable so...I've discovered myself.** Actually, I can do a lot more for myself and for the society. When I've discovered myself, I do something good for myself. No need to think about the society. The society is just a part of our life. We should be able to live with our life first and, then, if there is anything more than what we need, anything excessive, we can give it to the society. Once we give it to the society, we will get some friends back (31.2.16.583-594).

The following examples came from two participants who were dependent on their husbands since they got married. The first participant's

husband left her because of an argument in the family. The other participant's husband was suddenly dead. They both suffered from depressive symptoms. Finally, they discovered their self-worth and realized that they were important. They, then, turned to love and care for themselves. They also admitted that they never thought about this matter before. Additionally, they planed the actions to improve themselves as stated below:

...Well... No, that's not right. Why am I hurting myself? I would tell myself **nobody loves me as much as I do**. I did not think that far, actually. It was just...**I had to do something for my health**. If I lived unhealthily, frequently sick, I would become a burden for them even though they were my children. Should I live with hundreds of illnesses? I've seen the elders living with sickness all the times. Well...the children may be willing to take care of me, but why should I be their burden? I have to think whether I can live better without taking the medications. Should I try not to take the medications that the doctor gave me? (02.2.11.366-375).

Well...I care about myself now because I think I cannot be dependent on anyone except myself. I do anything I'd like to do. I mean...I'll go to a temple if I want to, I'll study if I'd like, or I'll pray if I want to. It means I run wild at an old age. (22.1.7.215-217).

Some participants were always willing to do anything for the happiness and success of other people in their life prior to the illness. They did not think of themselves. For example, they did not ask themselves what they wanted and/or who they were. After self-contemplation, they were aware of their being and got to know more about themselves. Finally, after they confronted the life-crisis, they diverted to love themselves and perceived their own self-worth, as exemplified below:

To have a second thought about everything, I've found I didn't do the right thing sometimes. I was wrong. I've just got to know myself. **It's unbelievable that I am forty something now and I've just known myself** (20.1.4.100-106). I have to tell myself – I must

love me. I had done everything for him for so long... for years. But he never did anything good for me, just bringing something bad to my life. So...OK... that's finished (20.2.2.61-63).

The participants foresaw negative outcome if they did not change. Many participants were aware of their importance and loved themselves more. They also realized that they were the ones who directed their life, not the others:

I'd better think about myself – think that if I am too stressed, my health will get worse and the symptoms will be worsened. Then, I'd need more medications and that would not do me any good. So I should put it down. I should think - whatever will be, let it be. **Everything depends on me** (11.1.2.54-59).

It was settled since I left that whatever happened to him, good or bad, I'd just let it be. I thought **I would care about myself first**. If I couldn't **work**, I'd be in trouble. If he could adjust himself, fine...no problems (12.1.8.264-266).

I felt I had been ashamed quite a lot. I felt...well...if I did not do this, things would get worse. Feeling sick all of a sudden was not good. I thought...My body was perfectly good, but my mind was very sick. So if I didn't do these things, I would get worse. That's why I said we should get up and do things that we'd like to (06.1.11.361-365).

In conclusion, the process of **'Discovering My Self'** is the process of **recognition of self-worth from one's internal development**. This process led to **the setting up of one's life goals and the action plan to achieve the goals**.

1.2 Redefining My Self and the Relationships with Other People

This is a cognitive reconstruction by modifying attitude in living, explaining, and defining the circumstance, as well as establishing relationships with other people again.



1.2.1 Redefining My Self

The participants redefined themselves after being aware of and accepting that their pattern of thoughts and problem-solving techniques encouraged depression. The self-redefining could be categorized into four approaches including living with the present, being more flexible, seeking alternative thoughts, and being self-reliant.

1.2.1.1 'Living with the Present' refers to when the participants had modified their viewpoint from an expectation of other people or even themselves and the expectation of other people's reaction to them to setting up the life-goals on the basis of their own action, as in the following examples:

A singled woman had changed her focus from an expectation of her nephew's success and control over the boy and had set up the goal of her action instead. She said:

...at that time I might expect too much from my nephew. I attached to my belief that he had to study hard, and he had had to do this and that. I wanted him to succeed. But not anymore now. Whatever will happen, let it happen. Whatever will be, let it be. If the fate is like that, leave it. I just ask myself whether I've done my best. If I have and that's all he can do, that's it ...(08.1.5.150-154).

A married woman living with her mother-in-law had changed her viewpoint from the final outcome, her mother-in-law's satisfaction, to look at her own actions. She said:

Sometimes I was in a stable mood...and I heard she complained--I don't like this, I don't like that. When I said I would buy her new ones, she said no...no; so I didn't know what to do. I try to please her so much since I feel sympathy for her too. She's blind. But she's not satisfied, and will complain. When she complains, I just

think...well you don't like it, don't like it then. I've done my best (05.1.9.284-286).

A single woman was disappointed by a friend who had changed and did not treat her as well as she did. This participant, then, changed her attitude and developed a different relationship with her friend by aiming at her action rather than other people's. She stated:

What should not be thought or something like...if a friend envies me, let her feel that way. I've done my best. I have good intention for her, don't envy her and I will feel contented. If I keep thinking about this and that, I'll get stressed in return (11.1.5.152-155).

1.2.1.2 'Being More Flexible' refers to the participants' changes from living within a regulation they had set up to being more flexible with the regulation to make themselves and other people more relaxed, as exemplified below.

The participant who had been very strict with her regulation for many years to the extent that her subordinates felt daunted had loosened her regulation to please everybody and to make the work continue:

Such as having a loud conversation in the office, eating all the time, having snack on the desks. All these are not my habit at all. I don't like it but now I become the chief. My subordinates are not considerate towards me anymore. I mean they have snack whenever they want, but they stay at work. I mean... they don't disappear from work they stay in the office working but they may have snack and chat too. Sometimes they are so loud that I can't concentrate, but I have to put up with it. **Previously, I was not like this. I was very strict, almost harsh, but my subordinate still loved me.** But I was very strict about eating because it violates the regulation and wouldn't look good in the visitors' eyes. Now we compromise. I just don't want to be... like I told you before...I don't want to be like this. Sometimes, I even encourage them, even join them. Sometimes...it's like--they take this money and get something to eat together. (laugh)

R : Do you feel uneasy that you have to do something you don't like?

P : No, not too bad. Maybe because I've changed. Maybe I swallowed it (laugh). I think it's more like I swallowed it. I felt uneasy at first. (01.2.13.411-427)

The same participant had changed her characteristics from a very strict person to be more flexible with herself and the others. She also worked only when she was ready, as she stated:

In the old time I had a regulation--getting up at five thirty to clean the house before the kids got up. My kids were not allowed to spill anything on the floor. Everything had to be in its place and not untidy. But now, in the weekends...well... help yourself, enjoy it. Whatever you want to play, whatever you want to take out, you can do it. Drinks and snacks are all around the house, and I don't say anything. I can tidy up on Monday. I would not put up with such things in the old days. I'd ask why my house was in such a mess? I used to put slippers on all the time at home because I felt annoyed when there was something on my feet or when my feet were dirty. So, I put on slippers all the time. I am not like that now. I let everything go naturally. I'll do it the day I like to do it. I'll do it when I'm ready (20.2.13.428-434).

Another participant reduced her strictness since she realized that being a very strict person is related to stress-related illness:

Being a strict person is not good. I was a hundred per cent strict at first, but I have reduced it to sixty per cent now. Being so strict makes me worried – this thing's not in its place, there's a crease here... and I could not take it. I got worried. I don't like...something like creased paper. I wanted only smooth one...something like that. But not now...I've left that feeling. Too tidy, too clean – all these are related to stress (11.2.15.450-457).

1.2.1.3 'Seeking Alternative Thoughts' means the participants chose to think in the way that would not make them feel uneasy. There were several approaches for seeking alternative thoughts; for example, accepting (putting it down),

ignoring, not trying to control the situation (letting it be), or redefining the event. The following examples demonstrate how the participants sought alternative thoughts.

A participant looked at an event with a new perspective by comparing it with a worse situation, and, as a result, accepted the circumstances:

I felt stressed from many things, including my grandma who threw away things everyday. Now, I've told her, and she has behaved better because she's afraid that I will be sick... but not all better. But I think it's good enough that she doesn't gamble. You see...I have to put down something...Yes... But, previously when I was under much stress, I didn't think like this. It's like, ...no, I could not stand this. I've got a headache... problems (laugh) (09.1.10.334-338).

Another participant had redefined the circumstance that induced negative feeling into a new feeling that made her feel better, and she said:

There are eleven siblings, but I received about two bahts whereas the others got tens. I thought I was not with them. At that time I thought why they were so unfair. They should have told me the day they would reveal the will. When mother was sick, I shared the expenses with them. In her funeral I helped as well as the others. But when they sorted the money and the assets, they never thought of me, like I am an outsider. So, when I think about that...I had to think, – well I didn't live with them, so they gave me two bahts as a souvenir then. But if those who got the money don't save, they'll spend it all even if they have ten, twenty, thirty, or hundreds (11.1.6.175-83).

Two participants, a widower and a divorcee, chose not to try to control the situation in dealing with problems with their offspring, such as coming back home late or always having a night-out. The participants detached themselves from the offspring's success or failure, and they did not try to control them. Instead, they tried to understand them as they were. One of the participants said:

I did not talk much. It was like strangers living in the same house, so I was more stressed. But I understood that they were like that. It was my fault that I was worried about them. They were my children, so I

was worried. Now I am not worried. I think it's no use to be worried because that's the way they are (22.1.6.202-205) ...Sometimes I was worried...why they came back home so late. But I'd think...up to them. They're grown up now. I shouldn't think...I am just worried about my kids. If I can put it down, there's nothing else to worry about (22.2.4.124-125).

R: What do you think about your children now?

P: I am not stressed with them and just let them go. They are both older than twenty years old now. So, let them do anything they'd like to. I may warn my daughter sometimes, but I'm not angry or mad at her. I feel happier now (23.3.6.173-175).

1.2.1.4 Self-Reliance refers to the participants' changes from an individual who was dependent on other people to be a self-dependent one. The participants lived their lives by relying on themselves. For example, a widower became self-reliant after having been dependent on her parents and her husband all the time. She said:

My husband took care of me like I was his child. I didn't learn much and never saw the outside world. When I was living and selling things with my parents, they let all my brothers learn but not me because I was a woman. The daughter should stay at home to help the parents, so I never saw the outside world. By the time I realized that, it was too late (22.1.8.267-569).

After her husband and her son were dead, this participant faced a life crisis and had depression. When she discovered herself, she changed from a person who was dependent on her husband and became self-reliant, she said:

Maybe because I was sick, the sickness made me think or made me get it out of my mind or something. If I am not determined, I'll be sick again. I have to determine that if I don't help myself, nobody can help me. I think like that (22.1.8.245-247).

1.2.2 Redefining the Relationship with Other People

‘Redefining the relationship with other people’ refers to the fact that the participants redefined and modified their action in having a relationship without having an effect on their mental health or having the least effect. According to the data, the participants’ approaches in redefining their relationships with other people can be categorized into four ways: 1) helping other people as they could but not with all they had, 2) understanding other people as they were and not trying to change them, 3) helping other people without expecting anything in return, and 4) relying on each other.

1.2.2.1 ‘Helping other people as they could but not with all they had’ refers to the time when participants changed their thoughts and actions in helping other people. Instead of helping other people to the extent that they might get into trouble themselves or helping others without thinking about themselves, the participants gave help to other people without putting themselves into trouble. The following two participants are examples of those who redefined their relationships with other people.

The first participant was a married woman who used to devote everything to her family, parents, and siblings. After that, she had recognized her value and worked for herself, but still helped other people sometimes if it was not too difficult. She said:

After I met the doctor and talked to him, he said...I didn’t do anything for myself at all. I thought back... In my whole life, I’d never done anything for myself. I did everything for my children, my husband, my parents, and siblings. If my parents were still alive, I would still have done things for them. But they passed away now, so I did everything for my siblings. What I did was thinking about

everything for them. Actually, after seeing the doctor, I asked myself why I had to think for them. They were all grown up now. **I should help them for what I could but not giving my whole self into it.** It's OK now. I've tried and I can do it.

D : Do you mean trying to do things for yourself?

P : Yes, I do things for myself. But I don't leave them completely. I still help them once in a while but not with all myself. Previously, I just put all myself into it (20.1.3-4. 86-96).

The second participant was a single woman who devoted everything to her friends, as her boyfriend reflected, *"You are a hundred percent sincere to other people. Whatever you have, you give people a hundred percent. When you feel sorry, you keep worrying about it. You just give, but the others don't give back to you as you do to them. You have to think about it, not a selfish thought. For those who are generous to us, we should give it back to them (11.2.11. 19-22)."*

Finally, this participant changed her pattern of relationships with friends after being aware of her thoughts that led to depression. She reappraised other people's action as not always consistent. She said:

I've changed the plan inside me now. Whatever other people want, **I'll give seventy percent, and I'll be sorry for thirty percent.** I won't think too much. Otherwise, I'll be stressed ...if I can cut it off, I'll do (11.2.5.119-124).

1.2.2.2 'Understanding other people as they were and not trying to change them to meet one's expectation' refers to the participants' modification of their thoughts and their actions. Instead of expecting, imposing, and/or devoting to other people such as their offspring or husband in order to change them according to their expectation, the participants became more understanding, and they did not

impose on other people or expect other people to be as they wished, as exemplified below.

A divorced participant sacrificed everything for her children but they did not succeed the way she expected them to. This participant, then, changed her thoughts and her action with the children, she said:

It's like...well...I've helped you as much as I could but everyone has his own karma. Just like this. I've already helped them, but whatever they can achieve I have to accept that. Sometimes I thought I wouldn't be able to accept it. I should have been able to help them more, making them better than they are. I used to think I would sacrifice everything – quitting my job and giving them the best. But this idea...sometimes it doesn't work like that. If I am still at work, I can be their pillar because both my children work for private companies, right? And the grandchildren are alright. So whatever their parents can do... that's it. Because if I try to impose on them, they will be annoyed. We will be annoyed with each other and may argue. So now I can accept it to a certain level (01.2.3.149-157). Even with my children, I give them freedom. All right, if you are in trouble, you can come to me. But I cannot commit myself to you too much anymore. I think it's better to think like this (01.2.7.232-233).

1.2.2.3 'Helping other people without expecting anything in return' refers to when the participants changed their thoughts and actions from expecting rewards from other people in return after helping them to giving help that was appropriate in terms of the time and circumstance and did not expect anything back, either in the form of objects or relationships. They shared their feelings as follows:

I've already cut him off as I don't expect anything back from him, right? If I want something back, I'll think. I give this to you and you must give something back. And that idea would make me think, 'why didn't he give me anything?' No, not necessary. Cut that off. Don't think about it (11.2.3.81-84).

...and I think people are always like this wherever I go. Even if I became a nun, I would still meet people like this. So, I feel I can live with such people, but I will not attach to them. I mean...people...sometimes I expected that they would be good to me, or they would love me. And when they didn't, I was disappointed. (The people)...could be my children, relatives, siblings, parents or someone like that. So, I'd better live with myself (01.2.7.208-212).

1.2.2.4 'Relying on each other' refers to when the participants redefined their actions to establish a balance between giving and taking. They changed from giving everything to other people so much that they got into troubles, e.g. having debts or economic problems, and they turned to be both the giver and the receiver in their relationship with other people, as in the following examples.

A participant changed her life from a person who always gave or was relied on to the extent that she got into trouble herself. She said:

I was aware that I was very self-indulgent sometimes. But I didn't indulge myself by taking advantage of friends. No, not that way. I just had so much sympathy for other people and wanted to give them things. (I) gave until I had nothing left. That's why my husband was so bored. He was bored of me because of these giving. I gave until I had nothing left, but I still gave anyway (30.2.6.202-205).

After losing almost all her assets, this participant became a receiver. She gradually learned how to take and to rely on each other, as she stated below:

R : Can you not give?

P : I can now because I start having this feeling... Well, I've been good to other people and there's nothing good for me. That's how I've seen it. Now, it's like... You know, doctor, I didn't have money to come here. I traded. Still I didn't have money. I got money from my nieces and nephews: two hundreds Bahts from this one, three hundreds baths from that one, and five hundreds baths from another one. I was going to see a doctor and it's my turn now. I had helped

you all a lot before. Everybody got a job because of me. I know lots of people because I am a trader. My nephew got a bank job, another one works in an insurance company, and the other one...whatsoever. They all have salary. Dad (her husband) got bored. He said 'you are too kind. You give everything to your parents and your siblings.' I devoted everything for my parents and my siblings. And now, who can help me? I see they can help. They can really help me. When it's time to help, they can help (30.2.10.219-227).

