The importance of social support for men and women, suffering from major depression

A comparative and explorative study.

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III Skärsäter, I., Dencker, K., Häggström, L., Bergbom, I., Fridlund, B. Women´s conceptions of coping with major depression in daily life, with the help of professional and lay support: a qualitative, salutogenic perspective. (Accepted by *Issues of Mental Health Nursing*)

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ABSTRACT

The aim of the thesis was to describe the phenomena of social support and social network as well as stressful life events and their relation to adult persons suffering from major depression. Another purpose was to describe how men and women, who had been treated for major depression, used social support in their strive to regain health. Both inductive and deductive approaches have been employed as well as quantitative and qualitative research methods. The study group consisted of 65 participants with major depression (DSM-IV) and 19 healthy volunteers. Open-ended interviews were used for the data collection as well as instruments such as the Support-Q and The Life Events Checklist. Data were collected between 1995 – 2000. Analysis of the data was mainly performed by descriptive and non-parametrical statistical methods and by a qualitative phenomenographic method.

The results showed that men and women with major depression perceived that they had insufficient social support, an insufficient number of people in their network, and lacked the most valued component, emotional support. When compared to healthy volunteers, they had fewer relatives and friends and less frequent telephone contact with them. The women required more social support than the men. Men and women with major depression were exposed to more stressful life events, especially increased arguments with their partner and family members, than healthy volunteers.

Women with major depression needed to undergo a process in order to gain both a cognitive and an emotional understanding of how to cope with their lives in order to recover from depression. This knowledge was subsequently translated into health-related actions. The process of development or growth guided the change for the women, and both family and friends were important for their reintegration into the social environment. Men with major depression who had regained their health prioritised changed lifestyle goals, and they needed lay support in order to feel that others had faith in them and their ability to solve problems. While the men received help and support from health care to restore their health, their *own* path to health was to regain their place in the public domain. In these efforts, it is primarily lay support that is important.

The experiences of getting through an episode of major depression and the subsequent strive to regain health served as a trigger for the men and women to change their lifestyles. The transition itself and the resulting ramifications for themselves, their families and other persons in their social network constituted an affirmation of a change in their health status. The transition was a long-term process, which involved adapting themselves to new roles and situations, eventually resulting in a new sense of meaning and a sense of mastery.

Key words: caring, coping, gender role, life change events, major depression, psychiatric mental health nursing, recovery, salutogenesis, social network, social support, transition

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For mother and father with love and gratitude

In order to understand

Build
a bridge
of trust and caring
of openness and sharing.

Listen to the words
listen to the silence
listen to the story
of the other.

Join
in
the dance
of a dialogue.

Halldorsdottir, 1996

CONTENTS

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Ingela Skärsäter. 2002. The importance of social support for men and women, suffering from major depression. A comparative and explorative study. Faculty of Health and Caring Sciences, Institute of Nursing. The Sahlgrenska Academy at Göteborg University, SE-405 30 Göteborg, Sweden.

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ORIGINAL PAPERS

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INTRODUCTION

Variations of mood are a natural part of life, indicating that a person is perceiving the world and responding to it. Among mood disorders, major depression is the oldest and most common psychiatric illness. It was described as far back as 1500 B.C., and is both familiar and mysterious. The word depression is used in a variety of ways. It can refer to a sign, symptom, syndrome, emotional state, reaction, disease, or clinical entity. In this thesis it is viewed as a clinical illness that is severe, maladaptive and incapacitating and differs both quantitatively and qualitatively from normal sadness or grief. The World Health Organisation (WHO) concluded that major depression is now the leading cause of disability globally, accounting for almost 12 % of all disability. Major depression ranks fourth in the ten leading causes of the global burden of disease and is expected to show a rising trend over the next 20 years (The World Health Organisation, 2001).

Data from recent epidemiological studies suggest a lifetime prevalence rate for major depressive disorders of 10-13% for men and 21-24% for women (Kessler et al., 1994; Kringlen, Torgersen, & Cramer, 2001). The Swedish Lundby-study (Rorsman et al., 1990) showed an even greater prevalence; every second woman and every fourth man run the risk of being struck by depression at least once in their lifetime. Point prevalence rates have been estimated at 5% - 9% for women and 2% - 3% for men (Kessler et al., 1994). Of all those who are depressed in any given year (Weissman et al., 1993), women aged 18 to 45 years comprise the largest group (Reiger et al., 1993). Single mothers face twice the risk of depression compared to married mothers (Brown & Moran, 1997). Offspring of depressed parents are at greater risk of a major depressive disorder, compared with the offspring of control parents, with onset at an early age as well as persistent behavioural, medical, and social problems (Nomura, Wickramaratne, Warner, Mufson, & Weissman, 2002).

Although some people only have a single episode of major depression and return to presymptomatic functioning, it is estimated that over 50% of those who experience such an episode will eventually suffer a recurrence, and 25% of patients will have a chronic depressive disorder lasting more than two years (Angst, 1988; Keller et al., 1992; Kupfer et al., 1992; Solomon, 2000; Thase & Howland, 1995). The recurrence intensity and frequency tends to increase with each episode, and every new recurrence tends to last longer than the previous one as well as being more resistant to treatment (Rush & Thase, 1997). The progression of untreated depression with its pattern of recurrences, cycle acceleration, and increasing severity is a key reason for the high burden of treatment-refractory depression (Berndt, 2000; Judd et al., 2000). For the individual's mental and physical health and quality of life, it is most important to prevent recurrence (Bebbington, 1996). Only one third of all people with depression who seek help are accurately diagnosed and obtain appropriate treatment (Ferro, Verdeli, Pierre & Weissman, 2000; Kessler et al., 1994). The reason for this lies in the symptoms themselves. Feelings of worthlessness, excessive guilt and lack of motivation deter individuals from seeking help (WHO, 2001). In addition, it appears that there is a conflict between the depressed patients' own conceptions of their problems, healthcare needs and treatment options, and the current healthcare professional emphasis on depression management (Bebbington, Marsden & Brewin, 1999; Horsfall, 2001; Kadam, Croft, McLeod & Hutchinson, 2001; Owen & Milburn, 2001). The patients wished that healthcare professionals would take a more holistic view of their life situation and preferred psychosocial inputs, such as counselling, to treatment options consisting only of drug therapy.

Major depression is linked to the adverse events of an individual's life, including home, family and work (Hirschfeld et al., 2000; Kornstein et al., 2000), and significant adaptation is required on the part of the individual and their families to cope with the illness. The experience of having a threatening disease such as major depression affects not only the individual's quality of life but also their relationships with others. A valuable component of coping with major depression is social support (Thoits, 1995a; Underwood, 2000). The belief in the potential of social support in terms of influencing health and health behaviour, reducing stress and enhancing coping abilities has been widely supported by the literature (Underwood, 2000). Evidence suggests that the availability of social support, as well as its acceptance, may influence the manner in which an individual copes with a situation as well as the outcome of these coping efforts (Pierce, Sarason, & Sarason, 1996). Social support from family and friends as well as healthcare professionals is identified as an important component of recovery for depressed women (Peden, 1996; Steen, 1995). Satisfaction with received social support and the quality of intimate relationships are the most powerful predictors of decreased depressive symptoms in depressed women (Aro, Nyberg, Absetz, Henriksson, & Lönnqvist, 2001). The social network is consequently a particularly important area in which to study the support process, as it provides many opportunities for examining the effects of supportive and counter supportive experiences that occur over the life span. Nevertheless, there is a crucial gap in the knowledge of how social support can assist a depressed patient to grow through pain and suffering to well-being and health and, how healthcare professionals can facilitate a supportive environment.