The process of redefining oneself and their relationship with other people simultaneously occurred, and it was difficult to separate one from another. The following example demonstrates a participant who concurrently redefined herself and her relationship with others, particularly when she mentioned her changes in defining her husband and assets. She did not value the mentioned subjects, did not expect and did not try to have control over the uncontrollable ones. She also changed her action with the husband, trying to talk with him as necessary, with no complaint and no criticism. She said:

...During the time when the problems were so serious around (B.E.)42, everything was not quite good, not exactly good. Sometimes I still think (about it). it's not like I didn't think at all, but I did only sometimes and I was not so obsessed with it like in the old days. In the past, I felt hurt and stressed all the time. I felt hurt because of him. (Now)...Whatever happens, let him go. If I don't have money, fine. I think this way. At that time I was stressed about losing the house too, and something else. Even now there's still a case in the court but I think, "let it be." If anybody wants it, take it. I don't have anything when I came. I came with nothing. When I think like that, I don't feel so stressed (10.1.4.119-124). Now, wherever he wants to go, I let him go. I don't care anymore. If he wants to gamble, do it. If he wants to lose everything, lose it. If he doesn't regret losing it, it's up to him. That's how I think...I don't regret losing it. I have something to eat day by day. I think like this, and I feel a bit better (10.1.10. 326-328).

In conclusion, 'Redefining myself and relationship with other people' is a process of the modification of life skill by explaining and defining events around oneself and re-establishing relationships with other people. As for redefining

oneself, the utilized approaches included living with the present, being more flexible, seeking alternative thoughts, and developing self-reliance. As for redefining of relationships with other people, the participants' approaches include a helping other people as they could but not with all they had, understanding other people as they were and not imposing them to be as expected, giving help without expecting anything in return, and relying on each other.

1.3 Restarting My Life

'Restarting My life' was the process that the participants gradually took actions after their feeling and energy fell down from the loss of self-worth and the suffering from the devastation of one's self. The process of restarting life gradually occurred after the self-worth was discovered. These actions increased the sense of self-worth and led to the increase in value of the person for other people. The actions might increase their income, capacity, network, and happiness in their life. Additionally, the actions might be beneficial for the community. The tasks were progressively more difficult, but they did not impose on the participants and were not acute. Furthermore, the outcome of the actions were not expected on the basis of the participants' competence. Instead, the actions encouraged the participants to make a progress and be satisfied with their life. The action should not be forced from external influence but should be done from internal desires of the participants:

I did what I wanted to do like if I didn't want to do that today, I wouldn't do it. I'd leave it to my employees and I'd do something else, like cooking. I'd change the menu to what I wanted to cook. Maybe a difficult dish. Or sometimes I'd bake a cake, something like that. I did it and threw it away, because I am the kind of person who

likes to try. And I could sell it, too. There were so many orders that I could not make it in time, lately. Now, I thought, baking cake was highly profitable, but there were so many details. So, I'd stopped because there was nobody helping me with the cleaning. There were really so many details and lots of equipment. I've changed to exercise instead. People that like selling and can sell their goods can make money. That makes them happy. I've got money and I was happy. So, there's some point that I can forget the depression. That's why they said whatever you want to sing or listen to, you should do it. Wherever you want to go, go. This is a good point (06.1.11.364-375).

The process of restarting life involved various activities. According to the data of this study, the activities could be categorized as follows:

1.3.1 Restarting Activity

The participants restarted the activities after they had lacked energy for a long time. They were most likely to lie down whenever they had available time or when they had the symptoms, but they forced themselves to start the activity. For example, a participant started the activities such as doing exercises to improve her physical health and body image and meditating for a good sleep:

And I tried to force myself, too. Sometimes I didn't want to get up, I'd tell myself "you have to get up." Get up. You have to do it. You have to exercise; otherwise, you'll be fat. You will not be able to put on your clothes and will waste your money because you'll need new ones. Or sometimes...praying will make you sleep well, so pray for other people and wish for other people's well-being (01.2.7.205-208).

1.3.2 Reconnecting with the Society

The participants tried to reconnect with the society after shutting themselves in for a long time. The following participant, for example, started by reading a magazine and newspaper. She said:

...and I'll read. I like reading. I think I am getting better, changing from not wanting to read, to listen, to do anything at all. I read. I read articles about current social events, an analytical comment, which I was not interested in the old days. I didn't want to know who did what and where. But I read it again now, such as Matichon Weekly which has the whole week is reviews and comments... like who did what. Something like that. And there are analytical articles and reports about who is dealing with that subject. It has entertaining section and sport section. I like watching sports, too such as football, golf, tennis. I read when I have free time. I read. And I look at the classified section, too. I just sent my resume to four or five companies two days ago. I think there might be some hope, so I sent it. (13.2.6.178-185).

While the participants were reconnecting with the society, they also developed their capacity. Moreover, reconnection to the society made them know other people and not feel alone. For example, a participant who stayed at home all the time prior to the illness found her new self when the depressive symptoms was absent; she started going out for social reconnection:

I think I'll do whatever I want to do. I learn whatever I want to learn. I go to the temple when I want to. It's like giving my life a reward because I didn't understand my life for a long time. I just spent my time worrying about the children, my family. I was worried about everything. So I turned to look at myself, to see what I should do with myself. Because it is useless to be worried about them, it just makes me stressed. (22.1.7.225-227).

1.3.3 Being Productive

Many participants were financially dependent on their husbands. The loss of the financial resources made them feel loss of self-worth. The participants needed to have incomes after they were separated, divorced, or became a widow. After discovering their self-worth, they relied on their own finance even though they had difficulties in their life:

When the problems happened, their father didn't give money to them at all, and I did not work at that time. Let's go, hurry up. It doesn't matter if we starve to death. At that time my children did not work yet. They were still at school. I didn't care. I tried to make money, just a little, but I could do it. But I didn't cheat anybody. I worked honestly, and took anything – fifty baths, a hundred baths. I fought every way. I would not beg...please stay with me...no, I'd rather die than doing such thing. I would not say that definitely (02.2.19...) .

A participant set up a business after leaving home. She subsequently discovered her self-worth:

I am the kind that generally tries thing. Sometimes when I can't do this, I'll try that instead. If I can't run the clothing business, I'll do something else. In the old days, when I left home, I took care of all clothing business. I opened my own shop. I could rely on myself. (27.1.6.202-204).

Another participant tried to learn and increased her capacity to be successful in the business:

Well, I was not good at this. I was not good, so I added that part in. I added this part into myself, working more with it. So, it would not be loaded during the time that they came for the examination. Something likes that. And it got better. It was getting a lot better (16.1.11.387-389).

1.3.4 Assisting in Community Services

The participants who fully recovered expressed their intention to contribute to the society. Some participants intended to help other people who had the same illness. They were willing to give advice for the management of depression. Some participants who partially recovered expressed hope that they would be useful for the society by the end of their life. The participants thought that providing services to the society would make them happy. For example, a

participant who was a nurse volunteered to care for infants in a government-run institute. She said:

Once I applied for a job at the Payathai Infant Care Centre at, just around here. I volunteered to care for the baby, and I wouldn't get any salary...but they said they had enough people. I thought I took my children to school everyday anyway, so I could come here, taking care of the baby, and went back home with my children in the afternoon. I thought so. Talking about work...for me, I nearly recovered completely. Even with my children, when I was driving them back home and I talked about work, I would feel very happy. It was like I was in paradise. It felt good. Whenever I talked about it, I'd be very happy (09.1.10-11.343-353).

The participants did activities for community service by 'gradually' 'proceeding' and 'not exerting' themselves; consequently, their actions to their 'self-worth' both for themselves and other people:

The following story came from a participant who had finished her career as an accountant and restarted with a simple job.

I am alright now, and I feel better. I am not lazy. Maybe it's the necessity, or maybe the brain is good. Or because I take medications and the brain has better ideas. Now I start working again. Before this, I would not touch an account. Now, I work with it, but it must be a simple account (20.2.1032-333).

Apart from gradually proceedings, the activities would be done only when the participants were ready, which depended on their decision, as a participant stated:

I should have moral support for myself. If I want to rest, I'll rest. If I want to do something, I'll do it. The day I felt bad, I didn't have to do it. At that time, I felt bad and still wanted to do it, so I felt more stressed. I did many things at the same time so I had to do it gradually (16.1.1.11-13).

The following participant decided to do activities that she would like to do. She did not exert herself and felt like it was a release from social chains as being a wife meant serving and taking care of the husband and the children:

I tell myself that I should do whatever I want to do. If I don't want to do it, stop doing it. It's simple. Like...ironing. If I want to do it, I'll do it; but if I don't want to, I will hire somebody to do it and pay per piece. I'll pay for my good feeling. At the moment, if I don't want to do anything, I really won't do it. I don't know why. If I force myself to do something, I won't feel very well. Like cooking – I don't like cooking, I'd like to buy foods, but my husband likes me to cook. Actually, I am not good at cooking at all; still, he likes me to cook. I don't care now. If I want to cook, I'll cook. But if I don't want to cook, I'll buy foods. Can you eat? Can or can't. If you can't, buy it yourself. In the old times, oh...I had to find it. If he didn't like the foods, I had to change. Not anymore now. If you can't eat, don't eat it. Go and buy something yourself. And I try to find something I like, such as cross-stitch, jigsaw, and crochets. If I have free time, I'll do these works, and I'll be relaxed (20.2.9.282-290).

The activities should require an attempt to be successful. The following example is from a participant who tried to overcome the feeling of fear, timidity, and lack of self-confidence in doing activities that she could not do while having the illness or never did before in her life. When the activities were accomplished, the success was a source of support and pride for her:

When I got the illness, I was discouraged of everything and was scared too. I came to Bangkok. I used to study at the Bangkok Technical College. I was scared. I had not been to Bangkok for a while. I needed to take my sister with me. See, I had this big body and still needed a sister with me. Later, I thought, well, let's try it. We had our own car at home. When I came here, I never looked at the route, so I was afraid that I might get lost. Later, I think, well, what am I scared of? I have a mouth. I can ask. I don't have to be afraid. So, I get better. When I can face with Bangkok, I can face other places, too (16.1.1.13-17).

Another participant was a middle-aged single woman who overcame the fear, timidity, and the belief that a woman should not travel a long distance on her own.

Once she succeeded in overcoming those feelings, it became a source for her pride and self-worth, as she stated:

At first, when I had so many problems and I couldn't adjust my mind, I took a car to upcountry straight away. The last time I went, I went to Krabi on my own. I went there on my own and looked for somewhere to stay. I didn't know anybody. Er...I checked in a hotel and wherever they had a tour group, I went with them. I bought a tour there. It gave me experience. It made me realize that I didn't have to attach to the idea about having family, having a husband, having this and that to take me with them. I have shown that a sole woman can travel. Yes, it may be dangerous, but we have to be careful. We must learn to be careful, to survive, and then we will be proud that we can do it. If I hadn't gone at first, I wouldn't have been able to go at all. I would be worried about the others, worried about my niece and my mother. I went there on my own. Whatever would happen, let it happen. So, I've known that a single woman can do it. I don't need anybody by my side to go somewhere. Here I am. I come here alone, I go alone. I just have enough money, and I'll go, but I must take care of my safety. So, it makes me feel confident that I can go everywhere, can do anything, and can solve any problem. So, these ideas support each other (08.1.5.162-179).

The activities that the participants chose to do should not be too difficult for their capability. The success in these activities would be an encouragement for them to realize their self-worth, as exemplified below.

I taught the kids about this, and they cooperated very well. They could do it very well, so I was happy. The happiness reflected inside me and made me happy by itself. Therefore, those who are ill like this, do something. If we do something and we accomplish it, it will give us mental power. Tablet medications don't help. It helps in our mind...like we have value. Like...I can do it. So, do anything that we can do but don't expect anything. For this illness, if we expect and don't get what we expect, it could come back again (16.1.17.598.605).

Moral support is the internal support of a person. The participants did not have to wait for support from external factors or moral support from other people, as one stated:

When I grew up, I had expectation. During the time I was sick, I worked and expected a two-level promotion. Now, I feel indifferent even if I do not get a level. If I get it I don't feel anything special...just normal, like this. I think about it as natural. Before this, no if friends from the same class got it, I should get it, too. But not now. It's like I can let it go. And I don't read many religious books either. I just put it down. I realize that if I want something so much, I'll be very sorry when I don't get it. And that's bad for me, right? I must not wait for moral support from anybody. I must be myself, comfort myself, and give myself moral support. I must stand up to fight. Other components like medications, friends, and good environment are only parts of it (16.1.18. 620-623).

In conclusion, the process of 'Restarting My Life' is the process of picking up various actions from the point where the actions were stopped or were left due to the sufferings from depression. The process gradually proceeded without exerting one's self, and it resulted in self-worth for the person and other people. This process consisted of restarting activity, reconnecting with the society, being productive, and devoting for community services. Redefining one's self and relationships with other people in combination with restarting one's life resulted in self-growth, which is discussed in the following section.

2. Self-Growth

Self-growth is a positive consequence of the process of recovering from depression in the 'Theory of self-regaining from loss of self-worth in depressive middle-aged Thai women.' The participants who had passed the process of recovery from depression and had reached this stage were able to perceive their growth and development. They were proud of themselves, were confident in their ability, and had stronger mental health. Their life was more peaceful than the time prior to the

awareness of illness; moreover, they could tell that they were at a contented point and were satisfied with their changes. The participants were also able to look back and see the differences in themselves, both at the time prior to the depression and during the time of depression, as demonstrated in the following statements:

...the same...yes, I feel it. I feel that myself is stronger than before ... (02.2.19)... I feel that I see things more. I feel better, much better than when I first came to see the doctor (02.2.22).

I don't think I am ill. I think I get better. Because I notice that at first I couldn't eat anything – couldn't eat at all. But now I can eat as usual. I feel hungry, and feel full. At first, I felt like my throat was constricted, and I couldn't eat it. That time, I thought I was in a bad condition. I used to be like that when my child could not pass the university entrance exam. I couldn't eat anything, and I just cried all the time (07.1.9.290-292).

At this stage, even though the participants still needed oral medications, they were aware of their self-growth:

R: So, now you don't feel like reducing the medications.

P: Unless you order it, doctor. Because I know it's chronic. But I think I am proud at this stage. I can think a lot by myself. I am not obsessed with the old stories. If I am like how I was before, when I feel sorry I would be obsessed with the problems for years, crying all day, and figuring things from the past all the time. But not now (11.2.12.355-2359).

The participants who had passed the process of self-regaining through the modification of actions and intellectual structure, comprising self-discovery, redefining one's self and the relationship with other people, and restarting one's life would recognize their self-growth, which was consisted of the perception of one's self as the life-center, self-control, internal motivation, and generating mental happiness and peace.

2.1 The Perception of My Self as the Center of My Life

The participants who had considered other people as the center of their life shifted the center to themselves. Consequently, they loved themselves, lived for themselves, and relied on themselves. The following statement came from a participant who perceived herself as the center of her life and was ready to accept the following circumstance:

I was very close with my stepmother, but I have to put down my worry about her. If I am too worried, I will cling on to her. Someday, she will not stay with me and I may not be able to carry on living. So, I have to let go. She's getting old now, and I have to think about myself. I have to think I won't have her with me someday...so...it's like I live alone (11.1.6.209-214).

The following participant shifted the center of her life from her husband to herself. She, then, lived a self-sufficient and self-reliant life, as she said:

I tried to help myself. I didn't ask him for help at all even though he has so much that he can give me anything. I don't ask. If he doesn't give, that's it. He doesn't give. I won't ask. I can live. I don't have much, so I don't spend much. I just live with my status. I feel better living like this, better than living with him. I feel that my mental health is better, and I can say so, although I may be lonely sometimes. When I am lonely, I work or go somewhere. Sometimes it can help me forget about things (27.1.11.352-356).

2.2 Self-Control

The participants had the ability to control their thoughts, emotion, and situation to keep them from the recurrence of the loss of self-worth that they experienced before. The participants were able to recognize negative feelings, even with a minimal change, and they could stop themselves before the circumstance had an

effect on their emotion and feelings to the extent of an unbearable level. The participants might react by modifying their perception of the circumstance and the world, accepting the situation, or ignoring it, as exemplified below:

...But for me, now... I think fast. If I think slowly, it's a waste of my brain, and I can't sleep. I can change quickly. Bang! Then, I change to positive thinking first. From my experience, there is a lot of thinking – this way, that way. But I must think positively. I change it into a positive way (11.1.11.359-363).

These days, there are emotions or something coming to me to... But I feel like I can take a break from my feeling at one level. I don't crash with my children. Before this, when they said something, I would crash with them right away. I crashed with them because I thought my talk and my teaching all came from my love for them. I had a good intention for them (02.2.13).

The changes after the process of recovery involved rethinking immediately after the recognition of negative feelings. The participants warned themselves not to think about it, as one said:

P: I try to tell myself – don't think. If I think, it will be a long story. I tell myself not to think, and the thoughts would come up immediately. No, don't think. If I think, it will be long. Once I have such thought, the negative feeling will be stopped.

R: Is it different from before?

P: Before this, when I thought about something, I would just lie down, crying; lied down, crying. I would lie in bed all day and thought all the time, thought about something bad, and I would feel sad all the time (10.2.5.162-163).