The course of depression and the progressively shorter care periods place increasing demands on an effective and holistic professional intervention and lead to greater lay involvement, both within the family and in the work place. The need to examine various sources of support from family, friends and healthcare professionals' in relation to recovery was noted by Artinian (1993) in her review of a decade of nursing research on social support. A literature review about evidence-based nursing and major depression (Berg, Dencker, & Skärsäter, 1999) found that, within psychiatric mental health nursing, knowledge of this area is still lacking. This shows the importance of studying how psychiatric mental health nurses can assist patients in the process of regaining health. Therefore it is important to acquire knowledge that could benefit the patients and their families, as well as the healthcare organisation. There is still a gap in the knowledge as to which social support components are of value to the patient struggling with depression, and as to how men and women use social support in their functional recovery from depression in a gender-specific way.

AIMS

The overall aim of the thesis was to describe social support and social network as well as stressful events in the life of adults with major depression. Another purpose was to describe how men and women in receipt of treatment for major depression, used social support in their striving for health.

The specific aims were to

- ✓ define to what extent a group of patients with major depression perceived that they had social support and a well–functioning social network (Paper I).
- ✓ identify variables which characterise patients with major depression who felt that they received sufficient social support and those who felt that they received insufficient social support (Paper I).

- ✓ compare patients with major depression to healthy volunteers in terms of social support, social network and stressful life events (Paper II).
- ✓ describe men's and women's conceptions of being free from major depression (Papers III, IV)
- ✓ describe, from a salutogenic perspective, how men and women cope with major depression in daily life with the help of professional and lay support (Papers III, IV).
- ✓ describe the movement towards recovery as reported by men and women with major depression (Papers III, IV)

BACKGROUND

A caring perspective on health

Health can be viewed in many different ways. The two main concepts of health are humanistic and biomedical-oriented. The biomedical-oriented concept regards health as the opposite of illness, while the humanistic orientation embraces different perspectives of the health-illness relationship: health and illness as a continuum or as different dimensions. Thus, within the humanistic orientation, health is regarded as more than the mere absence of disease. WHO's (Haglund, Pettersson, Finer & Tillgren, 1993) definition of health has been continuously developed and its current definition is that health is a resource and an essential prerequisite for human life and social development, and that it is ever changing, always in the process of becoming.

The goal of nursing practice is to support the individual's health experiences, regardless of their medically diagnosed health problems (King, 1990; Meleis, 1990; Newman, 1986; Parse, 1981). In order to accomplish this goal, nurses need to acknowledge the phenomenon of human responses to various life problems and to help people deal with the problems they experience. Considered a crucial ingredient of nursing's theoretical metaparadigm (such as person, environment, health, nursing and suffering), nurse theorists have elected to define health in the context of their proposed models (Eriksson, 1987; Fawcett, 1989; Meleis, 1990). Florence Nightingale (1860) wrote that health is ”not only to be well, but to be able to use well every power we have to use”. Even though one cannot be sure what Nightingale actually understood by the word “well”, Selanders (1995) argued that she meant ”being the best you can be at any given point in time” (p.26). This allows for an individual to be healthy even if medically unwell. Newman (1986) views health as the totality of the life processes that are evolving towards expanded consciousness. Orem (1995) distinguishes between health and wellness and defines health as a state characterised by soundness or wholeness of human structure and body, mind and mental function. Wellness is a state characterised by experiences of contentment, pleasure, and movement towards maturation and fulfilment of human potential. Peplau (1988) defines health as a forward movement of the personality that is motivated by interpersonal processes towards creative, productive, and constructive living. Eriksson, Bondas-Salonen, Herbert, Lindholm & Matelainen (1995) described an ontological health concept, whereby health is seen as multidimensional levels, that are an integral part of a human being's life. This means that bodily experiences cannot be seen in isolation and that caring for the body has consequences for the whole human being. In the view of Eriksson et al., health can be seen as a movement which can start to develop when a human being's own health potential is stirred, which can happen as a result of communication, relationships, nature, or belief in God. To reach this health potential, the person needs to be consciousness of his/her inner or deeper resources as well as his/her own health and suffering, which are a part of the life process. When a person is aware, he/she can start a movement towards health, even when the person is undergoing strain and suffering. To conclude, from a caring perspective health can be seen as more than physical health and the absence of illness. The perception of illness and health is subjective and involves the whole human being.

Caring is defined as the central phenomenon or the essence of nursing (Leininger, 1988). The primary idea of caring is to "alleviate human suffering and to preserve and safeguard life and health (Eriksson, 1997a; Eriksson, 1997b; Lindholm & Eriksson, 1998). Mayeroff (1972) argues that care, in its most pure form, is to help another human being to reach self-actualisation. Halldórsdóttir (1996) describes caring as life-giving and sees the encounter between the patient and the nurse as the essence of professional caring. The relationship between patient and nurse is central to psychiatric nursing, and good nursing presupposes a safe relationship (Berg et al., 1999). The study of interpersonal relationships and the manner in which they influence the mental health of individuals and their families is important in nursing or, in the words of Fawcett, Watson, Neuman, Hinton Walker, & Fitzpatrick (2001), "the art of nursing is expressed through the nurse-person process" (pp. 118). Peplau's theory (1988) comprehensively describes the relationship as a process that incorporates the patient perspective, therapeutic communication skills, and mutual decision-making. Peplau's nursing framework also focuses intervention in the form of communication, where the nurse can enter the world of the patient or the relative in order to understand the suffering. By means of communication and dialogue, the nurse can inspire hope in the patient as well as giving meaning to their situation in order to help them go on living. Kitson (1996) states that it is the potential of this kind of relationship that distinguishes nursing values from other care approaches.

Hummelvoll (1997) defines mental health nursing as a planned, caring and therapeutic activity that builds on a responsible patient-nurse relationship. Through dialogue, support, supervision and education, the nurse can motivate the patient to take an active role in the treatment process. Hill & Michael (1996) report findings supporting the premise that the core activity of mental health nursing stems from working with extraordinary people within ordinary relationships in changing contexts. Barker emphasises (2000) that the interpersonal dimension of caring can generate power within relationships, and when used appropriately it can help patients to grow as persons. The depressed person's inability to meet role expectations in interpersonal relationships creates a ripple of suffering that extends into their relationship network. The nurse has the opportunity of meeting the patients' suffering through listening to them, being present, inspiring hope and acting as a guide (Eifried, 1998). Confirmation of the patients' suffering also leads to respect for human dignity, when the nurse signals that he/she understands the unique experiences and feelings of the patient (Beech & Norman, 1995; Eriksson, 1997b; Lindström, 1995).

During the past decade, there has been an increasing interest in mental health and the wellness aspects of the recovery process. The Swedish Health and Medical Services Act (SFS, 1982) emphasises the rights of persons to have their individual needs met in the recovery process. Patients and professionals in mental health care have subsequently attempted to identify and define aspects of mental health and wellness that contribute to the recovery processes. Anthony (1993) states four qualities necessary for developing and supporting a patient's recovery process: empathy, affirmation, encouragement, and acceptance. When these qualities are present, patients may be more likely to use wellness and preventative behaviours. Recovery is perceived as a transformation of an individual grounded in direct experiences and perspectives, a change of the self, which is expressed in qualities such as empowerment, life satisfaction, self-determination, self-care and self-efficacy (Fallot, 1998). Recovery can be seen as a movement that for some reason changes the perception from illness to health, where the key point is the patient and the context involved and how the patient handles and manages this process. It is the person's own experiences that determine the persons' position in the process and whether health is present or not.

Mental ill health

Stress

There is a link between mental ill health and stress. Stress is a multidimensional concept covering the stressors, the current states of the organism, and the subjective experience. Stress is the experience of a disruption of meaning, understanding and smooth functioning with possible consequences for the person, in the form of harm, loss or challenge (Benner & Wrubel, 1989). A transactional view of stress allows for flexible definitions of coping at the expense of specific information with which to make decisions about optimal coping strategies (Lazarus & Folkman, 1984). The central concept in these models was that a given event or situation may be perceived in different ways by various individuals. It is the subjective perceptions – rather than the objective stressors – which are seen to be the main determinants of effects on subsequent behaviours and health status (See Table 1).