2.3 Internal Motivation

The motivation in doing activities came from the participants themselves; namely, the sense of pride and self-worth from doing activities, or the sense of

accomplishment when an activity was succeeded. The participants, however, were not disappointed when an activity failed. The following participant felt happy with the activity she liked and did it because she loved doing it, not because she wanted to overcome the depression or expected an outcome from external factors:

I like doing housework. After finishing at the pharmacy, I'll go to my father's house. I don't live with him. I help him with the laundry, cleaning, and feeding the dog. I feel happy when I am doing housework for my father. That's it. I like doing housework, being a housekeeper. I am happy when I do housework – cleaning or tidying up. When I feel better, I am encouraged to do more (25.1.15. 492-495). Now, I do it for my enjoyment. I do it because I like it. I love to do it. And I listen to music at the same time, doing housework at the same time like old songs – Sundhraporn. I am happy doing housework and think about the old days at the same time (laugh) (25.1.15.504-506).

2.4 Generating Mental Happiness and Peace

The participants could be happy by themselves, not depending on the circumstance or external factors. They could feel peaceful and happy even when they were alone. When they were with other people, they did not have to exert themselves to make people think they were happy. Additionally, the participants were not worried or afraid of the future and they could express admiration for themselves, as well as for other people:

To think about it, I've found the truth that the real happiness is being alone. It makes me feel unconfused. Sometimes, I have to go upcountry, you know. It's quite enjoyable. No, I don't like searching for something meaningless. I don't know how to say it. I can't explain it. It's just...being alone, giving time to myself. Giving something to myself makes me feel very good (02.2.1.2-6).

Sometimes I don't think much even if I am alone. I'll watch TV or go out for a walk if I feel lonely. I'll go out alone, looking at things;

and that's enjoyable enough. I will be tired when I go back home. So...I'll have a rest and will feel better (11.1.2.59-61).

Sometimes, when there's nothing wrong with me, I enjoy going out and chatting with friends. We'll laugh all day. But when I feel stressed, I can't enjoy with other people. They are all laughing, but I will sit there, working and pulling a long face. There are times when I don't think too much, and I can enjoy my friends and even help them with their work (11.2.16.474-477).

Yes, yes, I've recovered nearly a hundred per cent. I even talked to the doctor, asking to stop the medications. At that time, I was very happy to be normal. I could enjoy things, could do things, and could lead my friends to do whatsoever. But I did not exert myself to do it (07.1.1.8-10).

I am not afraid of having a depressive illness because, now, I think whatever will be, will be. Whatever will be, let it be. I do what I like here, and I'll do it. Whatever will be, will be. I am so old now. What will happen, let it be. People die, anyway. So, I am not afraid. If I am ill, let it happen. If I am not ill, fine. The doctor gave me sleeping pills to take before bedtime. I don't take it because I think if I can sleep, I sleep; if I can't, let it be (22.2.4.107.111).

In conclusion, 'Self-Growth' refers to the condition of the participants who had passed the process of recovery from depression. At this stage, the participants perceived themselves as the center of their life. They were able to control themselves, had internal motivation, and could generate mental happiness and peace.

Groups of Participants Who Did Not Fully Recover from Depression

The participants who did not completely recover from depression could be categorized into three groups according to their perception of the illness. The three groups were the participants who felt better but were still unhappy, the participants

who felt better but were still vulnerable, and the participants who still suffered from depression.

Participants Who Felt Better but Were Still Unhappy

These participants were aware of their improved mental health; still, they were unhappy. They could do their work as usual but never felt fully happy as they felt something was missing in their life such as an adviser who would reflect on their thought and action when they needed, or a person who could understand and listen to them. These participants lived their life very carefully, being aware that the depressive symptoms might recur, as in the following example:

But I had experienced happiness... that happiness... I was mediating at Suan Moke (temple) and the happiness came from the sense of detachment. No attachment to myself, no thinking about anything – just thinking about the present. It was real happiness, wonderful happiness. I felt like I could forgive anything. Everything I looked at seemed good. I would be good if I could be like that, but the chance was very small. I tried, though. I tried to reach that point. But at the moment, I just learned to protect myself. I can't say I am happy but I feel less suffered. I still feel irritated, and I still think a lot. My feeling is still unstable sometimes (101.2.7.238-240).

But I...umm...I live with the present now. I mean whatever I want to do, I'll do it. I'm interested in doing that, and I concentrate on doing it. My thoughts are not spread out too much, but I won't say I am happy. I don't think so. I am still suffered (01.2.7.220-223).

Participants Who Felt Better but Were Still Vulnerable

The participants in this group were aware of their improved condition, but they still had symptoms occasionally, depending on the circumstances:

OK...I feel better now, but if there's something disturbing my mind, the old symptoms will recur. But I try to control myself not to think too much. If I can get something out of my mind, I'll do it. I may feel sad for one or two days; then, I'll get it out of my mind because I know my body is not good. If I keep those thoughts, they will worsen my body, so I'll try to cut the thoughts off. After I have received the treatment, my family is happier. My husband is OK; he seems better when I've changed. The children become better, too (20.2.1.2-7).

Some participants lived a happier life and could normally work. Nevertheless, they still had symptoms and were vulnerable to the circumstance that was beyond their usual lifestyle, as in the following examples:

Like...at the moment...well, I am very happy today. Actually everyday is like this. I cook for myself or do some little things. Umm...why am I so happy today? The other days are the same as today. My mental health is better then (23.2.110.339-341).

Something is still frightening for me. When somebody speaks loudly, the phone rings, or a dog barks, all these frighten me. The sound of the door being closed, or any noise that is louder than usual, frighten me. I could be frightened and get frozen right there (28.1.1.2-3).

If I don't live my usual lifestyle, it will be like this. It's not excitement, and I don't feel sad because he doesn't involve in this. I would feel dizzy. I have to close my eyes. I don't want to see anybody, trying to avoid people. I don't want to talk...or...that's the symptoms. I don't understand if they're the symptoms (20.2.5.139-142).

Participants Who still Suffered from Depression

The participants in this group suffered from depression almost all the time. They could not motivate themselves to work or produce anything. The severity of the symptoms depended on external influences and internal factors coming from their mind. The participants in this group did not reach the stage of 'untying the knot.'

They did not discover themselves and did not modify their intellectual structure. However, they expected the recovery from depression when the circumstance was improved, as exemplified below:

R: Do you think you will get better if the circumstance changes?

P: Yes.

D: For the recovery, you need self-motivation as you just said?

P: Yes, and I am interested in my surrounding too. Like now, I don't want to do anything. Someday, if I am alone...if there's nobody at home, just suppose so because it's impossible as my mother-in-law is there all the time, I just want to sleep. Er...When I am asleep, I don't have to think about anything (13.1.7.216-220).

R: What do you mean by alternatively?

P: Sometimes I feel better. Sometimes I don't want to live anymore. It's boring.

R: Is it a long duration in-between?

P: No, not really. Only one day. Think this and that, this and that, alternatively.

R: So, you have both negative and positive feelings in the same day? (21.1.1.1-5).

The process of recovery from depression gradually proceeded, as stated in the following metaphor:

It gradually happened...gradually. Like changing from black. Suppose I was black before, then my color was gradually mixed and turned out as grey slowly. No, I don't mean I am purified as white. No, I just compare it. It gradually happened, getting brighter. But nobody is one hundred per cent, right? We have emotions, or have something all the time. But it's like I can give my feeling a break at a certain point (02.2.13.445-449).

Summary

The absence of depressive symptoms, self-awareness, and reappraising action/reaction of those who were the center of one's life concurrently occurred. These conditions led to self-regaining from depression in middle-aged women. The recovering process from depression was comprised of three components; namely, 'Discovering My Self,' 'Redefining My Self and the Relationship with Other People' and 'Restarting My Life.' In the process of 'Discovering My Self,' the participants found their self-worth which led to goal setting for self-growth. It was the condition that encouraged the participants to take actions for self-improvement and redefining themselves as well as their relationship with other people. As for 'Restarting My Life,' the participants took actions including restarting activities, reconnecting with the society, increasing ability to produce, and assisting in community services. The participants took actions slowly and did not exert themselves to do the activities; as a result, they regained the sense of self-worth for both themselves and from other people. Finally, the process of 'Redefining My Self' involved living with the present, being more flexible, seeking alternative thoughts, and being self-reliant. Regarding, redefining their relationship with other people, the participants took the following approaches: helping other people as they could but not with all they had, understanding other people as they were and not trying to change them, giving help without expecting anything in return, and relying on each other. The positive consequences of these actions included self-growth, which involved the growth and development in the aspect of shifting the life-center, having self-control, having internal motivation, and being able to generate mental happiness and peace. For the participants who did not pass the self-regaining process, they would have different

components after the recovery process. Some participants might be happier than before as they were in better circumstances, received higher income, and their children were more obedient. Nevertheless, these participants were at risk of recurrent severe depression if they encountered the circumstance that may cause the loss of self-worth again.



CHATER VIII

DISCUSSION

This chapter addresses the summary and discussion of the study findings. The strengths and limitations of the study are also presented.

Summary of Study Findings

This study answered two questions: first, what was the meaning of depression from the perspective of middle-aged Thai women who were diagnosed with major depressive disorder; and secondly, how middle-aged Thai women experienced and managed the problems in their lives and how they moved from depression towards recovery. These study findings were obtained from in-depth interviews of 31 women who were diagnosed with major depressive disorder. They accessed services at the psychiatric out patient unit in three medical school hospitals in Bangkok. These hospitals provide services for the Thai people from all regions of Thailand. Grounded theory methodology as a type of naturalistic inquiry was adopted as the research design. The study findings revealed that the meaning of depression was the process with continuous changes or dynamics, and discovery of substantive theory could be used to explain the phenomena of recovering from depression labeled ‘Theory of Self-Regaining from Loss of Self-Worth of Depressive Middle-Aged Thai women,’ each of which will be concluded as follows:

Meanings of Depression

Meanings of depression were continuously changing according to the condition interacted with their life. The process started when depression was viewed as something unknown until participants accepted depression as a part of their life in those that did not fully recover from depression. With regard to the participants who fully recovered from depression, they viewed depression as a phase of life. As a result of this study, the meanings of depression from the participants who were diagnosed with Major Depressive Disorder accessing treatment in the psychiatric unit of the general hospitals were defined. Meanings of depression were divided into four phases by turning points in relation to depressive symptoms as follows:

Phase I : Before access to health care services

Phase II : Access to health care services

Phase III : Understanding cause of depression

Phase IV : Recovering from depression

Before access to health care services, the meaning of depression was viewed as something unknown and as *jai-kho-mai khoi-dee* (hopelessness or helplessness). When the participants accessed the health care services, depression was redefined as a disease of the insane, a disease of a loser, or as a tacit disease. Consecutively, the participants tried to understand the cause of depression after they were diagnosed with a major depressive disorder. Depression was redefined again according to the explanation from the medical perspective as a disease of an obsessive or stressed



person or a disease of a love deprived person. These meanings viewed depression in the individual level and the people who had the illness were blamed as the people who had dysfunctional problem solving. Additionally, the disorder in the present is connected with the defection in the past or from the younger age. As for the meaning in the final phase, the meaning came from the interaction between the participants and the environment. These meanings include a part of life, a phase of life, or just as a common problem that everyone undergoes. These final meanings are redefined by the participants and the disease is separated, not as being unique between the person and the disease as perceived previously. In other words, the participants transformed the sense of self, or they changed their identity of one's self.

Theoretical Findings

The substantive theory developed in this study was entitled “Theory of Self-Regaining from Loss of Self-Worth of Depressive Middle-Aged Thai Women.” The theory was generated to explain how depressive middle-aged Thai women recovering from depression. This developed theory consists of three phases including:

Phase I : Causal condition of depression

Phase II : Learning about depression

Phase III : Recovering from depression

In this section, the constructs and concepts in the theory are presented consecutively according to the process of recovering from depression and their relationships between constructs and concepts in each phase and between phase. They

are described as follows (see Figure 2, and the model in detail is shown in Figures 3-5). Definition of the constructs and concepts which were obtained from this study are proposed in Table 6.

Phase I, ‘Causal Condition of Depression’ The study findings reveal that ‘Tying the Knot’ is a basic social psychological problem or the starting point of the problem in the depressive middle-aged Thai women. ‘Causal Condition of Depression’ consists of three constructs including ‘Tying the Knot,’ ‘Symptoms of Depression,’ and ‘Recognition of Depression.’ These constructs consist of five concepts as follows:

1. ‘Tying the Knot’: This construct is abstracted from ‘The Center of My Life,’ ‘Negative Appraisal of the Center of My Life’s Reaction,’ and ‘Perceived Loss of Self-Worth’;
2. ‘Symptoms of Depression’: This construct is abstracted from ‘Devastated Self’; and,
3. ‘Recognition of Depression’: This construct is abstracted from ‘Recognizing Self-Deviance.’

This phase begins with the interaction between two concepts, ‘The Center of My Life’ and ‘Negative Appraisal of the Center of My Life’s Reaction’ lead to a consequence of ‘Perceived Loss of Self-Worth.’ The more ‘Perceived Center of My Life,’ the greater ‘Negative Appraisal of the Center of My Life’s Reaction.’ The more ‘Negative Appraisal of the Center of My Life’s Reaction,’ the greater ‘Perceived Loss of Self-Worth.’ This consequence leads to ‘Devastated Self;’ that is, the response of

‘Perceived Loss of Self-Worth,’ until ‘Recognizing Self-Deviance,’ that is the last concept in this phase.

Phase II, ‘Learning about Depression’ consists of three constructs and six concepts that explain strategies for managing depressive symptoms. These constructs and concepts can be summarized as follows:

1. ‘Depression Self-Management’ construct consists of two concepts including:
 - 1) *Tamjai* (accepting the situation)
 - 2) Diverting My Self
2. ‘Help Seeking’ construct consists of two concepts including:
 - 1) Seeking Informal Help
 - 2) Seeking Professional Help
3. ‘Contemplation about My Self’ construct consists of two concepts including:
 - 1) Self-Awareness
 - 2) Reappraisal of Reactions/Actions of Those Who Were the Center of My Life.

The three constructs overlap, and any construct can happen before or after the others. Moreover, the three constructs are interrelated. The negative outcome of ‘Depression Self-Management’ would positively influence ‘Help Seeking.’ In turn, the positive outcome of ‘Help Seeking’ would positively influence ‘Depression Self-Management’ and ‘Contemplation about My Self.’ The positive outcome of self-management would positively influence ‘Contemplation about My Self.’ The

negatively outcome of 'Contemplation about My Self' would influence the more 'Help Seeking.' The outcome of these constructs is the turning point to the next phase.

Phase III, 'Recovering from Depression' consists of two constructs and four concepts including 'Untying the Knot' and 'Self-Growth.'

1. 'Untying the Knot' is the abstract of three concepts including:

- 1) Discovering My Self
- 2) Redefined My Self and Relationships with Other People
- 3) Restarting My Self

2. 'Self-Growth' is the construct of 'Regaining a New One' that is the positive consequence of the process of recovering from depression in depressive middle-aged Thai women. 'Untying the Knot' is positively directed for 'Self-Growth.'

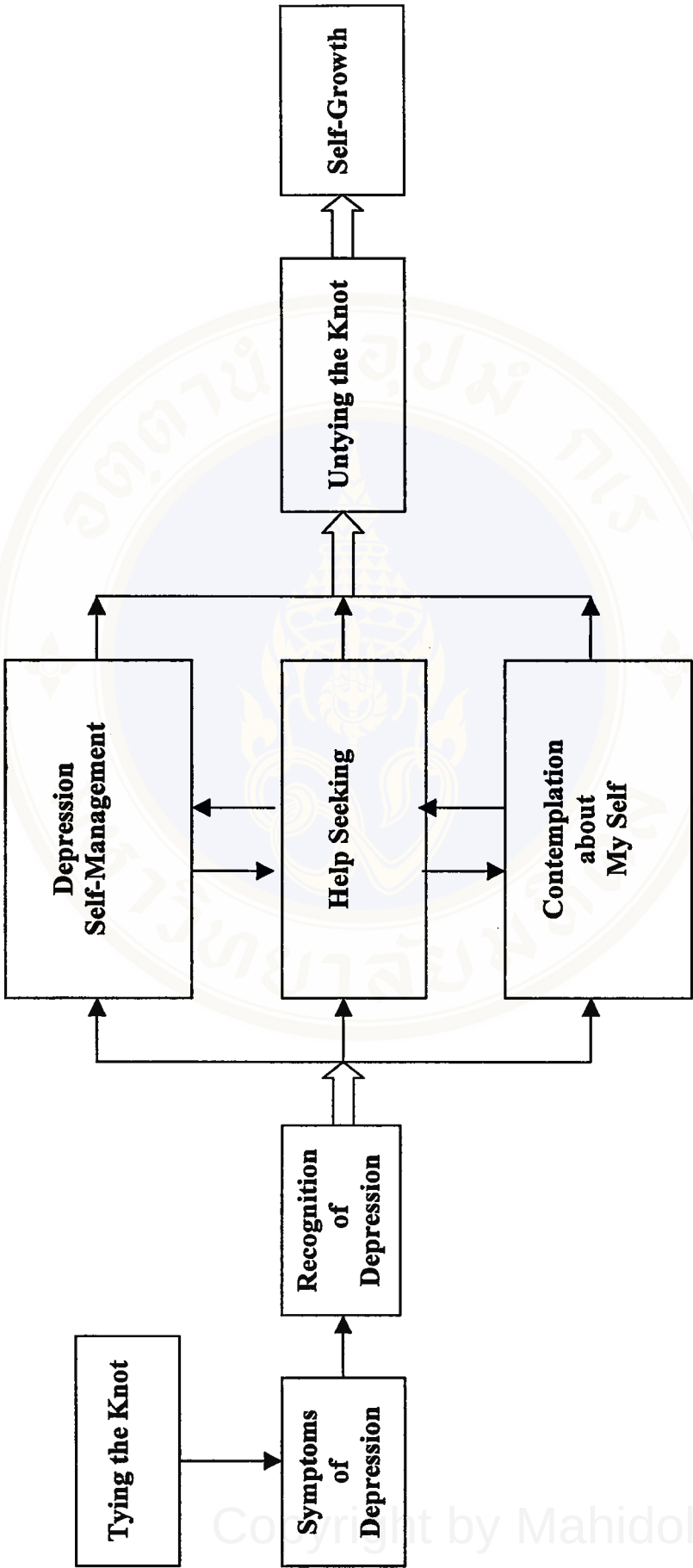


Figure 2: The constructs of the developed theory

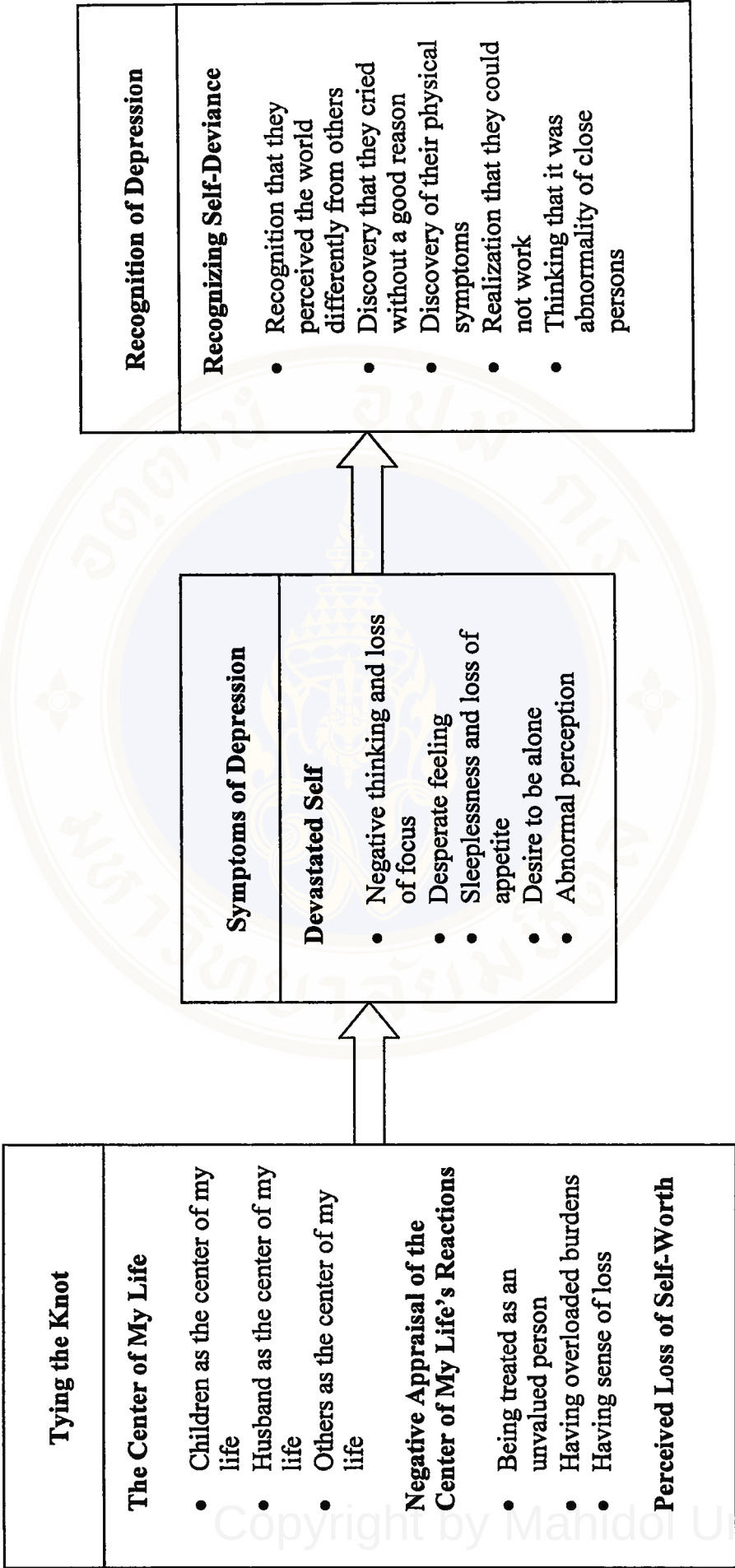


Figure 3: A Diagram Illustrating Phase I : Causal condition of depression

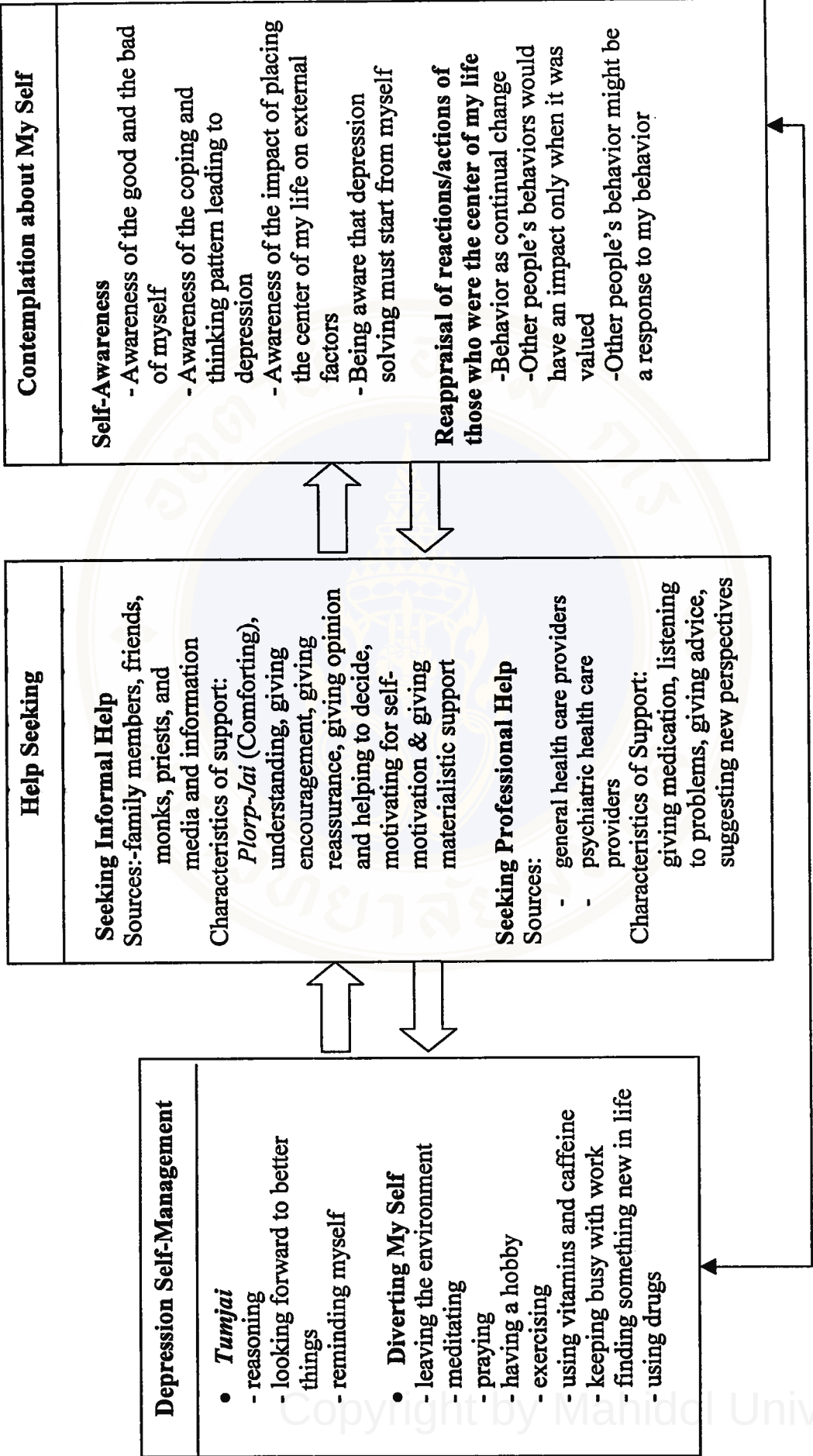


Figure 4: A Diagram Illustrating Phase II : Learning about depression

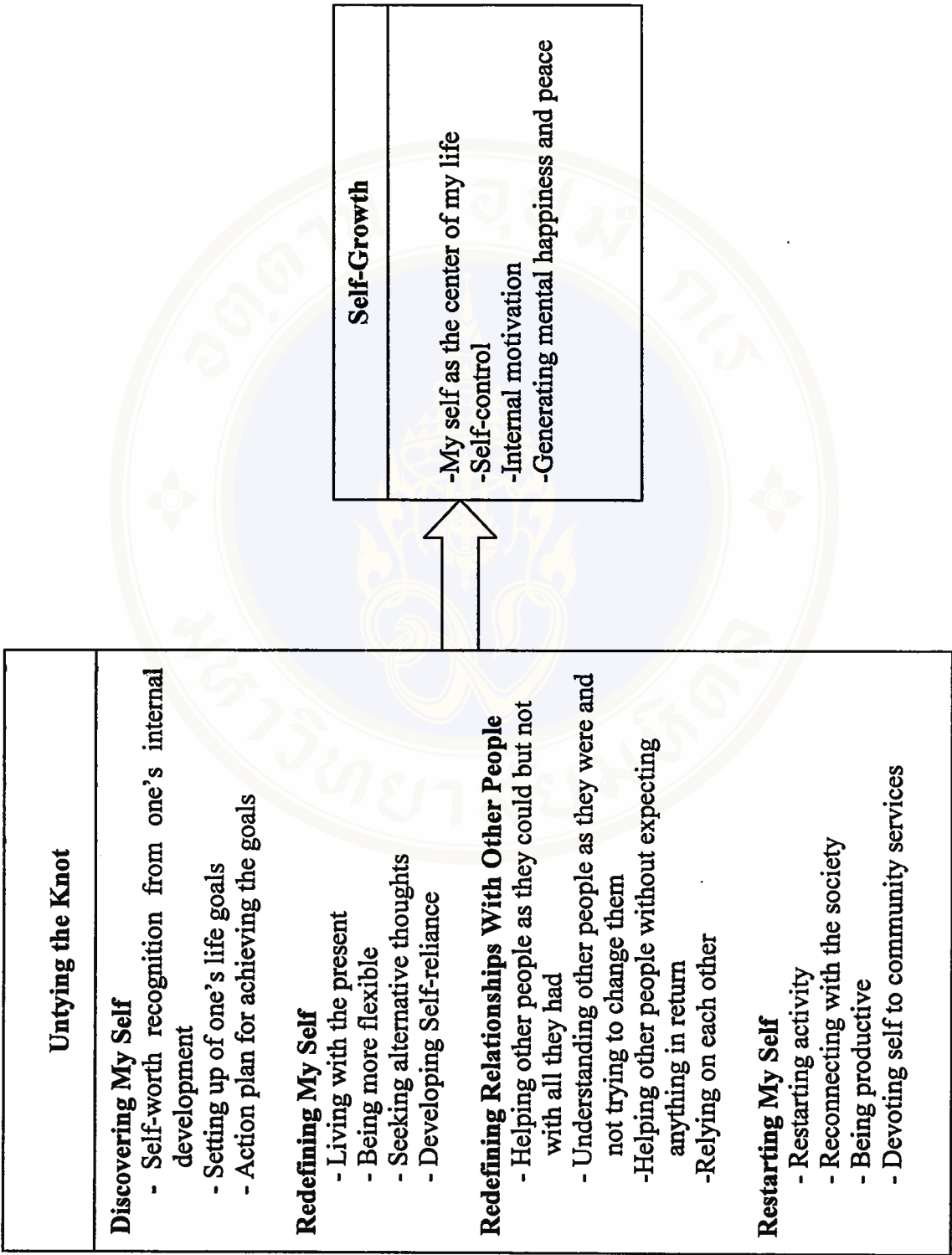


Figure 5: A Diagram Illustrating Phase III : Recovering from depression

Table 6 : Summary of the Definitions of the Constructs and Concepts

Constructs	Concepts	Definitions
Tying the Knot		The process in which the women have tied a knot in their lives by tying their self-worth with the sense of being important to people who were the center of their life.
	The Center of My Life	A person or a group of people who were important and of great value for the women, as well as being their source of pride.
	Negative Appraisal of the Center of My Life's Reactions	The appraisal of women who thought that they were treated as unvalued people, had overloaded burdens, and / or had sense of loss resulting from the behavior of the centers of life. The center of life was a husband, children, or significant others.
	Perceived Loss of Self-Worth	The perception of the women who considered that they were treated as unvalued people, had overloaded burdens and/or had a sense of loss resulting from the reactions of the center of life.
Symptoms of Depression	Devastated Self	The response of the perceived loss of self-worth which occurred as a vicious cycle starting from negative thinking and loss of focus followed by desperate feeling, less sleep and loss of appetite, desire to be alone, and abnormal perception.
Recognition of Depression	Recognizing Self Deviance	The women's awareness that they were different from what they once were. Their mean of recognition could vary depending on signs, degree of intensity, knowledge of depression, and ability to assess their thinking, feelings, and emotions.
Depression Self-Management		A deliberated process that aimed to decrease or eliminate symptoms of depression involving intention, action, evaluation of the action, and repetition of the action when the result was satisfactory.
	<i>Tumjai</i>	Acceptance of circumstances by managing one's thoughts and feelings through reasoning, hoping, and self-reminding. When one realized one's self, realization of the negative effect that could result was a process composed of intention, action, and evaluation for further action.
	Diverting My Self	The intention to divert one's thoughts and feelings in order to reduce or eliminate depression and the torture accompanying it. Activities that were used were leaving the environment, meditating, praying, having hobbies, exercising, using vitamins and caffeine, keeping busy with work, finding something new in life, and using drugs.

Table 6 : Summary of the Definitions of the Constructs and Concepts (cont.)

Constructs	Concepts	Definitions
Help Seeking		A process composed of considering sources of help to see whether which source worked, weighing between advantages and disadvantages of seeking help, selecting information that would tell which source would reveal how much of personal information, evaluating and repeating it when necessary
	Seeking Informal Help	Seeking help that had no definite format or pattern, but was natural, composed of processes to determine the source of help, weighing advantages and disadvantages of seeking help and choosing information that could be revealed, evaluated and repeated.
	Seeking Professional Help	Seeking help with a definite purpose from general health care providers and psychiatric health care providers. This was a multi-stage process composed of processes to determine the source of help, weighing the advantages and disadvantages of seeking help and choosing information that could be revealed, evaluated, and repeated when necessary
Contemplating about My Self		Restating, reflecting, considering, validating and comparative between information of one's self with the new information obtaining from religious teaching, psychological book, the book related the life, and the words of other people
	Self-awareness	Realization about oneself and some issues related to depressive symptoms. The contents of self-awareness included the good and the bad about one's self, depression coming from the ineffective coping pattern, the impact of placing the center of life on external factors, and the way to solve depressive symptoms starting from myself.
	Reappraisal Reactions/Actions of Those Who were the Center of My Life	Reconsideration and reevaluation of the reaction or the action of persons who were the center of their life. The reappraisal reactions of the others were as follows: Behavior was not static, but was a continual change; other people's behaviors may impact on one's self if one gave importance to it; and my behavior may impact on reaction of other people.

Table 6: Summary of the Definitions of the Constructs and Concepts (cont.)

Constructs	Concepts	Definitions
Untying the Knot		The point that women viewed the way to develop one’s self, occurring with the absence of depressive symptoms, self-awareness, and reappraising reactions /actions of those who were the center of one’s life.
	Discovering My Self	The process of recognition of self-worth from one’s internal development. This process led to the setting of one’s life goals and the action plan for achieving the goals.
	Redefined Myself and Relation with Other People	A process of the modification of life skills by explaining and defining events around oneself and re-establishing relationships with other people. For redefining oneself, the utilized approaches included living with the present, being more flexible, seeking alternative thoughts, and developing self-reliance. For the redefinition of relationships with other people, the utilized approaches included helping other people as they could but not with all they had, understanding other people as they were and not imposing expectations on them, helping without expecting anything in return, and relying on each other.
	Restarting My Self	The process of taking various actions that proceeded gradually without exerting one’s self and its results in self-worth for the person and other people. This process consisted of restarting activity, reconnecting with the society, being productive, and assisting in community services.
Self-Growth	Regaining a New One	The state in which women perceived themselves as a central of their life, were able to control themselves, had internal motivation, and could generate mental happiness and peace.