Although all individuals experience stress, people interpret and react to it differently. Some stressors are viewed as challenges creating stimulation and excitement. Other stressors are viewed negatively, perhaps because they are considered undesirable, uncontrollable, or emotionally distressing. Many persons remain healthy despite being exposed to stressful circumstances, and some people mature more rapidly after effectively managing stressful life events (Benner & Wrubel, 1989; Pender, 1996). A central assumption underlying all stress process formulations is the existence of factors that mediate the experience of stressors and the expression of symptoms of illness or dysfunction. These mediating factors either intervene between stress and illness or have interactive or buffering effects that moderate the impact of stressors on distress and disorders. Social resources or social support, coping resources, and coping responses or behaviours are some critical groups of mediating factors. Thus, social supports, such as family and friends, and individual coping styles have all been shown to moderate the effects of stressors on depression (Brown & Harris, 1978; Lazarus and Folkman, 1984).

In the theory of general vulnerability, Cassel (1976) highlights the fact that a lack of social support and social network has a negative effect on physical health and is associated with a number of different diseases. He bridged the gap between stress research and social epidemiology by describing how the social environment influences bodily reactions. Cassel pointed at a likely effect modification between stressors on the one hand and other types of more specific exposure and genetic/physiological prerequisites for health on the other. This could explain how one type of stressor could be associated with a number of different diseases or different causes of death. According to Cui (1996) and Monroe & Depue (1991), depression is caused by a combination of the individual's vulnerability, sensitivity to stress and the occurrence of mediating factors, such as for example social support.

Stressful life events

One group of stressors that have received much attention in the healthcare literature are stressful life events. Life events (Holmes & Rahe, 1967; Paykel, 1983) are discrete, observable events representing significant life changes, with a relatively clear onset and offset, and a relatively well-defined set of sub events describing the normal process of the event. The defining issue in a life event is its discreteness, both in a typical time frame, and occurring over a period of time.

Table 1. Stress, Coping, and Health outcomes as defined in stress theories (Modified from Lyon, 2000)

Scientic View	Conceptualization of Stress	Conceptualization of Coping	Health Outcomes
Response based (Seley, 1956, 1983)	Stress is the non-specific response to any negative stimulus. The physiological response is always the same regardless of stimulus – the general adaption.	There is no conceptualisation of coping per se. Instead, Seley used the concept of ”resistance stage”, the purpose of which is to resist damage.	Basis of the assumption was that each person is born with a finite amount of energy and that each stress encounter depletes energy stores that cannot be rejuvenated. It was proposed that stress causes ”wear and tear on the body” that can result in various diseases based on the person’s genetic propensity.
Stimulus based (Holmes & Rahe, 1967)	The term stress is synonymous with ”life event”. Life events are ”stress” that requires adaptation efforts.	Coping is not defined.	A summative accumulation of adaption efforts over a threshold level makes a person vulnerable to developing a physical or mental illness within a year.
Transaction based (Lazarus, 1966; Lazarus & Folkman, 1984)	The term stress is ”rubric” for a complex series of subjective phenomena, including cognitive appraisals (threat, harm, and challenge), stress emotions, coping responses, and reappraisals. Stress is experienced when the demands of a situation tax or exceed a person’s resources and some type of harm and loss is anticipated.	Coping is conceptualized as efforts to ameliorate the perceived threat or to manage stress emotions (emotion-focused coping and problem-focused coping).	Adaptional health outcomes are conceptualised as short-term and long-term. Short-term outcomes include social functioning in a specific encounter, during and after an encounter, and somatic health in symptoms generated by the stressful encounter. Long-term outcomes include social functioning, moral, and somatic health. Both short-term and long-term health outcomes encompass effective, affective, and physiological components.
Phenomenological view (Benner & Wrubel, 1989)	Stress involves ”the disruption of meanings, understanding, and smooth functioning so that harm, loss, or challenge is experienced” (p. 59). Stress thus involves both the person and the situation, each influencing the other.	Coping is how one deals with the disruption.	Well-being is defined as “congruence between one’s possibilities and one’s actual practices and lived meanings and is based on caring and feeling cared for” (p.160).

The relationship of stressful life events to the cause, onset, course, and outcome of major depression has been the focus of much research. This association generally holds true for both clinical and community samples and for persons of all ages and groups (Bifulco, Bernazzani, Moran, & Ball, 2000; Daley, Hammen, & Rao, 2000; Gotlib & Hammen, 1992; Mundt, Reck, Backenstrass, Kronmuller, & Fiedler, 2000; Paykel, 1994). Experiencing a loss or threat, whether physical, social, or psychological, is seen as an important risk factor for depression (Bifulco, Brown, Moran, Ball, & Campbell, 1998; Brown & Harris, 1978; Lloyd, 1995; Paykel, 1994; Weiss, Longhurst, & Mazure, 1999), poorer treatment response and outcome (Monroe, Kupfer, & Frank, 1992), and relapse (Lara, Leader, & Klein, 1997). However, despite the fact that all people experience stressful life events, not all people become depressed. This suggests that specific events only partially contribute to the development of depression.

In both the stress and the social support lines of research, investigators have been willing to acknowledge that the relationship between stress and social support may well be directional (Hammen, 1995; Kendler et al., 1995), which means that it is essential to consider the direction of the stressful life events or lack of social support, which can follow rather than precede the illness or distress. One possible clue is that it appears that depression can affect a person's ability to cope with stressful life events (Hammen, 1995; Kendler & Karkowski-Shuman, 1997). This suggests that the depressed persons may shape their environments, and that the consequences of their depression and behaviour may serve to generate stressful conditions and events, which in turn cause additional symptomatology.

Major depression

The broad category of depressive disorders includes major depressive disorders, dysthymic disorders and depressive disorders not otherwise specified (Saddock & Saddock, 2000). An episode of major depression (Table 2) is characterised by patterns of signs and symptoms related to affective, cognitive, behavioural, social, and physiological functioning. Experienced in isolation, each of these symptoms is capable of generating significant distress and dysfunction. However, when experienced in combination, their cumulative impact is felt as a maelstrom that soon spirals the depressed individual into feelings of futility and despair (Karp, 1996). Aspects of functioning may be impaired at a mild, moderate, or severe level, and can be episodic, recurrent or chronic (Table 2).

Major depression significantly impacts on the mental and physical health, well-being, and quality of life of the sufferer. Existentially speaking, depression affects how individuals function in and as a part of the social and physical world surrounding them; how people experience this world; and how, cognitively and emotionally, they understand this world. This altered state of being in, experiencing, and understanding the world not only touches the person but also impacts on those who live with the person suffering from depression: partners, parents, children, close friends etc. A major depressive episode is experienced by the sufferer as qualitatively distinct from grief or other understandable reactions to loss or adversity.