Discussion of the Findings

The results of this study were compared to previous relevant theories and studies. The purpose of this comparison was to find similarities and differences between the findings and to identify specific contributions of the current study. Because of the lack of studies related to depression in Thai women, most of the relevant studies used in the comparison were qualitative studies and theories conducted in western culture. This discussion is divided into four sections: meaning of depression, causal condition of depression, learning about depression, and recovering from depression.

Meaning of Depression

In the perspectives of women who lived with depressive symptoms and who recovered from depression, the meaning of depression was dynamic by the interactions among the women, the environment, and the course of major depressive disorder. The meaning of depression started from something unknown to the acceptance of depression as a part of life, a phase of life, or just as a common problem everyone underwent. These meanings of depression were socially constructed and redefined over time. Karp (1994) described that the processes of how those who lived with depression interpret and respond to their problems consisted of the process of transformation in the person's conception. He linked the experiences of depressed men and women to 'a career process' in which alterations in their self-conception moved. The notions of career and identity were intertwined as participants described their experiences of living with depression. The key points in the career process were (1) having inchoate feeling of distress in which the participants lacked the vocabulary

to label their experience as depression, (2) coming to feel that something was “really wrong,” (3) having a crisis that thrust them into a world of therapeutic experts, (4) coming to grips with an illness identity, during which they theorized about the cause(s) for their difficulty, and sometimes, (5) defining depression as a condition one could get past. Each of these career moments assumed and redefined self.

The meaning of depression in the participants’ perspective in the first phase ‘Before access to the healthcare services’ is as something unknown and as *jai-kho-mai-khoi-dee* (hopelessness and helplessness). These meanings come from Thai culture contexts which are different from the meaning in the medical perspective. The medical perspective views depression as a group of symptoms or a disease that needs to be treated. However, the meaning of depression in the Thai social context is influenced by the Buddhist perspectives. Buddhism views that the nature of life has happiness and suffering and these continually change in the daily living. In other words, there is no real happiness in life, but there are only feelings of suffering from the least suffering to the most suffering. Hence, the depressive symptoms in the Thai context are viewed with the commonsense perspective that people have to solve their sufferings by themselves or by following their religious teachings in order to obtain well-being. This result supported a number of works in anthropology that suggested that depressive symptoms were culturally constructed (Schieffelin, 1985).

When accessing health care services, depression is defined as ‘symptoms of a disease.’ These symptoms are a disease of an obsessive or stressed person, or a disease of the love deprived person, each of which are medically defined in terms of dysfunction in the chemicals in the brain. The cause of the illness is explained as the

dysfunctional problem solving and adaptation or lack of skill for coping with stressful life events. These meanings are consistent with the explanation in the theory of stress and coping by Larsarus (1975:181) that viewed the person who has dysfunctional coping with stressful life events might lead to somatic health, morale and social functioning.

By seeking help from health care services, either hospitals or private clinics, the participants received the explanation by the health care providers that the health problem that they confronted was a disease of the obsessive or stressed person and was an emotional problem. As a result, the participants redefined the meaning of depression from their previous view as *jai-kho-mai-khoi-dee* to a disease of a stressed or obsessive person or a disease of a loser.

Changing the meaning of depression after access to health care services could be clearly explained as a result of the profound influence of the power of the health care providers on the clients. In the Thai society, the clients respect, trust and obey the health care providers, particularly a physician, because he/she has great knowledge and could make the clients get well or have absence of symptoms. Therefore, when the health care providers explained the illness as a mental illness, the participants most likely accepted the meaning. Moreover, if the participants received treatment at a psychiatric hospital or psychiatric unit in the general hospital the meaning as a disease of a stressed person and emotionally disease was added with the meaning as a disease of the insane.

As for the meaning of a disease of the insane or a loser, it came from the fact that the participants endured a social stigma to be a mentally ill patient. The social

stigma with mentally ill patients occurred in relation to being treated as a psychiatric patient. The access to services from the psychiatric institution and being treated by a psychiatrist were the symbol of being labeled with a mental illness. These symbols exist in the Thai culture from the established specialty hospitals providing services to mentally ill patients. Nevertheless, although the participants who accessed treatment with the physician in the general hospital or private unit might not perceive the social stigma, they were still afraid of being labeled with a mental illness. In addition, meaning of depression as a disease of an insane or a disease of a loser increased the problem that the participants had to deal with. This result reinforced the theory by Goffman (1963) that stigmatized individuals to manage to limit the effects of stigma on their lives. According to Goffman, a 'discredited' person is the person who fails to handle stigma by limiting the effects of stigma on social relationships. A 'discreditable' person whose condition is not known to others manages information in a way that conceals his/her identity. In this study, the participants who viewed depression as a disease of the insane avoided being labeled with mental illness. The participants tried not to disclose the information and symbols that others could refer to being a mentally ill patient. They erased or closed the remark of the institution and the diagnosis from the various documents that came from the psychiatric unit. They intended to control their general appearance, expressing the feelings and performing actions as a "normal" person when they were in public and the workplace. For the participants who could not control themselves from performing these actions, they might isolate themselves or limit social relationship. However, the participants tried to deal with the sense of being labeled by cognitive reconstruction or modified thought. They transformed their identity by increasing the value and importance of one's self

and decreasing the importance of the external factors and the sense of value that came from others. They redefined depression as a phase of life that they could overcome. Although they could not totally overcome the depressive symptoms, they could accept depression as a part of life, and they viewed depression just as a common problem everyone underwent. This result was consistent with the work by Karp (1994).

Theory of Self-Regaining from Loss of Self-Worth of Depressive Middle-Aged Thai Women

The result revealed that 'Regaining One's Self' was the basic social psychological process of which middle-aged Thai women used for recovery from depression. 'Regaining One's Self' was a process that the participants journeyed from the recognition of depression to the end of the process in which they were able to perceive their self-growth. When comparing with the naturalistic inquiry related to depression and recovery from depression, the central concept in this study reinforced the study in the same phenomena. The central concept of this finding 'Regaining One's Self' was similar to other results of qualitative studies that focused on the importance of self in the recovering process including '(Re)Defining My Self' (Schreiber, 1996, 1998), 'Transformed Self,' 'Self as Healer,' (Chernomas, 1997), and 'Identity Turning Point' (Karp, 1994). Moreover, the main conditions that contributed to 'Regaining One's Self' was mostly similar to other studies as well. These are 'Seeking Help,' 'Telling My Story,' 'Revealing,' 'Acceptance and Belonging,' 'Contemplation about My Self,' 'Seeking Understanding,' and 'Making Sense of Depression-Meaning and Understanding.' The detailed comparisons of these conditions are discussed in the process of learning about depression. Furthermore,

‘Causal Condition of Depression,’ the first phase in the current study, will also be compared with the existing studies and theories as discussed below.

Causal Condition of Depression

The Phase of ‘Causal Condition of Depression’ consisted of three constructs: ‘Tying the Knot,’ ‘Symptoms of Depression,’ and ‘Recognition of Depression.’ Each of the constructs would be discussed consecutively as follows:

1. Tying the Knot

This study found that ‘Perceived Loss of Self-Worth’ was the consequence of the interaction between ‘The Center of My Life’ and ‘The Negative Appraisal of the Center of My Life’s Reaction.’ This consequence led the participants to have the ‘Depressive Symptoms’ or ‘Devastated Self.’ The result revealed that the sense of self of the participants depended on the relationship with the significant others. The participants could not separate life of themselves from the life of their significant others or loved ones. It meant that the participants gave importance of themselves to the external factors. Whenever the participants perceived the negative reactions of people who were the center of their lives, they experienced loss of sense of self. This perspective or this method of thinking led to recurring depressive symptoms.

The center of life that depended on others such as a husband, children, and the family was socialized and cultivated by the patriarchal perspective underpinning the Thai society. This perspective indicated how the women perform a role, such as the daughter’s role, wife’s role, mother’s role, and the role of a member in society. The most important person for the women is who they marry. The husband is the head

of the family. This value reflects the gender inequality in Thai society. It comes from the fact that the value has been socialized through classic poems, Thai literature, proverbs, and morals for a long time. For example, 'women will be good or bad depending on their husband,' and 'a husband is as a multi-tiered state umbrella that enables the women to keep their grace and identity. These proverbs emphasize whether the women are good or bad, or have happiness or not, depends on their husband or their marriage. As for the daughters role, the women have to obey the parents. The parents especially a father will be the person who makes choices in the important things in life, particularly decisions related to daughter's marriage. When the women get married and have their own family, the significant person in their life is added into their life. This is an offspring. As for the mother's role, their function is to teach their child to be a good person and give them the love and emphatic understanding. Hence, success of the family is based on either their husband or their children, apparently the source of sense of value. On the contrary, if the family is not prosperous and has to endure an illness of the husband or dysfunction of the daughter, the women will feel devalued. Moreover, they take care of their daughter in a different way from their son. The daughter has to take responsibility for completing the housework.

According to the study of Belenky et al. (1986), entitled 'Women Way of Knowing: the Development of Self Voice and Mind,' women are socialized to be 'received knower' more than being 'constructed knower.' The women are in the position to receive knowledge derived from a sense of 'who am I' from the definition others supply and the role they fill. Sense of self is dependent on the telling of others that you are a good person, a good mother, or a good wife. The women receive from

others words to explain their self. They do not construct their own knowledge about the good mother or good wife in their context. Therefore, the evaluation of their own sense of self most likely is dependent on the reaction of others toward one's self. Moreover, they perceive the social value as the standard criteria to assess the right and the wrong things. Most women's self-worth is the knowledge or reality that is constructed from the perceived knowledge of others in the family and society of what the reality is. How should I do? How should I think? The women have not been taught to construct their own knowledge. They are socialized in the position of the received knowledge. The women's sense of self therefore, comes from the reaction of others, and they never know their own actual self, or 'who am I.' As a result of this reaction, the women could not always control the reaction as they expect, sometimes in a negative way. This situation might lead the women to perceive a loss of self-worth. This is consistent with the work of Schreiber (1996) that explains the women's process of recovery from depression in Southern Ontario and in two bordering U.S. states that social psychological problems of depressive women took place when they could not answer the question 'who am I?' It can be a metaphor as some parts in the puzzle are lost. Hence, the causal condition of depression in the participants of this finding reinforced both works.

Moreover, this study result clarified the classical theory of depression which proposed that women's vulnerability to depression grew out of their unhealthy dependence on relationships for the definition of self and self-esteem maintenance (Jack, 1987, cited in Beeber, 1996a). Unhealthy dependency was viewed as a pathological outgrowth of a failed process of differentiation, and field-dependency or relativity in the definition of the self and self process was seen as a less healthy way of

organizing experience. It has become clearer, however, that these theories using the experiences of men as the standard for determining healthy development may not hold for women (Jack, 1987 cited in Beeber, 1996a).

In addition, the concept of 'Perceived Loss of Self-Worth' in this study further reinforced the explanation of the concept of self worth by Satir (1988:30) that self-worth is a central energy source. Self-worth and self-esteem are interchangeable. Self-esteem is the ability to value one's self and to treat oneself with dignity, love, and reality. Satir is convinced that one's self-worth is the crucial factor in what happens both inside people and between people (Satir, 1988 : 22). The women's self-worth that were in this current study did was according to self-worth in the Satir's concept, "A person who does not value him- or herself will expect someone else--a wife, husband, son, or daughter--to be responsible for bestowing that value. This often leads to endless manipulations that usually backfire on both parties (p.31)."

Furthermore, this study result also supports 'Theory of Interpersonal Relations' by Paplau (1989, 1991, cited in Beeber & Charlie, 1998: 249) that self-esteem is either enhanced or diminished as a result of how the women gauge their degree of control through their actions and acquires internal and external appraisals in the process of acting on their behalf. Negative appraisals increase anxiety and decrease self-esteem. Because interpersonal provides appraisals, problematic interpersonal relations add more negative appraisals, erode self-esteem, and thwart the acquisition of the information and support necessary to effectively manage the transition. Therefore, depressive symptoms are the result of change in one's self and relations that develop to manage anxiety.

2. Symptoms of Depression

'Symptoms Depression' which was the construct of 'Devastated Self' was the response of perceived loss of self-worth expressed as a vicious cycle from negative thinking and loss of focus, desperate feelings, sleeplessness and loss of appetite, to abnormal perception. Characteristics of the 'Devastated Self' found in this study were consistent with the theme of 'Loss of Self' which was the central feature in the women experiencing depression in western culture (Chernomas, 1997:396). It was the basis for women's explanations of their feelings of powerlessness and difficulties in negotiating their everyday activities. Losing one's self affected their relationships with others and their limited ability to take the functions they should. Moreover, it reinforced the concept of 'Dying of Self' in the substantive theory of postpartum depression labeled 'Teetering on the Edge' (Beck, 1993). However, the participants in this study did not perceive their devastated self as the illness or something wrong. Their 'Devastated Self' was an awareness that there were the depressive symptoms after they were diagnosed with major depressive disorder by the doctor.

3. Recognition of Depression

'Recognition of Depression' which was the construct of 'Recognizing Self-Deviance' varied in the method on how participants recognized the symptoms. It depended on severity of 'Devastated Self,' knowledge of depression, and ability to assess their thinking, feelings, and emotions. Nevertheless, the most common and easy recognition of the deviance was the discovering of physical symptoms such as insomnia, loss of appetite, and realization that they could not work. The current finding contributed to the cross-cultural study of depression by anthropologists and

psychiatrists. They found the contrast between the depressive syndrome in western patients with its emphasis on psychological factors (e.g., the feelings of sadness, hopelessness, and worthlessness) and the primarily somatic symptomatology of non-western patients (vague aches and pains, stomach malaise, insomnia, and loss of vitality) (Schieffelin, 1985: 101). It may be the results of the eastern view a change in their mind was their commonsense perspective, but the change in their physical well-being was viewed as the illness perspective. Furthermore, the recognition by which they perceived the world differently from others, and that fear that their nightmares would come true, supported the phase of 'Seeing the Abyss' of the women's process of recovery from depression (Schreiber, 1996:477). The 'Seeing the Abyss' consisted of four dimensions: 'Recognizing My Self as Different,' 'Using Images and Metaphors,' 'Feeling Afraid,' and 'Taking Action.' Recognition of the deviance of one's self led participants to find out the strategy to solve the problems.

Learning about Depression

After recognizing their self-deviance, the participants tried to manage depression by themselves by seeking help when they realized that they needed it, and they contemplated about one's self. These strategies led to the absence of depressive symptoms, resulting in self-awareness, and reappraisal of the reactions/actions of those who were the center of their life. However, there were differences in strategies used by each participants depending on the belief about illness, existing resource, and past experiences.

1. Depression Self-Management

‘Depression Self-Management’ in this study is constructed from two concepts: ‘*Tamjai* (Accepting the situation)’ and ‘Diverting My Self.’ Participants themselves tried to manage depressive symptoms before seeking any help because they viewed depressive symptoms with a commonsense perspective. In other words, they viewed depressive symptoms as mental suffering, not as a disease or illness. The participants were most likely to find out the method to help them when they could not endure to go on. Nevertheless, if the symptoms were severe enough to threaten their life, they were most likely to seek someone to help and manage themselves simultaneously. Some of the self-management methods were underpinning the Buddhist beliefs such as meditation and prayers. Some were chosen based on past successful experience, while others from the suggestions of the health care providers and close relatives. This ‘Depression Self-Management’ concept expanded the ‘Being Strong’ concept that Schreiber (1998) discovered. The ‘Being Strong’ was the basic social process from a non-dominant culture background that Black West-Indian Canadian women used to ameliorate or manage their depression. ‘Being strong’ included ‘Dwelling on It,’ ‘Diverting My Self,’ and ‘Regaining My Composure.’ For most of the women, the range of available life choices was limited to the three processes; however, a few engaged in ‘Trying New Approaches.’ These women were less limited in their range of cultural and behavioral boundaries than were the others, and they began tentatively to explore other options for themselves. ‘Being Strong’ occurred within the overlapping areas of three social contexts: the cultural stigma of depression, male-female roles, and belief in Christian doctrines. The finding from West Indian culture was similar with this finding in that the women tried to help

themselves and to understand that cultural and social context were important for them to construct the meaning of their life.

2. Help Seeking

'Help Seeking' in this study was constructed from two concepts: 'Seeking Informal Help' and 'Seeking Professional Help.' The participants decided to use resources for seeking help depending on the type of cues or signs and symptoms of depression, and intensity of the cues. Seeking help was the process in which the participants considered what resources they could use. They weighed the pros and cons of seeking help and selecting the information that could be revealed. They evaluated the outcome of seeking help and repeated it if they perceived it was needed. Mostly seeking informal help came from a close relative or friend, and a priest or monk in their community. The help was both mental or material support such as money, time, and doing their responsible task. With regard to seeking help from help care providers, the participants were likely to seek help from the physician in order to treat physical symptoms. They turned to seek help from a psychiatrist when their symptoms were severe or they were suggested from physicians.

The concept of seeking help in this study was expanded from 'The Theory of Help Seeking Behavior' proposed by Mechanic (1980: 122-148). He identified the help seeking behavior as the illness behavior that reacted toward the occurring of signs and symptoms. Patients sought the way to discriminate the abnormality. Conditions that made the help seeking behavior in each one different included visible characteristics, awareness of the importance of the abnormality, impact on performing functions both in the individual and family levels, frequency and duration of the

symptoms, severity of symptoms, meaning the symptoms, and the access to health care services.

This current study expanded the previous 'Help Seeking Behavior' concept as the 'Help Seeking' in this study also included 'Seeking Informal Help,' depending on characteristics of the helper and suitable time for seeking help. In the 'Seeking Informal Help,' the Thai participants were most likely to seek help from close relatives and friends, or a monk and a priest. The characteristics were specific in the Thai culture and social context that the relatives and close friends were most likely to be interdependent all the times, when they were in trouble or happy. Particularly, for Thai women, the parents are the first source that they recognize. Beside that, another item that expanded the Mechanic's theory was the characteristics of those participants who decided to seek help. These characteristics included ever having a similar problem, ever being interdependent, and realizing that the helper had an empathic understanding. Furthermore, in this study, it was found that the effectiveness of help seeking behavior and support from others had to be congruent with the course of the illness or symptoms of depression, and the readiness of the help from the receiver.

Regarding seeking help from health care providers, the majority of participants decided to seek help when they realized the physical symptoms or could not perform their function. This finding was consistent with the study by Lotrakul, Saipanit, and Theeamoke (1994) that most patients who were diagnosed with depression were presented with somatic symptoms at their first visits. Some pathoplastic cultural influences were found, among which were the infrequency of feelings of hopelessness and the idea of self-insufficiency. Nevertheless, when

compared with studies from the west, these feelings in Thai women were less present than those in the western patients.

3. Contemplation about My Self

‘Contemplation about My Self’ was the process consisting of reviewing, reflecting, considering, validating, and comparing between the appropriateness of the action of oneself and the newly obtained information. The ‘Contemplation about My Self’ led the participants to self-awareness and self-understanding, and it modified the previous thinking until they understood the reaction of others. The concept ‘Contemplation about My Self’ was consistent with the concept of ‘Seeking Understanding’ by Schreiber (1996), ‘First Turning Point’ by Steen (1996), and theme of ‘Making Sense of Depression-Meaning and Understanding’ by Chronomas (1997) on that the participants could connect between past experience and outcomes that they were facing at present. Moreover, they could be aware of the pattern of their thinking and their problem solving that led them to have depressive symptoms. However, in this study learning about stigma proposed in the work of Schreiber (1996) is discussed in the section of meaning of depression.

‘Contemplation about My Self’ in this study supported the cognitive therapy by Beck. The effectiveness of ‘Contemplation about My Self’ had the underpinning of the three conditions: peace of mind, learning new perspectives, and analytic thinking skills. Consistently, the cognitive therapy addressed the problem in order to help the client realize one’s self and the world. Additionally, the learning about a new perspective was emphasized instead of the previous perspective which included negative thinking.

‘Depression Self-Management,’ ‘Help Seeking,’ and ‘Contemplation about My Self’ in the phase of ‘Learning about Depression’ became the conditions that the participants could enter in the last phase: ‘Recovering from Depression.’ In other words, these three constructs were the intervening conditions that could make the women regain one’s self from loss of self-worth.

Recovering from Depression

In the phase of ‘Recovering from Depression,’ the construct of ‘Untying the Knot’ was the process of regaining the importance of one’s self and achieving ‘Self-Growth.’ The consequence of the recovery of depression will be discussed as follow:

1. Untying the Knot

The concept of ‘Untying the Knot’ in this study was congruent with the ‘Clueing In’ phase in the ‘(Re)Defining My Self Process’ (Schreiber, 1996,1998). Women clue in or come to a cognitive and emotional realization of themselves in relation to the world. They seem to be able to put in place the final piece of the puzzle of who they are, and what is their true self. This phase is similar with the ‘Discovering of My Self’ in that the participants could perceive the worth of themselves. Moreover, two of three properties of ‘Clueing In’ that were stated by Schreiber (1998): ‘(Re)Inventing My Self’ and ‘Controlling the Right Stuff’ are similar to ‘Discovering My Self’ and ‘Redefine My Self and Relations with Other People.’ In ‘(Re)Inventing My Self,’ the women gain a new understanding of themselves and become able to make conscious changes for a more congruent image of who they are. Likewise, the women discover their value and plan the action to

achieve the goal. In 'Controlling the right stuff,' the women give up a need to control their entire environment, and take control of what they can appropriately control. Similarly, the women 'Redefined My Self in Relations with Other People' in this study. Another property, 'Weighing the evidence,' was also consistent with the 'Contemplation about My Self,' since the women made judgments and informed decisions about themselves and their world. However, 'Restarting My Self' was stated in this study, but not in Schreiber's work. It may be because participants in this study had more severe depressive symptoms than those in Schreiber's study, so they had to force themselves to take action in various aspects.

In addition, this study reinforced the phenomenology studies which aimed to understand the meaning of recovering from depression (Steen, 1996; Chernomas, 1997). According to Steen, the data came from 22 white women 40 to 55 years of age who had been diagnosed with, and treated for clinical, unipolar depression. The meaning of the women's experiences of recovering from depression was the process which consisted of five phases including existential alienation/pain, crises of the adulthood, first turning point, second turning point, and becoming a gardener. In the first turning point, the women realized that they needed help for the reason that childhood experiences had affected their functioning as adults and their pattern of negative thinking. In the second turning point, the women became their own agent and sought out the sustenance they needed to feed and nurture themselves. As regards another feminist and symbolic interactionist perspective, Chernomas (1997) reported the experiences in living with depression from ten women's perspectives in recovery in six themes: transformed self, wanting and monitoring, the self as healer, revealing

vs. concealing, acceptance and belonging, and making sense of depression-meaning and understanding.

Regarding psychotherapy, the process that participants regained one's self in this study contributed to the process of change in Satir's Model and Satir's approaches (Satir, Banmen, Gerber, & Gomori, 1991). The Satir's Model is a model of human growth which focuses on transformational or change therapy. The philosophy underpinning is 'Change is possible. Even if external change is limited, internal change is possible.' Change, according to Satir, is basically an internal shift that in turn brings about external change (1991:85). In the Satir's Model, therapists help clients transform their survival stances,--the way people respond when they feel their survival is threatened including placating, blaming, being super-reasonable, and being irrelevant--into congruent communication or to affect any other change. Through the process of transformation, therapists carry out four major concepts of change including discovery, awareness, understanding, and new applications. Discovery refers to what was the past, to what exists now, and to how they are connected. Awareness means developing a double listening attitude: listening for content and listening for process. The content answers the question of what has happened. The process reveals beyond the word, and that process relates to meaning, feelings, feelings about feelings, family rules, and defenses. Moreover, understanding means learning how to make meaning of events and messages. In the last concept, new applications refer to what we have discovered, been able to appreciate, and now understand in new ways that support our growth. In turn, in the process of regaining one's self, the participants transformed themselves through self-awareness and reappraisal of reactions/actions of those who were the center of their life. After that, they entered the process of 'Untying the Knot'

where they discovered the worth of themselves, redefined themselves in relations with other people, and restarted themselves. Finally, they could perceive they were a new person that was different from the former self. Through the process of regaining one's self, they received new information about themselves, a new perspective that led to contemplation about themselves. The difference between the Satir's Model and the current process was that in the Satir's Model, the therapists provide context for positive change in the clients, but in the regaining one's self process the participants tried to transform by themselves.

2. Self-Growth

Self-Growth was the positive consequence of the process of regaining one's self. This concept was similar to other consequences of the process of recovery from depression in related studies including 'Seeing with Clarity' (Schreiber, 1996), 'Cultivating the Self' (Steen, 1996), and 'Getting Past It' (Karp, 1994). These concepts or themes are positive events or state. All of the participants expressed having felt a profound shift in the life experience and appreciated where they were now. The participants' perception of themselves as the center of their life was similar to a part of cultivating women's self, that they could look more realistically at what was already growing in their garden, to weed out some of the old ideas, and to plant new ideas they had learned from their experiences in life (Steen, 1996). Moreover, the participants in this study had the ability to control their thoughts, emotion, and situation to keep them from recurrence of depressive symptoms. This was congruent with 'Monitoring and Taking Corrective Action' in the phase of 'Seeing with Clarity' defined by Schreiber (1996).

Strengths of the Study

Obtaining new knowledge that explains the process of recovering from depression of middle-aged Thai women is the most common strength in this study. In addition, this study consists of other strengths including the rich data that came from profound feelings of the participants. There were also many experts in the psychosocial area that validated the result of this study and various characteristics of the participants.

The presentation of the substantive theory explains the phenomena of recovering from depression in terms of process that consists of new concepts and some concepts that expand the existing concepts as the most common strength of this study. The findings reveal that recovery from depression in the perspective of middle-aged Thai women is the process rather than the state of absence of symptoms. Instead, they transformed themselves from the women who had the significant others as the center of their life to be new persons who realized their own value. This is the main issue in the process of recovering from depression. The concepts of 'Tying the Knot' and 'Untying the Knot' are new concepts that had not been found before. These concepts are sensitive toward Thai culture and social context that emphasize the relationship with significant others. This study reveals that 'Discovering My Self,' 'Redefining My Self and in Relations with Other People,' and 'Restarting My Self' are the important concepts for promoting and protecting mental health of the women. Moreover, there are two concepts that expand the existing knowledge including the concepts of 'Depression Self-Management' and 'Help Seeking.' Furthermore, this study has discovered some properties of the concepts that were not previously

presented including the causal condition leading the middle-aged women to depression and consisting of 'The Center of My life,' 'Negative Appraisal of the Center of My Life's Reactions,' self-management of depression with '*Tamjai* (accepting the situation)' and seeking informal help from relatives and close friends.

Since the participants trusted the researcher and they were willing to share their story, the raw data were most likely to come from their heart-felt feelings. The participants were aware that their stories would benefit other women that face similar experiences. The internal conflicts, sufferings, and difficulties that they could get past until they had regained themselves were disclosed through their mind. These raw data have contributed to the process of analysis and interpretation.

This study was validated by two experts in qualitative studies and by two experts in depression phenomena. They were the committee members in this study. They offered the suggestions and recommendations in detail about the process of this study. Moreover, there were two qualitative researchers whose interest lied in women's mental health. They provided their advice, and all the advice helped the researcher to shift from the familiar perspectives to the new ones.

The final strength is that the data were derived from participants whose experiences and characteristics varied widely. There was a wide variety of types of reactions of the people who were the center of one's life, severity of depressive symptoms, methods of recognition of self-deviance, and strategies of depression self-management. Participants differed in terms of age, education, and income. These various data made the concept findings in this study intense and cover almost all properties and dimensions except the data in the third phase.

Limitations of the Study

Since being a mentally ill patient in Thai culture is perceived as a social stigma, the women with depression that were recruited to be participants were limited only to the clients who had received treatment at the psychiatric unit in the hospital. The clients with a full recovery from depression were most likely to terminate receiving treatment by themselves. They did not like to come to follow-ups until the completion of the course of the treatment. Thus, the various data in the third phase, 'Recovering from depression' was less than those in the other phases of the process. The concepts in the third phase: 'Untying the Knot' and 'Self-Growth' needed to be developed further to be more extensive.

Theoretical sampling in order to obtain data to examine the tentative hypothesis was quite difficult, because the people who had fully recovered were not clearly visible. Therefore, the researcher interviewed every woman that was willing to be a participant until the data were found to confirm or reject the hypothesis. As a result, this process of theoretical sampling took a long time.

Every participant was interviewed based on suggestions from a psychiatrist at a different time and with different frequency. However, the result of this study can be transferred only to middle-aged Thai women that received treatment in the psychiatric unit in the hospital. The results do not transfer to the women with depression that are in the community that never receive treatment or the women that have minor depression.

The majority of the participants were Buddhists, with only a few participants from other religions. The process of recovering from depression of the participants from other religions may be different.

Participants in this study were diagnosed with major depressive disorder as the main problem. They might have other mental disorders such as personality disorder, or they may first be diagnosed as major depressive disorder and then diagnosed to be dysthymia later. Therefore, the finding may not be generalizable to other patients that were diagnosed with other diseases.

Since the process of recovering from depression is a subjective experience, most of the data came from in-depth interviews. Hence, the use of triangulation by observation and interviews of members in the family was difficult to elicit the experience of recovery of the participants.

Summary

This study found that the meaning of depression in the perspectives of middle-aged Thai women who were diagnosed with major depressive disorder was continually changing from something unknown to their acceptance of depression as a part of life, as a phase of life, or just as a common problem that anyone underwent. Regarding the process of recovering from depression, this study discovers that the process of regaining one's self was the main issue in recovering from depression. This study presents the term of substantive theory entitled 'Theory of Self-Regaining from Loss of Self-Worth of Depressive Middle-Aged Thai Women.' This finding reinforced the qualitative research that explained the women's process of recovering from depression, Satir's Model, and brief psychotherapy by Satir. For the conditions of regaining one's self, the 'Help Seeking' concept supports and expands the theory of help seeking behavior, and the concept of 'Contemplation about My Self' supports the cognitive therapy of Beck. The most common strength in this study was obtaining new knowledge that explains the process of recovering from depression. The recovering from depression is more than the absence of symptoms. The limitations of this study are that the process of regaining one's self needs to be further developed for more density and variety. This result can only be transferred to middle-aged women who are diagnosed with major depressive disorder. The people with other types of depressive disorders and those who do not receive treatment in the psychiatric unit cannot be covered.

CHAPTER IX

IMPLICATIONS AND CONCLUSION

This chapter discusses the implications of the findings of this study for further research and the development of theories concerning depression and recovery. The implications for health care policy, education policy, and nursing practice are also included, as well as the conclusion of the study which is presented at the end of this chapter.

Implications for future research

Recommendations for future research based on the findings of this study vary varied from developing and expanding knowledge of recovery from depressive illness in middle-aged Thai women to related areas. The implications are discussed in details as follows:

1 The 'Theory of Self-Regaining from Loss of Self-Worth' generated from the findings of this study should be refined with theory-testing procedures. The relationships between concepts and the model need to be extensively identified and examined. For example, a causal model of depressive symptoms and relationships among the 'Recognition of Depression,' 'Depression Self-Management,' 'Help Seeking' and 'Contemplation about My Self' is recommended.

2. In order to test the theory with quantitative methodology, the measurement of various concepts in this study should be developed such as 'Depression Self-

Management,' 'Help Seeking,' 'Self-Awareness,' and 'Self-Growth.' Properties and dimensions of the concepts identified in this study could be used to guide the development of the measurement.

3. In order to increase explanatory power of the theory, studies of recovery from depression should be carried out in different contexts including different levels of socioeconomic status from this study. Moreover, there should be studies in depressive women with certain characteristics such as women in the remote country, adolescence women, working women, and elderly women. A study of depression in men is also interesting for the benefits of comparative results between different genders.

4. This study could be developed into a formal theory generalizing self-regaining process after the loss of self-worth in application to people with similar experiences. A research study can be conducted for a development of a grounded theory for people who lose vital organs, who are drug addicts, who are severely ill or incompetent to work, and who have been raped or sexual abused.

5. Longitudinal research is necessary for a study of self-regained people to investigate whether they develop further self-growth or revert to severe depression.

6. A study can be conducted by shifting the unit of analysis from an individual to the family level. The study may examine the effect of depressive illness on family and society, as well as the family care for depressive people.

7. The concept and model of this study could be applied to develop a participatory action research with depressive women and nurse pragmatists as participant researchers. This participatory action research can lead to the development

of complete model that is consistent with women's requirement and can be appropriately applied to clinical practice. Moreover, the theory obtained from this research may be further developed into a therapy program which can be examined for efficiency and efficacy with quasi-experimental research.

8. There should be an exploratory research investigating the components and characteristics of each concept generated from this study e.g. 'Recognition of Depression,' 'Depression Self-Management,' and 'Contemplation about My Self.'

9. There should be a study in women who have not fully recovered from depression in order to investigate how these women continue to live with depression.

10. Factors related to recovery from depressive illness should be studied in details in order to enhance effective recovery. These factors include meaning of depression in laypersons, access to health care services of depressive persons, dealing with stigma of mentally ill persons, and meaning of chemical treatment in depressive persons.

Implications for national policy

The results of this study indicate that traditional social values and social expectations are involved in the development of mental health problems in women. In addition, current health care services for mental support in women are insufficient. The following implications for health care policy and education policy are recommended based on the findings of this study.