The cause of major depression is in most cases multi factorial. Biological vulnerability sometimes genetically determines the interplay between psychological and psychosocial stress variables (Brown & Harris 1978; Cui & Vaillant, 1996; Kendler & Karkowski-Shuman, 1997; McGuffin, Katz, Watkins, & Rutherford, 1996; Paykel & Priest, 1992) and may be explained by the general vulnerability theory (Cassel, 1976; Monroe & Simons, 1991). Social stressors have received more attention than other risk factors for major depressive episodes across the life cycle. Furthermore, Post (1992) suggested that life events may play a greater role in the initial onset of depressive episodes. After the initial episode, fewer patients had experienced life events prior to the onset. This is referred to as the "kindling effect". Kindling takes its name from the idea that a tiny spark will lead to a roaring fire. In a similar fashion, a stimulus to neurons, repeated over and over, will eventually lead to full-blown activity in the absence of a stimulus. Post and his colleagues (1996) suggested that a kindling-like phenomenon may be responsible for certain manifestations of affective illness, such as the autonomy of episodes in which the illness shifts from being precipitated by psychosocial stressors to occurring autonomously. Moreover, they suggest that a sensitisation or kindling phenomenon may be responsible for the development of treatment resistance. Post & Weiss (1995; 1997) and Post et al., (1998) hypothesised that kindling and sensitisation are responsible for what clinicians see as a lack of response to pharmacological treatment. The kindling phenomenon has been replicated in later studies among depressed women (Kendler, Thornton & Gardner, 2000) as well as in patients with recurrent major depression (Ehnvall & Ågren, 2002).

Table 2. Diagnostic criteria for major depression. Modified from the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (American Psychiatric Association, 1994).

At least five of the following (including one of the first two) must be present most of the day, nearly daily, for at least 2 weeks:

- depressed mood,
- anhedonia or loss of interest or pleasure in activities, "not caring anymore".
- significant weight loss or change in appetite,
- sleep disturbance, which may involve difficult getting to sleep, waking up and then returning to sleep, or waking up early.
- psychomotor agitation or retardation. Agitation may take form in inability to sit still, and retardation may involve slower speech and body movement, longer pauses before answering.
- fatigue or loss of energy, even the smallest task may seem difficult or impossibly to accomplish
- feelings of worthlessness and guilt,
- impaired concentration,
- and recurrent thought of death or suicide.

There are serious consequences associated with depressive episodes, one of which is suicide. Approximately 20 % of all patients who have been hospitalised for severe major depression commit suicide. This is especially so when the patient has a comorbid anxiety or somatic disorder, where the risk of suicide is doubled relative to those without such comorbidity (Ballenger et al., 1999). Kasper, Schindler, & Neumeister (1996) argue that major depression is the key factor in approximately half of all suicide cases, which is also confirmed by Murphy (1998). Women are more likely to attempt suicide whereas men are more likely to complete suicide (Kornstein, 1997). Another serious consequence is the psychiatric and somatic co-morbidity rates for major depression. Common psychiatric disorders include anxiety disorders, substance use or dependence, personality disorders

(Zajecka, 2000) and somatic diseases, as well as coronary artery diseases (Bjorntorp, 2001; Glassman & Shapiro, 1998; Hippisley-Cox, Fielding, & Pringle, 1998), arthritis (Fifield, Tennen, Reisine, & McQuillan, 1998) and endochrinological disorders (Thakore, Barnes, Joyce, Medbak, & Dinan, 1997).

Chronic major depression is characterised by either prolonged episodes of illness lasting two years or more or an incomplete remission between episodes (Keller, 1994). Chronic illness may result from the fact that many individuals remain untreated or without adequate treatment, i.e. treatment leading to full remission. Chronic depression is associated with severe functional impairment, more severe than that seen in many chronic medical disorders, including hypertension, diabetes, and arthritis (Hays, Wells, Sherbourne, Rogers, & Spritzer, 1995, WHO, 2001). Depressed patients have poorer social and role functioning, more days in bed, poorer current health, a worse financial situation, and more bodily pain (Hirschfeld et al., 2000). Compared to people with chronic medical conditions, depressed individuals are often less able to perform as parents or employees and perceive themselves to be in worse health (Hays et al., 1995). In a study of people with severe depression, Judd et al. (1998) found that, over a nine-year period, these patients were symptom free for only 27% of the time. Chronicity of depression appears to affect women more seriously than men, as manifested by earlier age of onset, more family history of affective disorders, more reported symptoms, poorer social adjustment and poorer quality of life (Kornstein et al., 2000; Thase et al., 1994). It seems that once depressed, women also have a higher risk of experiencing recurrent episodes of depression (Livingston, Watkin, Milne, Manela, & Katona, 1997; Mueller et al., 1999). The term treatment-refractory depression is used for a subgroup of individuals with a major depressive disorder, who fail to respond to conventional treatment approaches. In the literature there are no well-accepted definitions of treatment-refractory depression (Berman, Narasimhan, & Charney, 1997; Kornstein & Schneider, 2001). Guscott and Grof (1991) note that refractory depression is "first and foremost a sociological fact – a phenomenon of labeling".

Gender and major depression

The gender differences in terms of prevalence appear to rise sharply in adolescence and early adulthood, particularly in females (Cyranowski, Frank, Young, & Shear, 2000; Olsson & von Knorring, 1997). The overrepresentation of women abates in older age groups (Bebbington et al., 1998) due to a reduction in the prevalence of female depression rather than an increase in male prevalence. The gender differences in the prevalence of depression are found in cross-national epidemiological surveys across diverse cultures (Patel, Araya, de Lima, Ludermir, & Todd, 1999; Weissman et al., 1996). Three hypotheses have been proposed to explain the predominance of major depression in women: the artefact hypothesis, the biological hypothesis, and the psychosocial hypothesis (Kornstein, 1997; Pajer, 1995).

The artefact hypothesis takes gender differences into account in symptom reporting and help-seeking behaviour as well as cultural and diagnostic biases. As the name implies, the artefact hypothesis proposes that the greater prevalence of depression in women is the result of an artefact – particularly, the greater propensity of women to report symptoms of depression and to more frequently seek psychiatric help (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993). One explanation of gender differences in depression rates may be the result of men developing disorders in response to stress, such as antisocial behaviour and alcohol abuse. In support of this, several studies show that the expected gender differences in depressive disorders are offset by higher male rates of alcohol abuse and drug dependency

(Kessler et al., 1994; Melzer, Baljit, Petticrew, & Hinds, 1995; Rutz, Wålinder, von Knorring, Rhimer, & Pihlgren, 1997). Interestingly, in the Amish community in the US with its agrarian culture, large families and virtual absence of substance abuse, the rate of major depression is low and is equal for men and women (Egeland, Hostetter, & Eshleman, 1983). With regard to gender differences in individual symptoms, women report more symptoms of fatigue, increased appetite and sleep disturbance, as well as anxiety and other somatic symptoms, such as body aches compared to men (Kessler et al., 1993; Silverstein, 1999). Weight loss (Kessler et al., 1993) and hostility are more associated with male depression (Katz et al., 1993). Males often have difficulties in expressing mild forms of depression but, in more severe states of depression, no differences in symptom profiles between men and women could be identified (Stage, 1995).

The biological hypothesis attributes the gender difference in the prevalence of depression to the frequent shifts in reproductive hormone levels in women (Pajer, 1995). Hormonal influences on depressive episodes, related to reproductive events such as pre-menses, pregnancy, postpartum, and menopause, have been observed. A change in oestrogen status, such as the oestrogen deficiency due to menopause, can lead to modulation of the serotogenic function and increase the risk of depression in women (Joffe & Cohen, 1998). Biological theories have proposed differences in brain structure and function between men and women, including neurotransmitter, neuroendocrine, and circadian rhythms, as well as genetic factors and reproductive functions (Kornstein, 1997).

The psychosocial hypothesis emphasises that, in general, women have a lower socio-economic status and are more prone to stressful life events, victimisation, and maladaptive coping styles, all of which may contribute to their higher risk of depression (Kornstein, 1997; Pajer, 1995). In addition, in Berndt et al.' s (2000) study, early onset of major depressive episodes affected even the educational achievement of women but not of men. Some researchers have presented other approaches to gender differences in depression, which are largely the result of differences in roles and the stresses and expectations that go with them (Bebbington, 1996; Nazroo, Edwards, & Brown, 1997; Oakley, 1993). Women more often report seeking social support, distracting themselves and venting their feelings in an emotional, vigilant and expressive style (Thoits, 1995a; Weidner & Collins, 1993) as well as internalising and blaming themselves for their unhappiness (Busfield, 1996). Another feature is that women use ruminative coping styles (a process of frequently returning to thoughts about the depression and related issues, characterised by a sense of the intrusion of these thoughts during daily activities) (Nolen-Hoeksema, 1995), which Greenberg (1995) found was a necessary element in coping with trauma and a possibly factor leading to post traumatic growth. Men more often report controlling emotions, accepting the problem, not thinking about the situation, and engaging in problem-solving efforts (Weidner & Collins, 1993). They tend to give expression to their feelings of loss and stress and to blame others, through, for instance, aggression and violence (Busfield, 1996). On the other hand, women are better adapted to long-term stressors and pay more attention to their physical well-being, thus increasing the likelihood of seeking medical care early and preventing stress-related illness (Krohne, 1996).

Recovery from depression

Treatment consists of three phases: acute, continuation, and maintenance (Figure 1). The goal of the *acute treatment* is to eliminate all symptoms. If patients improve as a result of treatment, they are said to exhibit a therapeutic *response*. A successful acute treatment brings patients back to an essentially symptom-free state and to a level of functioning comparable to that before the illness. This phase usually lasts 6 to 8 weeks and, if patients are restored to full health, not only in terms of symptoms but also in terms of functioning, they are said to be in *remission* by the end of that time. The goal of *continuation treatment* (4 to 10 month) after remission is to prevent a *relapse*, which is the return of symptoms, and to promote *recovery*. The risk of a relapse is high in the first 4 to 6 months after remission, and one error in the treatment of major depressive episodes is the failure to continue a successful treatment for a sufficient length of time. The purpose of the *maintenance treatment* (one or more years) is to prevent a *recurrence* or a new episode of the illness. Patients may continue on medication during the whole of this treatment phase.

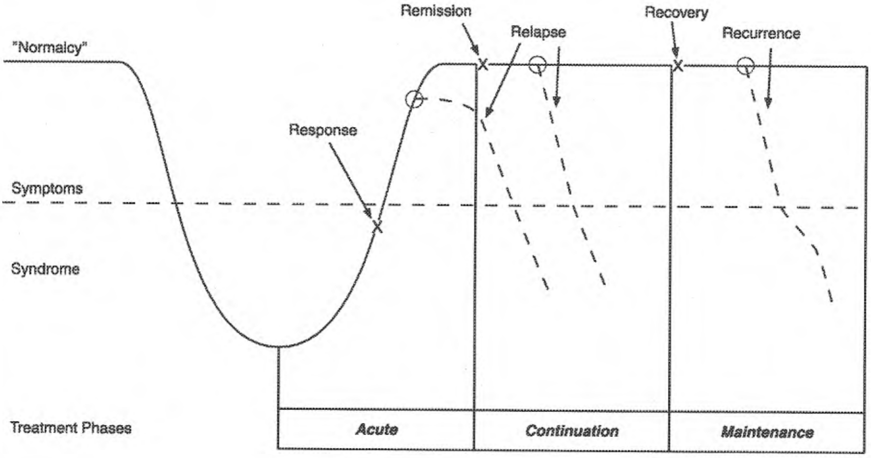

Figure 1. The phases of treatment for mood disorders. Kupfer, D.J. (1991). Longterm treatment of depression. *Journal of Clinical Psychiatry, 52*(Suppl), 28-34. Reprinted by permission.

Relapse during long-term antidepressant treatment, a depressive breakthrough (Nierenberg & Alpert, 2000), has been reported to be as high as 57% (Byrne & Rothschild, 1998) and may be the result of a number of overlapping factors, including inadequate treatment, comorbid medical or psychiatric illness, psychosocial factors, and poor compliance. Failure to achieve a full remission of depressive symptoms during the acute treatment phase increases the likelihood of relapse (Fava, Grandi, Zielezny, Canestrari, & Morphy, 1994; Rush & Thase, 1997). Even when symptom remission is achieved, there is often a time lapse until there is full recovery of social and occupational functioning (Lonnqvist et al., 1994), and long-term treatment may be necessary to achieve remission and restored functions (Keller et al., 2000).

The first-line treatment for most people with major depression consists of pharmacological treatment, psychotherapy, or a combination of the two. Depression-focused interventions such as Beck´s (1976) model of cognitive-behavioural therapy (CBT) and interpersonal psychotherapy (IPT) (Klerman, Weissman, Rounsaville, & Chevan, 1984) have been tested in numerous clinical trials and generally found to be as effective as tricyclic antidepressants for the treatment of outpatients with mild depressive episodes (Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Thase et al., 1997). CBT consists of a 16- to 20-session intervention focusing on increasing experiences that identify, counter and provide a pleasurable sense of mastery over irrational negative thoughts about the self, the world, and the future. IPT, a 16- to 20-session intervention, focuses on the alleviation of acute psychological stress associated with an unresolved grief reaction, a life role transition, interpersonal conflicts with someone close, or pervasive difficulties in relation to others. Among patients with severe or recurrent major depression, combined therapy, pharmacological therapy and the buttressing of coping skills with CBT have been found to be more effective than treatment with just one kind of therapy (Keller et al., 2000; Thase et al., 1997). A meta-analysis (McDermut, Miller, & Brown, 2001) showed that group psychotherapy and individual psychotherapy did not differ in effectiveness and that CBT was more effective than psychodynamic group therapy. A naturalistic 18-month follow-up study (Zlotnick, Shea, Pilkonis, Elkin, & Ryan, 1996) reported no gender differences in treatment outcome after psychotherapy. At follow-up, similar life events and social support influenced the depressive symptoms of men and women. Fewer stressful life events and more social support were associated with lower frequency and/or intensity of depressive symptoms in both genders. It was concluded that men and women with major depression reported comparable levels of depression and that both genders may benefit from treatments that enhance the use of psychosocial resources, especially peer support.

Sharing experiences in a group may also have an impact on individuals' ways of managing their situation, as group members who tell their stories provide opportunities for comparison (Stewart, 1990). The effects of group intervention using cognitive strategies were a decrease in irrational beliefs and negative self-dialogue (Beck, 1991). Women who participated in the structured cognitive group were found to have lower depression-, hopelessness-, and anxiety scores as well as higher self-esteem scores than either women who participated in a support group or women in the control groups (Adams, 2000; Berg et al., 1999; Gordon & Gordon, 1987; Gordon, Matwychuk, Sachs, & Canedy, 1988; Maynard, 1993). There are very few men who have participated in support groups, and there are no corresponding studies available on groups made up of men only. Self-help groups extend natural networks, where members exchange experiential knowledge and supply emotional, informational, affirmational and occasionally tangible support (Katz, 1993). Healthcare professionals' involvement in self-help groups differs significantly from the direct care-provider roles played in traditional, individual,client-professional relationships (Stewart & Tilden, 1995). Nurses collaborate with self-help groups in many ways: as consultants, evaluators, facilitators, sources of referrals and partners.