Implications for health care policy

The national health care policy should have a specific section that focuses on the promotion of woman mental health care and the prevention of mental health problems in women. Mental health services should be available in every community and at every level of health care centers. Women of all ages and status should be able to easily and conveniently access these services. Additionally, health care professionals at health care centers should be well trained in assisting depressive women to resolve their restricted condition, providing new perspectives, and supplying information about all available alternatives. The assistance from health care professionals should aim to help depressive women in crystallizing their thoughts, leading to clear perception of their problems and the solution, including ability to accept the outcomes of their decision.

Implications for education policy

The education at the fundamental level should include sex study with the contents that impede the culture of sexism and aim at the modification of male attitude of sexual exploitation. The education should also promote equivalent relationships between male and female. Similar education should also be provided to the general public through the long-distance educational system.

Implication for nursing practice

The understanding of meaning of depression in women diagnosed with major depressive disorder and the process of recovery from depression provide guidelines of nursing care for depressive women that meet the women's requirements. The following recommendation is an implication of the findings of this study for nursing practice in each phase of the recovery process.

Phase I : Causal Condition of Depression

The nursing care for depressive women in this phase may start since the person is not present with depressive symptoms or already has severe depression. The care should be delivered in the following order:

1. Balancing Center of Life

The results of this study indicated that middle-aged women with depression perceive that close persons are more important than themselves. Hence, the action in this phase should involve the provision of information about self-worth to women of all ages in order to promote their capability in balancing their importance with that of other people. The information may be strategically given via the mass media of woman interest, e.g. advertisement in television, soap operas, magazines, or books.

2.Modifying Negative Appraisal

The negative appraisal of reactions of the center of life means the women perceive themselves being treated with their self-worth unrecognized, bearing all burdens, and suffering losses. These perceptions lead to the loss of self-worth. Nurses



who deliver counseling care to women in communities or women seeking help in health care centers for any reason should be aware of the importance of appraisal that leads to negative appraisal reaction such as a woman left by her husband, with disappointment in offspring, or having a burden of caring for an ill person in the family. Health care professionals should give advice with some new perspectives for consideration. Depressive women should have an opportunity to review the situation, leading to a revision of their appraisal. In addition, nurses should inform depressive women about social support resources, the access and utilization of support resources, and other useful resources including job-training center or other help centers. These practices can inhibit loss of self-worth which may eventually result in depression.

3.Distributing Information about Depression

The information about depression will help depressive women to recognize abnormal symptoms from a low level; hence, the information should be distributed for an awareness of mental changes. The distributed information should be present in a concrete form that is easy to compare with the condition of general people or compare with previous dominant characteristics or the condition of a person. For instance, changing from a not-too-sensitive person to a very sensitive one; developing sad feeling very frequently as never felt before, such as feeling overly sympathetic towards other people with no apparent reason; or thinking of committing suicide. The information should cover knowledge about depression, resources for mental health care, techniques of mental health care, and the outcomes of mental health care.

4.Educating Health Care Professionals of All Subjects and at All Levels

Health care providers, either in a community or in a health care center, should have sufficient knowledge to identify the indications of depression. The health care providers, then, should be able to give advice to depressive women on self-care and to plan for further management that is appropriate for a woman's condition.

5.Preventing Dangers in Women with Severe Depression

In case of severe depression such as a woman overcome by fear of death or loss of self-control, health care professionals need to understand the patients' sufferings and should express sympathy and understanding, as well as arranging environment that creates sense of security. The patients must be protected from committing suicide to escape from the feeling of fear, and must be protected from possible threatening individuals. Transferal to specialist care may be necessary for further management.

Phase II : Learning about Depression

Depression Self-Management

Referring to the results of this study, depressive feeling is managed with two different approaches: accepting situation and diverting one's self. There are many techniques effectively applied to self-management of depression in these two approaches; for instance, self-reminding, self-reasoning, hope, leaving environment that encourages depressive feelings, meditating, praying, and having exercises. Nurses should work with depressive women to find a technique for depression self-

management that is most appropriate for the women's situation, resources, skills and preference. An evaluation and modification of the management technique is needed if the management does not succeed. On the other hand, if the depression is well managed, the patient should be reinforced to continue with that management technique.

Help Seeking

Depressive women may seek help with an informal approach or may request professional mental health care.

1. Seeking Informal Help

1.1 Setting Up Self-Help Group or Support Group

Women are inclined to seek help from people who have similar problem. For instance, those who have problems with children are likely to consult each other. Additionally, the help may be sought among people who usually provide help to each other. Hence, a self-help group should be set up in a community. The group will help depressive women to acknowledge understanding from other people and to realize that they are not the only one with problems. Depressive women will be aware that other people are also suffered or are even more suffered than them. Moreover, they may learn from other people's experience of successful solution and may try to apply the solution with their own problems.

1.2 Providing Educational Programs for Relatives of Women with Depression

Family members, siblings, and close relatives are people from whom depressive women will seek help. These people will provide help and support to the women over the period of illness and whenever any problem arise. Hence, there should be educational programs for relatives of women with depression to improve their knowledge and understanding in each phase of depressive symptoms. The relatives should be taught to observe behavioral changes and should be able to deliver help that is consistent with the requirement and the readiness of the depressive woman in certain circumstances. They should also receive information about help resources.

1.3 Increasing the Potentiality of Support Resources in a Community

The support resources already existing in communities such as a temple and resources that depressive women can easily access and are perceived as a reliable place for relaxation. The potential of these places, therefore, should be improved to become efficient support resources. Moreover, the mass media should also receive information about depression and assistance of people with depression.

1.4 Setting up Indirect Support Resources in a Community

Indirect support with various activities that women can participate can reduce depressive feelings. Moreover, the activities may enhance their potential and their sense of self-worth. Activities that can be done in a community include a regular

exercise program, an assembly of community members for doing activities of public benefits, or activities that provide women with income or increased capability.

1.5 Advertising Support Resources

Support resources are essential in almost every step of recovery from depression. Therefore, wide distribution of information about support resources and the access to support resources, either professional-run or informal resources, is very important.

2. Seeking Professional Help

Nurses should be aware of the following three issues in delivering care to depressive women:

2.1 Sense of Stigma

Depressive women always seek help from mental health specialists under the condition of severe depression to the extent that it cannot be self-managed or helped by relatives. This worsening condition may be due to the unawareness of mental disorder and the fear of social stigma of mentally ill persons. In addition, the women seeking professional help may be concerned about the revelation of their personal life. Therefore, nurses should express understanding and sympathy for depressive women and should provide medical services on the basis of complete confidentiality. Any marks or evidence of a mental institution related to the patients' identity should not be publicly presented. A mental clinic, including its waiting

department, should be carefully set so that patients are undisclosed and the information about patients must be kept confidential.

2.2 Rejection of Being Mentally Ill

Women who are unprepared for mental illness cannot accept that they are mentally ill. These patients will discontinue the treatment when their symptoms improve, or they may have difficulties in adjusting to the illness and have more stress. Therefore, nurses should provide opportunities for the patients to thoroughly examine their problems by give them a chance to talk about themselves and express their feelings. As a result, the patients will be aware of their changes. Additional information about the treatment should be provided to assure the patients of the positive outcomes of the treatment.

2.3 Information about the Provided Services

Referring to the findings of this study, women receiving care from a mental health care center for the first time have a vague idea about the services they are about to receive. Their knowledge about mental health care service is improved only after receiving therapy from a mental health care center. Therefore, information about mental health care services should be publicized to help people make a decision when professional care is needed. The mental health care for depressive women consists of giving medication prescription, listening to the problems, counseling, and providing new perspectives.

Contemplation about My Self

The process of 'Contemplation about My Self' is comprised of reviewing, reflecting, considering about oneself, examining, and comparing the appropriateness of one's action with the new information which may be received from an external resource or may be reflected from self-review. 'Contemplation about My Self' leads to self-awareness and reevaluation of other people's action. The nursing roles in this phase include those of counselor and supporter, assisting depressive women in achieving their goals.

1. Counseling

When a woman has an opportunity to talk about her life and experience in combination with receiving questions that encourage her to think carefully, the woman may subsequently review, re-examine, reflect, and contemplate about her life and the circumstance. The conversation techniques that should be applied to counseling include raising open-ended questions to encourage the woman to talk about her life, listening, asking about her opinion and feeling to generate self-understanding, reflecting her idea for further consideration, and allowing her to ask questions when in doubts.

2. Assuring Patients that Everybody Can Change

Women who are confident and determined to improve themselves with belief that they can recover from the illness will attempt to develop themselves for a well-being condition. Nurses, therefore, should assure depressive women that they can

change to a well-being condition, although it may take times, depending on the problems of each person.

3 Setting Up a Library Corner

New information or new perspective is another factor that can promote self-awareness and the reevaluation of other people's action. Thus, nurses should set up a library corner containing books and documents about life, psychology, religious teaching, depression, or empowerment in women. The patients may borrow these books to read at home.

Phase III : Recovering from Depression

Depressive women gradually untied their mental knot by discovering their self-worth, redefining themselves and relations with other people, reconnecting with themselves and the society and, eventually, developing self-growth. Nurses should observe changes in the patients such as livelier look, changes in general appearance, and being more attentive to their clothes. Nursing roles in this phase include supporting, giving moral support, and preventing the recurrence of depression as detailed below:

1. Collaborating with Patients in Setting up Goals and Drawing Action

Plan

In this phase, depressive women have discovered self-worth from loving and understanding themselves. They started looking for the goal of their life and making

plan to achieve that goal. Nurses, then, have a role in supporting and encouraging the women to set up a goal and assisting them to draw a plan to achieve that goal.

2. Supporting the Development of Balance between Oneself and the Environment

After discovering themselves, the women started modifying their intellectual structure by redefining themselves and reestablishing relationships with other people. Nurses should not judge patients' modification but should support and assist them in the development of balance between themselves and the environment.

3. Giving Moral Support and Reinforcement

Nurses have a role in giving moral support and reinforcing patients for their success in taking an action. Women may be reinforced after succeeding a small action as an encouragement for them to take more difficult action in the next step.

4. Expressing Readiness in Counseling and Helping a Patient

Women may encounter a barrier during the process of untying the mental knot. Thus, nurses should express readiness in providing support and help preventing the recurrence of depression.

5. Being Flexible with the Patient

Women's roles have changed from passive to active roles, and they may negotiate for a change of treatment plan. Health care professionals have to be flexible in providing the treatment that is consistent with the patients' lifestyle and their

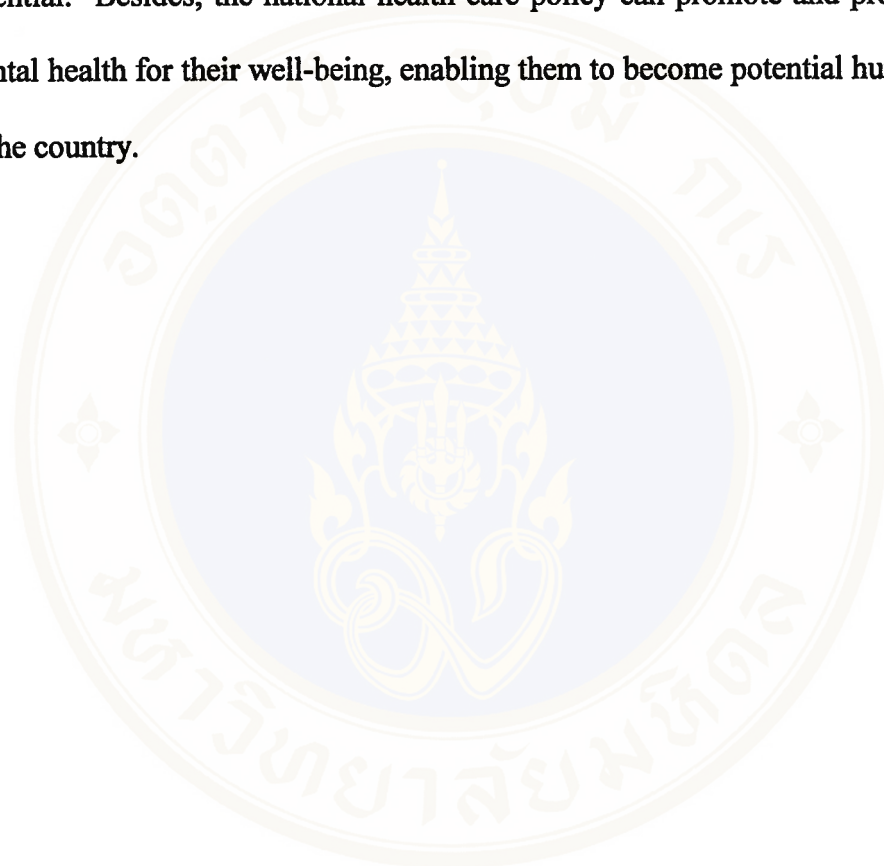
chemical changes. In other words, the care providers should find a balance between psychosocial and chemical changes for the patients' well-being.

Conclusion

From the beginning to the end of this study, it is evident that depression is not just a mental illness and the recovery from depression does not only mean the absence of depressive symptoms. The meaning of depression, according to the women diagnosed with major depressive disorder (MDD), continually changes in relation to the interactive environment. Depressive women range from those who do not know the meaning of depression, do not feel very good, have depression as part of their life, to those who have made a full recovery from depression. The process of recovery from depression is the process of self-regaining. The conditions that contribute to self-regaining consist of self-management, seeking help, and self-contemplation. These components promote successful self-regaining, leading to self-growth. This study portrays influences of the western health concepts on the eastern beliefs and knowledge, as well as the influence of social values about women in Thai society. This social value has a strong effect on the development of depression in women to the extent that the recovery from depression is difficult unless certain conditions for women are resolved.

The results of this study indicate that women's experiences have complexity that may easily lead to depression and the recovery are not simple. The self-regaining process found in this study is a long journey for some women but may not be too long

for others, depending on various conditions. The self-regaining process requires cooperation from many people; however, the recognition of self-worth and the desire for self-change are the key principles. In the self-regaining process, health care professionals can support and guide the women to their goal, according to their potential. Besides, the national health care policy can promote and protect women's mental health for their well-being, enabling them to become potential human resources of the country.



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No. 15/2001

Documentary Proof of Ethical Clearance

The Committee on Human Rights Related to

Human Experimentation

Mahidol University, Bangkok

.....

Title of Project : Recovering from Depression of Middle-Aged Thai Women :
A Grounded Theory Study

Principal Investigator : Mrs. Ajcharaporn Seeherunwong

Name of Institution : Faculty of Nursing

Approved by the Committee on Human Rights Related to Human Experimentation

Signature of Chairman :

S. Danchaivijitr

(Professor Dr. Somwang Danchaivijitr)

Signature of Head of Institute :

P. M. J.

(Professor Dr. Pornchai Matangkasombut)

Date of Approval : 18 JUN 2001

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 โทร. ๔๑๑-๑๔๒๙, ๔๑๑-๓๒๕๓
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Faculty of Medicine Siriraj Hospital
 Mahidol University

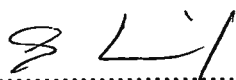
Documentary Proof of Ethics Committee
Faculty of Medicine, Siriraj Hospital, Mahidol University

No 102/2001

Protocol Title	Recovering from depression of middle-aged Thai women : A grounded theory study
Protocol Number	—
Principal Investigator	Mrs. Ajcharaporn Seeherunwong
Name of Department	Faculty of Nursing

The aforementioned project and informed consent have been reviewed and approved by the Ethics Committee, Faculty of Medicine Siriraj Hospital, Mahidol University, based on the Declaration of Helsinki on July 20, 2001

Signature of Chairman



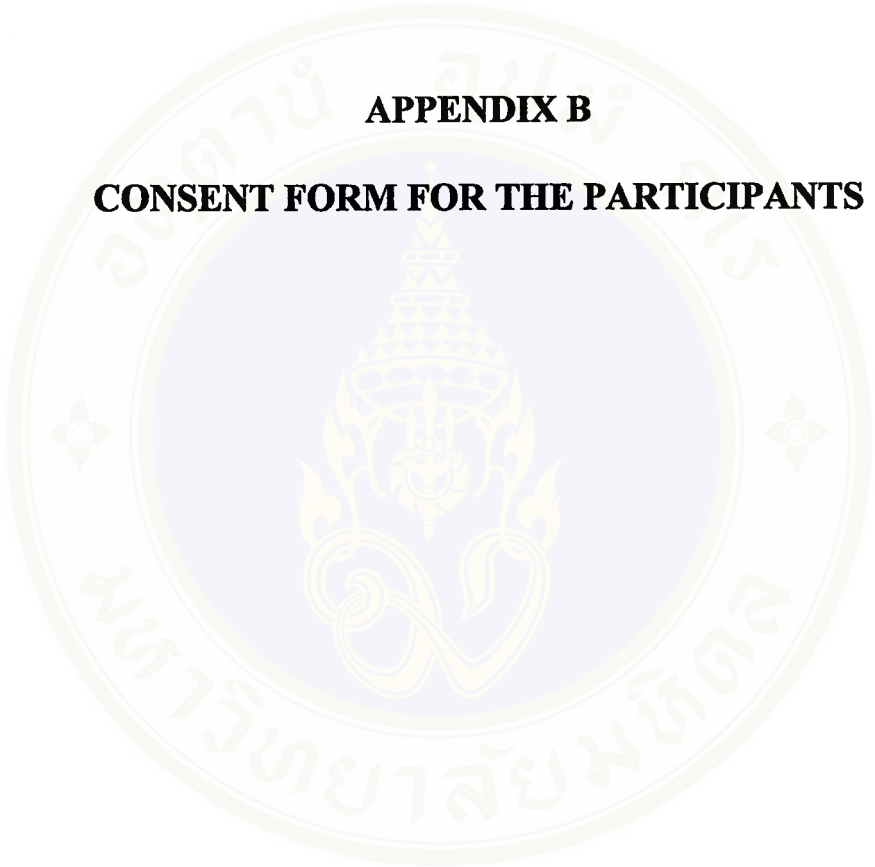
 (Prof. Sumalee Nimmannit)

Signature of Dean



 (Prof. Piyasakol Sakolsatayadorn)

APPENDIX B
CONSENT FORM FOR THE PARTICIPANTS



คำชี้แจงและการพิทักษ์สิทธิของผู้ให้ข้อมูลหลัก

ชื่อโครงการ การฟื้นฟูหายจากความซึมเศร้าของสตรีวัยกลางคน: การสร้างทฤษฎีจากข้อมูลพื้นฐาน

ดิฉันนางอัจฉราพร สี่หิรัญวงศ์ เป็นพยาบาลจิตเวชและเป็นอาจารย์สอนนักศึกษาพยาบาล ที่คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล ขณะนี้กำลังศึกษาปริญญาเอกทางการพยาบาล ที่คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล และกำลังทำวิทยานิพนธ์เพื่อศึกษาระบบการฟื้นฟูหายจากความซึมเศร้าของสตรีวัยกลางคน ซึ่งดิฉันสนใจที่จะเรียนรู้เกี่ยวกับการปฏิบัติตัวของท่านเพื่อให้หลุดพ้นหรือฟื้นฟูหายจากความซึมเศร้า ท่านมีความคิด ความรู้สึกอย่างไรต่อโรคซึมเศร้าที่ท่านเป็นอยู่ รวมทั้งมีวิธีการจัดการอย่างไรทั้งการรักษาที่ได้รับ และการดูแลตนเอง ข้อมูลที่ได้จากการศึกษาครั้งนี้จะช่วยให้พยาบาลและบุคลากรทีมสุขภาพนำไปใช้ในการพัฒนาและปรับปรุงการให้ดูแล และช่วยเหลือสตรีที่ป่วยด้วยโรคซึมเศร้าให้ฟื้นฟูหายจากอาการซึมเศร้าได้มีประสิทธิภาพยิ่งขึ้น

ดิฉันจึงขอเชิญท่านเข้าร่วมการวิจัยครั้งนี้ ซึ่งจะศึกษาในสตรีวัยกลางคนที่ป่วยเป็นโรคซึมเศร้า อายุตั้งแต่ 35 ปีถึง 59 ปี ไม่อยู่ในระหว่างการตั้งครรภ์ มีสติสัมปชัญญะสมบูรณ์ ไม่อยู่ระหว่างการรักษาในโรงพยาบาล สามารถพูดคุยกับผู้สัมภาษณ์โดยใช้ภาษาไทย และมีภูมิลำเนาอยู่ในกรุงเทพไม่น้อยกว่า 6 เดือน ท่านเป็นผู้หนึ่งในจำนวน 20-30 ท่าน ที่ได้รับเชิญเข้าร่วมการวิจัยนี้ จากการเข้าร่วมการวิจัยนี้ ท่านจะได้เรียนรู้เกี่ยวกับโรคซึมเศร้า และการดูแลสุขภาพของท่านเพิ่มมากขึ้น

เมื่อเข้าร่วมการศึกษานี้ ท่านจะได้รับการสัมภาษณ์อย่างน้อย 1 ครั้ง ซึ่งใช้เวลาประมาณ ½-1 ชั่วโมง การสัมภาษณ์ครั้งต่อไปขึ้นอยู่กับความพร้อมของท่าน และจะห่างจากครั้งแรกประมาณ 2-4 สัปดาห์ สถานที่ทำการสัมภาษณ์ขึ้นอยู่กับความสะดวกของท่าน อาจจะเป็นที่บ้าน ที่ทำงาน หรือในโรงพยาบาลก็ได้ ในการสัมภาษณ์ดิฉันจะถามคำถามเกี่ยวกับประสบการณ์การป่วยเป็นโรคซึมเศร้า ความหมายเกี่ยวกับโรคซึมเศร้าที่มีต่อตัวท่าน และประสบการณ์การฟื้นฟูหายจากโรคซึมเศร้า ส่วนข้อมูลจากบันทึกสุขภาพของท่านที่ดิฉันต้องการศึกษา คือ ประวัติการเจ็บป่วยด้วยโรคซึมเศร้า การวินิจฉัยโรค การรักษาที่ได้รับ ข้อมูลนี้จะถูกรวบรวมต่อเมื่อท่านอนุญาต

ข้อมูลที่ได้จากการสัมภาษณ์และบันทึกสุขภาพจะถือว่าเป็นความลับ ไม่มีการเปิดเผยชื่อจริงของท่านในข้อมูล และจะใช้ประโยชน์เพื่อการศึกษาเท่านั้น ในระหว่างการสัมภาษณ์ดิฉันขออนุญาตให้เครื่องบันทึกเสียงเพื่อบันทึกข้อมูลต่างๆที่คุณให้มาทั้งหมดเพื่อความสมบูรณ์ของข้อมูล และแถบบันทึกเสียงจะถูกลบทิ้งทันที ภายหลังจากสิ้นสุดการศึกษานี้

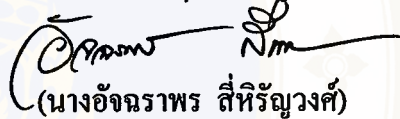
การศึกษานี้จะไม่ก่อผลเสียใดๆต่อท่าน นอกจากท่านอาจจะเสียเวลาในการสัมภาษณ์บ้าง อาจจะรู้สึกอึดอัดไม่สบายใจ เมื่อจะต้องพูดคุยเรื่องส่วนตัวบ้าง ในกรณีเช่นนี้ท่านสามารถขอให้

หยุดการสนทนาได้ตลอดเวลา หรือสามารถที่จะปฏิเสธการตอบคำถามที่จะทำให้ท่านไม่สบายใจได้ นอกจากนี้แล้ว ท่านอาจจะนำบุคคลที่ท่านไว้วางใจให้เข้าร่วมฟังในระหว่างการสัมภาษณ์ได้

การเข้าร่วมการวิจัยนี้เป็นไปโดยความสมัครใจของท่าน ท่านไม่ต้องเสียค่าใช้จ่ายใดๆ และจะไม่ได้รับค่าตอบแทนจากการเข้าร่วมการวิจัยนี้ การเข้าร่วมการวิจัยนี้จะไม่มีผลกระทบใดๆ ต่อการรักษาที่ท่านจะได้รับจากทางโรงพยาบาลที่ท่านกำลังรักษาอยู่

ในระหว่างการเข้าร่วมวิจัย หากมีข้อสงสัยประการใด ดิฉันยินดีตอบข้อสงสัยของคุณตลอดเวลา โดยติดต่อได้ที่ นางอังกรพร สี่หิรัญวงศ์ คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล โทรศัพท์ (02) 286-0279 และ 6760347 หรือจากอาจารย์ที่ปรึกษาวิทยานิพนธ์ครั้งนี้คือ รศ.ดร.ทัศนานุญทอง คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล โทรศัพท์ (02) 4197476-80 และ 5897121

ขอขอบพระคุณอย่างสูง


(นางอังกรพร สี่หิรัญวงศ์)

แบบยินยอมเข้าร่วมการศึกษา

วันที่.....เดือน.....พ.ศ.....

ข้าพเจ้า.....อายุ.....ปี อาศัยอยู่บ้านเลขที่.....

ถนน.....แขวง.....เขต.....จังหวัด.....

ได้รับทราบรายละเอียดของโครงการวิจัยเรื่อง การฟื้นฟูสุขภาพจากความเครียดของสตรีวัยกลางคน :
การสร้างทฤษฎีจากข้อมูลพื้นฐาน

ข้าพเจ้ามีสิทธิที่จะของการเข้าร่วมโครงการวิจัยนี้ และการงดการเข้าร่วมการวิจัยนี้จะไม่
มีผลกระทบต่อ การได้รับบริการ หรือการรักษาที่ข้าพเจ้าหรือผู้เกี่ยวข้องมีสิทธิจะได้รับแต่
ประการใด อีกทั้งได้รับทราบจากผู้วิจัยว่า จะไม่เปิดเผยข้อมูลหรือผลการวิจัยของข้าพเจ้าหรือผู้
เกี่ยวข้องกับข้าพเจ้าเป็นรายบุคคลต่อสาธารณชน

ข้าพเจ้าและผู้เกี่ยวข้องกับข้าพเจ้าได้รับทราบข้อมูลจากผู้วิจัยจนหมดข้อสงสัยโดยตลอด
แล้ว และยินดีให้สัมภาษณ์ในการวิจัยนี้เป็นเวลาประมาณ ½-1 ชั่วโมง จึงได้ลงลายมือไว้เป็นหลักฐาน
ต่อหน้าพยาน

ลงชื่อ.....ผู้ยินยอมหรือผู้แทนโดยชอบธรรม
()

ลงชื่อ.....หัวหน้าโครงการวิจัย
(นางอัจฉราพร สี่หิรัญวงศ์)

ลงชื่อ.....พยาน
()

ลงชื่อ.....พยาน
()

The seal of Mahidol University is a large, faint, circular emblem in the background. It features a central golden crown-like symbol (Chakrasana) surrounded by a blue circle. The outer ring of the seal contains the university's name in Thai script: "มหาวิทยาลัยมหิดล" (Mahavithayalai Mahidol) at the bottom and "จุฬาลงกรณ์มหาวิทยาลัย" (Chulalongkornrajavidyalaya) at the top.

APPENDIX C
INITIAL INTERVIEW GUIDE

**การวิจัยเรื่อง การฟื้นฟูจากความซึมเศร้าของสตรีวัยกลางคน : การสร้างทฤษฎีจากข้อมูลพื้นฐาน
แนวคำถามกว้างๆในการสัมภาษณ์ participants**

แนวคำถามนี้จะใช้ในการเก็บรวบรวมข้อมูลครั้งแรก ซึ่งจะยืดหยุ่นและปรับเปลี่ยนให้มีความเฉพาะเจาะจงตามสถานการณ์

1. กรุณาเล่าความเป็นมาหรือความเจ็บป่วยของคุณตั้งแต่เริ่มต้นว่าเป็นอย่างไร
2. อาการซึมเศร้าของคุณมีการเปลี่ยนแปลงอย่างไร
3. การเปลี่ยนแปลงเหล่านั้นคงอยู่นานเท่าใดและมักเกิดขึ้นในเวลาใด
4. มีสิ่งใดที่เกิดขึ้นก่อนหรือเกิดร่วมกับการเปลี่ยนแปลงเหล่านั้นหรือไม่
5. หลังจากมีการเปลี่ยนแปลงแล้วเป็นอย่างไร
6. อะไรที่ช่วยให้อาการหรือความรู้สึกของคุณดีขึ้น
7. อะไรที่ทำให้อาการหรือความรู้สึกของคุณแย่ลง
8. คุณทำอะไรบ้างเพื่อช่วยให้ชีวิตของคุณดีขึ้น ไม่ว่าจะเป็นการจัดการภายในตนเอง หรือการจัดการสิ่งแวดล้อม
9. มีใครช่วยเหลือคุณบ้างไหม และให้การช่วยเหลืออย่างไร การให้ความช่วยเหลือเหล่านั้นมีการเปลี่ยนแปลงอย่างไรบ้าง
10. การเจ็บป่วยนี้มีผลต่อชีวิตคุณและครอบครัวอย่างไรบ้าง
11. คุณทำอะไรบ้างที่ช่วยป้องกันไม่ให้ความรู้สึกหรือการเจ็บป่วยของคุณกลับเป็นอย่างเดิม
12. คุณมองว่าคนที่เจ็บป่วยด้วยโรคซึมเศร้าเป็นอย่างไร มีความคิดเห็นอย่างไรกับโรคซึมเศร้า

Title: Recovering from depression of Middle-aged Thai women:**A grounded Theory study****Guideline for participant interview (English)**

This question guideline was utilized at the first time of the collection of data. The following questions were adaptable and could be modified to suit the circumstances during the interview.

1. Please tell the background of your illness from the beginning and how it started.
2. How did your depressive symptoms change?
3. How long did the change in the symptoms sustain and when did it always occur?
4. Did anything happen before or at the same time as the change of symptoms?
5. How did you feel after the change?
6. What made your symptoms better or made you feel better?
7. What made your symptoms worse or made you feel worse?
8. What did you do to improve your life, both with yourself and with your environment?
9. Did anybody help you and how? How did the help change your illness?
10. How did this illness affect your life and your family?
11. What did you do to prevent the reversal of illness or the old feeling?
12. What do you think about people with depressive illness and what do you think about the illness?

The seal of Mahidol University is a large, faint, circular emblem in the background. It features a central golden crown-like symbol (Chakrasana) surrounded by a blue circle. The outer ring of the seal contains the university's name in Thai script: "มหาวิทยาลัยมหิดล" (Mahavithayalai Mahidol) at the bottom and "จุฬาลงกรณ์มหาวิทยาลัย" (Chulalongkornrajavidyalaya) at the top.

APPENDIX D
PERSONAL INFORMATION SHEET

The background of the page features a large, faint, circular seal of Mahidol University. The seal contains a central emblem with a crown and a flame-like base, surrounded by Thai script. The text "APPENDIX E" and "ASSESSMENT OF SEVERITY OF DEPRESSION" is centered over the seal.

APPENDIX E

ASSESSMENT OF SEVERITY OF DEPRESSION

HAMILTON RATING SCALE FOR DEPRESSION

1. อารมณ์ซึมเศร้า (เศร้าใจ, สิ้นหวัง, หมดหนทาง, ไร้ค่า)

0. ไม่มี

1. จะบอกภาวะความรู้สึกนี้ ต่อเมื่อถามเท่านั้น

2. บอกภาวะความรู้สึกนี้ออกมาเอง

3. สื่อภาวะความรู้สึกนี้เป็นภาษากาย ได้แก่ ทางอาการแสดงสีหน้า, ท่าทาง, น้ำเสียงและ
มักร้องไห้

4. ผู้ป่วยบอกเพียงความรู้สึกนี้อย่างชัดเจน ทั้งการบอกออกมาเองและภาษากาย
2. ความรู้สึกผิด

0. ไม่มี

1. ตีตนอง รู้สึกตนเองทำให้ผู้อื่นเสียใจ

2. รู้สึกผิด หรือครุ่นคิดถึงความผิดพลาดหรือการรุกรมในอดีต

3. ได้ยินเสียงกล่าวโทษ หรือประณาม และ/หรือ เห็นภาพหลอนที่ข่มขู่คุกคาม
3. การฆ่าตัวตาย

0. ไม่มี

1. รู้สึกชีวิตไร้ค่า

2. คิดว่าตนเองน่าจะตาย หรือความนึกใดๆเกี่ยวกับการตายที่อาจเกิดขึ้นได้กับตนเอง

3. มีความคิดหรือทำที่จะฆ่าตัวตาย

4. พยายามที่จะฆ่าตัวตาย (ความพยายามใดๆที่รุนแรง ให้คะแนน 4)

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17. การหยั่งเห็นถึงความผิดปกติของตนเอง

0. ยอมรับว่ากำลังซึมเศร้า และเจ็บป่วย

1. ยอมรับความเจ็บป่วย แต่โยงสาเหตุกับ อาการที่เลว ดินฟ้าอากาศ
การทำงานหนัก ไวรัส การต้องการพักผ่อน ฯลฯ

2. ปฏิเสธการเจ็บป่วยโดยสิ้นเชิง

BIOGRAPHY

NAME	Mrs. Acharaporn Seeherunwong
DATE OF BIRTH	25 December 1959
PLACE OF BIRTH	Ranong, Thailand
INSTITUTIONS ATTENDED	Mahidol University, 1977-1981: Bachelor of Nursing (Maternal & Child) Chulalongkorn University, 1983-1986: Master of Education (Educational Psychology) Mahidol University, 1998-2002: Doctor of Nursing Science
RESEARCH GRANT	Doctor Collaborative Program, Ministry of University Affair, Thailand
POSITION & OFFICE	1981-1989, Siriraj Hospital, Bangkok, Thailand Position: Staff Nurse 1989-1995, Faculty of Nursing, Mahidol University Position: Nurse Instructor 1995-present, Faculty of Nursing, Mahidol University Position: Assistant Professor