Health resources

Social support

The foundations of the concept of social support were introduced into the scientific community nearly three decades ago by Antonovsky (1974; 1979), Caplan (1974), Cassel (1976) and Cobb (1976) when they began to examine factors that could alleviate the effects of stressful events. Social support systems can be helpful in emphasising the strength of individuals and families as well as focusing on health rather than on illness. The prevalence of both professional and lay support groups for all manner of health and social challenges attests to an inherent belief in the potential advantages of this factor. However, research findings often appear ambiguous. Explanations are frequently centred on a lack of consistent conceptualisation, use of different measurement tools, often without sufficient psychometric strength, and lack of clarity about the theoretical underpinnings and the role that social support plays (Artinian, 1993; Stewart, 1995). Since the time of Florence Nightingale (1860), social support has been identified as central to nursing. Theoretical definitions of social support include all or part of the following categories: (a) the act of providing a resource, (b) a description of outcome of support that includes the recipient having a sense of well-being or of being cared for, (c) an implied positive outcome, and (d) a description of the relationship between recipient and provider (Hupcey, 1998). House (1981) has defined social support as the interactive process in which emotional concern, instrumental aid, information, and appraisal are obtained from one's social network. According to House (1981), emotional support involves the provision of caring, empathy, love and trust. Instrumental support is defined as the provision of tangible goods and services and is described as concrete assistance - for example giving financial assistance or performing assigned work. Informational support is defined as the provision of specific information to another during a time of stress. Appraisal support involves helping an individual to better understand stress as well as what resources and coping strategies might be mustered to deal with the stress (House, 1981). Each of these four defining attributes of social support is helpful, protects the person receiving the support, and enables an exchange of reciprocal supportive actions (Hinson Langford, Bowsher, Maloney, & Lillis, 1997). However, Hupcey (1998) includes an additional attribute; the receipt of social support. Although social network may influence what actions are taken, Hupcey (1998) stresses that the boundaries of social support are such that an action taken, which concerns an organisation, the community, or a professional, does not constitute social support.

Closely related to the concept of social support is that of social networks. A social network is defined as a web of identified social relationships that surround an individual and the characteristics of those linkages. Each individual is viewed as a node in a network of individuals, and each exchange between them is a link. A social network is a group of people with whom contact is maintained. It contains some form of social bond and is defined in terms of its size, frequency of contact, density or integration of the network, existence of a confidant, the network composition, and perceived support (Bowling, 1991). Social networks are important to individuals and families to the extent that they fulfil members' needs. Through the interpersonal exchanges within a social network, individuals are influenced and supported in their health behaviour choices (Heaney & Israel, 1996). Many researchers stress that it would be wrong to assume that one particular type of network will always be the most supportive in times of crisis; rather different network members are likely to provide differing types and amounts of support (Gottlieb & McLeroy, 1994; Lanza & Revenson, 1993; Wenger, 1994). For example, family members most often provide long-term assistance, while neighbours and friends are more likely to provide short-term aid (Gottlieb & McLeroy, 1994).

The importance of relationships for health and well- being

Social interaction and relationships are important for individuals' well-being and perceptions of health (Eriksson et al., 1995). The WHO (2001) identified strengthening social networks and social support as a health promotion strategy. Despite the multitude of research articles on social support, our knowledge about social support processes – what starts them and how they affect health and well-being – is still poor. A number of studies have shown that social support and social networks have an impact on the promotion of health, morbidity and mortality as well as on health habits, life satisfaction and psychological well-being (Seeman, 1996; Underwood, 2000). The quality of social relationships predicts general health and mortality, (Berkman, 1985; House, Landis, & Umberson, 1988; Stewart, 1995) as well as healthy coping abilities (Stewart, 1993). However, not all types of social support are necessarily perceived as good, and more social support is not always better, as social support can also take a toll on the supporter. Both the absence of relations and certain characteristics of social relations can serve as stressors that can have a negative impact on health (Cacioppo, 1994). The form of social support and who provides it may be perceived as more or less helpful in different situations (Norwood, 1996). In some social support relationships, the recipient may feel diminished by receiving help, guilty for causing inconvenience to others, or angry because of loss of personal control or feelings of indebtedness to the support giver. The positive effects of support may be diminished by the cost of obtaining it (Norwood, 1996). Sources of support may be viewed differently with respect to the forms of support they are able to provide. Support from family and friends may be valued, but these persons are not necessarily a resource for obtaining the information necessary to facilitate effective coping in a given situation. Therefore, healthcare professional sources may at times play a more prominent role (Underwood, 2000).

Social support and caring

Although the provision of social support can attempt to influence the thoughts and behaviours of the receiver, it must be provided in an interpersonal context of caring, trust, and respect for each person's right to self-determination. This quality distinguishes social support from some other types of social influence that derive from the ability to provide or withhold desired resources or approval (Heaney & Israel, 1996). Although social support models have been developed by nurse theoreticians and researchers, almost all are based on and derived from theories advanced by psychologists or sociologists (Stewart, 1993), and no new theories have been generated by nurses. The environment, which is highly relevant to the social support and social network, is given limited attention in traditional conceptual theories of nursing. Furthermore, the perspectives of the client are not always incorporated in nursing models. Orem (1980) identified the balance between solitude and social interaction as one of six universal self-care requisites and referred to the nurse who provides a supportive environment. However, Orem focuses on the care of dependent family members and on nurses regulating the capability of patients to engage in self-care, rather than on potentially supportive social networks and lay groups, and she portrays nurses as the final decision makers. Swanson (1991) developed a middle-range theory of caring, which is compared not only to Watson's (1979; 1985) nursing "carative" factors and Benner's (1984) delineation of the helping role of the nurse, but also to Cobb's (1976) definition of social support. Swanson argues that, although caring consists of supportive relationships, not all caring relationships are experienced as social support, as there is no reciprocal obligation.

Social support as a coping resource

Social support may not only have a protective effect in preventing or decreasing the risk of development of illness, but may also be helpful for people who have to cope with the stress of a chronic illness. Much of the interest in social support has stemmed from the hope that research on this topic may yield information that can assist in the development of coping enhancing interventions. Significant others can participate in stress management efforts in a number of ways, such as helping to alter a stressful situation, changing its meaning, or modifying the emotional reactions that are elicited. Thus, a wide variety of behaviours qualify as coping assistance. Social network members can also assist in the process of assimilating and reinterpreting stressful life events in order to minimise their more harmful elements, thus helping the stressed individual to deal with the resulting negative emotions.

Functions of social support – buffering, mediating and main effect models

Integration in a social network and the ability to draw resources from that network has been shown to protect health and promote recovery from illness. This impact of support on health may occur through a buffering or moderating effect, a mediator effect, or a main or direct effect. The *buffering or moderating model* (Antonovsky, 1974; Caplan, 1974; Cobb, 1976, Gluhoski, Fishman, & Perry, 1997; Sansom & Farnill, 1997) proposes that social support acts as a buffer to protect people from the potentially harmful influences of acute stressful events, but does not alone prevent illness. The model suggests that those with high levels of social support are more able to cope with and adapt to stressors than those with lower levels. Social support intervenes directly between stressors and mental health. *The mediating model* predicts that social support acts as an intervening variable indirectly influencing the effects of stress and health (Eckenrode, 1991). *The main effect model* (Aneshensel & Stone, 1982; Cassel, 1976; Cohen & Wills, 1985; Hatchett, Friend, Symister, & Wadhwa, 1997) suggests that lack of social support constitutes a deficiency or strain, which increases the risk of illness, or enhances health and well-being irrespective of stress level.

There is increasing evidence that social support operates differentially within the context of gender. Women are primarily responsible for maintaining social networks that both men and women use. Thus, social networks demanding high energy for maintenance can be a source of strain as well as a potential support for women (Due, Holstein, Lund, Modvig, & Avlund, 1993). Men appear to rely heavily or even exclusively on their wives for social support, although only a small proportion of women consider their husbands their primary source of support (Cutrona, 1996). Women have larger social networks, including family and friends, from whom to solicit help and are thus more likely to seek support outside their marriage (Cutrona, 1996; Edwards, Nazroo, & Brown, 1998).

The impact of social support on recovery from major depression

Social factors play a major role in the causation, maintenance, and resolution of depressive episodes. Social support moderates depression by providing an experience incompatible with depressive withdrawal. It also provides increased self-esteem by reinforcing approval, acceptance, recognition, and support. Women with higher levels of social support have a lower risk of developing depressive symptoms than women without such support (Hauenstein & Boyd, 1994). There is evidence that baseline social support is implicated in recovery (Brown, Harris, Heoworth, & Robinson, 1994; Zlotnick et al., 1996). Social support seems to be a buffer against the adverse consequences of major depression (Appleby, Dennehy, Thomas, Faragher, & Lewis, 1999; Gordon and Gordon, 1987; Gordon et al., 1988; Kessler and Magee 1994, Maynard, 1993). Volunteer befriending has a significant positive effect upon remission among women with chronic depression (Harris, Brown, & Robinson, 1999a, 1999b).

Several studies have found that a good relationship with a confidant, especially for women, improves a patient's chances of recovering from depression (Dickinson, Green, Hayes, Gilheany, & Whittaker, 2002; Goering, Lancee, & Freeman, 1992; Lin & Peck, 1999; Moos, 1990) and even acts as a protective factor in the face of stressful life events (Brown, 1992). For married men, there was a strong tendency to select the spouse as the confidant. It is more common for women than men to obtain support from a confidant or a close friend (Bowling, 1995). An identified lack of a close, confiding relationship was a factor that increased women's vulnerability to depression (Brown & Harris, 1978, 1986). Family members play a key role in caring for depressed people and are in many ways their primary carers. A family in which one or more members are depressed will suffer in a variety of ways not only because of the disease, but also because of marital disharmony, increased likelihood of divorce, and disruption of the family's other social roles, such as the transmission of culture, rearing of children, and support of family members in trouble. Studies have shown that good family support is related to a better prognosis for depression (Badger, 1996), thus stressing the need to support the family as well as the patient. The impact of depression on family and social life restricts social and leisure activities, puts a strain on the marital relationship and leads to a lack of support, which may exacerbate the course of the illness (Badger, 1996; Zieba, Jawor, & Dudek, 1996). If the illness or disability occurs in families already vulnerable due to long-term chronic family strains or an accumulation of stressors impinging on the family from other sources, members' ability to provide support may be seriously weakened. A family's ability to provide support for patients, however, is likely to be influenced by its ability to obtain external support to mitigate illness-related family stress.

Salutogenesis

Antonovsky (1987) coined the term salutogenesis (*salus,* Latin for "invincibility", "well-being", "happiness"; *genese,* Greek for "genesis", "origin") and used a metaphor to illustrate his thoughts on the conception. The metaphor of the river as a symbol of life and the idea that a person is always swimming in a more or less dangerous river lead to the question: What shapes one's ability to swim well? (Antonovsky, 1987, p.90). The individual ability to swim is analogous to a personality characteristic that serves as a psychological stress-resistance resource, which Antonovsky terms "sense of coherence". Salutogenesis offers three advantages compared to pathogenesis. The former focuses attention on the common denominators of health, including individuals´ subjective interpretations. Secondly, it embraces the notion of multiple causations and encourages a broad approach consistent with the field of health promotion. Finally, salutogenesis seeks to describe and explain factors that move individuals towards the healthy end of a health continuum. Health and illness are no longer regarded as dichotomies. Rather, a multidimensional health-illness continuum is posited, with "two poles that are useful only as heuristic devices and are never found in reality: absolute health and absolute illness" (p.37). The model seeks to describe the process of staying healthy despite exposure to stress. The model of Antonovsky can be compared with the Neuman System Model (Neuman, 1996), where health is equated with wellness and is placed on a continuum with optimal stability (negentropy) at one end and illness (entropy) at the other.

To understand how individuals can remain healthy despite being exposed to a great deal of stress, Aaron Antonovsky developed a theory about what it is that connects them under special circumstances; a sense of coherence (SOC). Antonovsky (1987) held that a strong SOC mobilises a person's abilities to use resources towards both avoiding and managing stress. An individual with a strong SOC, who is confronted with a stressor, is more likely to feel a sense of engagement, commitment, and willingness to cope. Furthermore, he or she is likely to have developed a rich repertoire of generalised resistance resources (GRRs) including factors such as: material resources; knowledge and intelligence; ego strength; mastery of flexible, rational, and far-sighted coping strategies; social support; commitment to one's social group; cultural stability; a stable system of values and beliefs derived from one's philosophy or religion; a preventive health orientation; and, a genetic or constitutional strength. The sufficiency of and ability to use these SOC resources is a crucial determinant of one's position on the health continuum.

Sense of coherence has three components, namely, comprehensibility, manageability, and meaningfulness (Antonovsky, 1987). The person who experiences the world as *comprehensible* expects that future stimuli will be predictable or, when they come as surprises, will be orderable and explicable. People who experience their world as *manageable* have the sense, aided by their own resources or by those of trustworthy others, that they will be able to cope. A person who experiences the world as *meaningful* will not be overcome by unhappy experiences but will experience them as challenges, be determined to seek meaning in them and do his/her best to overcome them with dignity.

Sense of coherence is applicable to individuals and groups as well as society at large. It also changes dynamically in the course of a lifetime, especially during the first three decades of a person's life. The concept of sense of coherence is not comprised of specific strategies; instead it mirrors the individual's own perceptions of their ability to cope with difficult situations. Antonovsky's theory is interesting because, among other things, it illuminates a new dimension of coping.

Coping

In order to develop and solve problems during the life span, one has to have the ability to cope. The ability to cope appears to be a requirement for positive mental health (Rohde, Lewinsohn, Tilson, & Seeley, 1990; Tengland, 1998; Thoits, 1995b). On the other hand, there are features of depression that affect the choice of coping strategies as well as their actual and perceived effectiveness (Antonovsky, 1987; Bifulco & Brown, 1996; Bouhuys, Geerts, & Gordijn, 1999; Zauszniewski & Rong, 1999). The definition of coping most often used in the nursing literature (Backer, Bakas, Bennett, & Pierce, 2000) has been the one proposed by Lazarus and Folkman (1984), who define coping as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141), or simply stated, coping is the effort to manage stress (Lazarus, 1999). The way a person appraises an event is the key to understanding coping efforts as well as the nature and intensity of the coping response. Three types of appraisal were identified: primary, secondary, and reappraisal (Lazarus & Folkman, 1984). Primary appraisal is a judgment by an individual about what a situation holds in store for him or her. Specifically, a person assesses the possible effects of demands and resources on well-being. The perception of threat triggers the secondary appraisal, which is the process of determining what coping options or behaviours are available to deal with a threat. Often primary and secondary appraisals occur simultaneously and interact with one another (Lazarus & Folkman, 1984). Reappraisal is the process of continually evaluating, changing, or re-labelling earlier primary and secondary appraisal as the situation evolves. What was initially perceived as threatening may now be viewed as a challenge or as benign or irrelevant. Often, reappraisal results in the cognitive elimination of a perceived threat. Susan Folkman (1997) described an additional approach to Lazarus and Folkman's model (1984), where coping processes were associated with positive psychological states or events while under intense stress.

Coping is a central concept in Benner & Wrubel′s (1989) model of nursing, where coping is presented as a key factor. There is emphasis on human possibilities as well as the importance of supporting the patient in his/her development. Benner & Wrubel′s nursing model (1989), which links up with Lazarus and Folkman's theory of coping (1984), focuses on the nurse's possibility of guiding and supporting the patient to cope successfully, thus leading to well-being. The model conveys a positive view of humanity through its emphasis on possibilities, not limitations, and on support in order to increase the patient's own capacity. It enriches nursing by placing the patient within a context and focusing on stress and coping processes as the important factors with regard to well-being. The concept of coping verbalises and illuminates an important human dimension within nursing, the vital intrinsic force. The phenomenological model of Benner and Wrubel is a theoretical model and has not been tested empirically.

THEORETICAL FRAMEWORK

A conceptual model

A model was proposed as a guideline for the antecedent factors, the mediating processes and the health outcome in the light of major depression (Figure 2). The proposed model draws from the work of Antonovsky (1987), Benner and Wrubel (1989), Folkman (1997), House (1981), and Lazarus and Folkman (1984). Their research results have contributed to our understanding of how to deal with major depression.

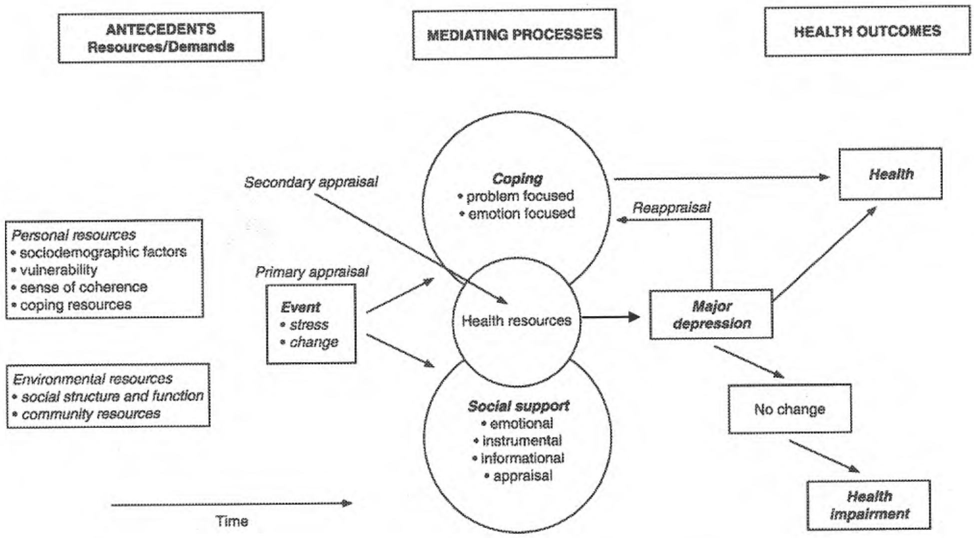

Figure 2. A conceptual model of suggested assumptions between antecedents, mediating processes and health outcomes due to major depression

Antecedent factors are **personal resources** and **environmental resources**. The personal resources include socio-demographic factors (such as age and gender), vulnerability, and constructs like sense of coherence, and the person's coping resources. The environmental system is characterised by the individual's social structure and function (relationships) and what resources are available in the community. The primary appraisal of an event can be perceived as a change/challenge or as a threat, which can trigger secondary appraisal and stress caused by the individual's emotional reaction. Individual responses to stress are highly variable. What may be mildly stressful for one person may be insurmountable for another.

Mediating processes or health resources may alter an individual's reactions to potentially stressful events. The health resources described in this model are the individual's coping resources, which form the strategy for managing stress. Another component of the mediating factors is social support. Social support is effective if the individual is satisfied with the support and feels that it meets his or her needs. It might be helpful to determine whether certain forms of support are more relevant to coping in specific situations. The individual's perceptions may be modified by both individual and situational factors. If the mediating strategies are successful, the result may be personal growth, which predicts health. If the functional mediating strategies break down or if they are lacking, this may lead to illness in the form of major depression. Major depression may have a positive effect insofar as it can lead to reappraisal and to personal growth and health, but a lack of reappraisal may result in no change or even health impairment.

Transition

The experience of living and coping with major depression was found to be an ongoing process of transition, and the literature on transition served as a framework for the kind of changes that the patients were going through. Transition is a dynamic process highly influenced by protective factors (Meleis, Sawyer, Im, Messias, & Schumacher, 2000). Transition can be seen as a passage or movement from one life phase, condition, or status to another, and the process and experiences of undergoing a transition can result in health, new meaning and a sense of control (Meleis & Trangenstein, 1994; Meleis et al., 2000). Transition refers to both the process and outcome of complex person-environment interactions. It may involve more than one person and is embedded in the context and the situation (Chick & Meleis, 1986; Meleis & Trangenstein, 1994). Transitions both result in and are the result of changes in lives, health, relationships and environments (Meleis, 2000). Not all change is related to transition, although all transitions involve change (Bridges, 1996; Meleis, 1994).

A theoretical framework of transition (Meleis et al., 2000) has been developed that includes 1) types and patterns of transition; 2) properties of transition experiences; 3) transition conditions: facilitators and inhibitors. Patterns of response of the transition are 4) process indicators and 5) outcome indicators. Types and patterns of transition, i.e health-illness experiences, development and life span transitions, social-cultural and organizational transitions (Meleis, 1994; Schumacher, 1994). The characteristics of transition experiences include awareness, engagement, change and differences, time span and critical points and events. Transition conditions are the facilitators and inhibitators, which can be defined as the meaning attributed to events precipitating a transition and to the transition process itself, which may facilitate or inhibitate healthy transitions. Preparation and knowledge of what to expect during a transition and what strategies might be helpful in managing it are required. Process indicators can develop confidence where the informants have to understand the level of different processes inherent in diagnosis, treatment, recovery, and the limitations brought about the illness; in the level of resource utilization; and in the development of coping strategies. Process outcome can indicate when a transition is complete, although the determination of when it is complete depends on the nature and process of transition (Meleis et al, 2000).

Transition is a central concept in nursing (Meleis & Trangenstein, 1994) but may be considered as related to such concepts as adaptation (Roy, 1989), self-care (Orem, 1980), unitary human development (Rogers, 1989), expanding consciousness (Newman, 1986), human becoming (Parse, 1981), disintegration and integration (Eriksson et al., 1995), and negentropy and entropy (Neuman, 1996).

METHODOLOGICAL FRAMEWORK

The design of this study was descriptive, comparative and explorative, and both inductive and deductive research methods were used, comprising quantitative as well as qualitative analysis (Table 3). Quantitative and qualitative research complements each other because they generate different kinds of knowledge that are useful in nursing practice (Burns & Grove, 2001, p. 27). Further, they may give a varying yet complementary understanding of the phenomenon under investigation, such as social support for patients with major depression. The first and the second papers comprise descriptive (Papers I, II) and comparative (Paper II) studies and include details of patients with treatment-refractory major depression. As the patients referred to in these two papers had severe treatment problems and were suffering from the consequences of their illness, one can assume that they used different kinds of strategies to manage their daily life.

Table 3. A survey of the study (papers I-IV)

Papers	Design, aim and participants	Data collection	Data analysis
I	Descriptive study of perceived social support, social network and stressful life events among outpatients suffering from major depression (n=27) and what characterised patients who received sufficient social support and those who received insufficient social support	Sociodemographic variables Hamilton Depression Rating Scale (HDRS) Support-Q The Life Event Checklist	Statistical analysis Wilcoxon rank sum test Fisher's exact test The chi-square test
II	Descriptive, comparative study of perceived social support, social network and stressful life events among outpatients with major depression (n=40) compared with healthy volunteers (N=19)	Sociodemographic variables Hamilton Depression Rating Scale (HDRS) Support-Q The Life Event Checklist	Statistical analysis Wilcoxon rank sum test Fisher's exact test The chi-square test
III	Descriptive, explorative study of women's perceptions of coping with major depression – a salutogenic perspective N=13	Sociodemographic variables Montgomery Åsberg Depression Rating Scale (MADRS) Audio-taped interviews	Qualitative analysis Phenomenographic approach
IV	Descriptive, explorative study of men's coping with major depression in daily life with the help of professional and lay support (N=12)	Sociodemographic variables Montgomery Åsberg Depression Rating Scale (MADRS) Audio-taped interviews	Qualitative analysis Phenomenographic approach

Complex issues such as perceived availability or received social support are not easily or adequately assessed by quantitative measurement approaches and may be better assessed through qualitative research methods that allow for the analysis of interactions. It is important to describe the patient's own conceptions about how they have benefited from social support, in order to promote knowledge of how social support can facilitate recovery. Paper III and Paper IV therefore used a descriptive, qualitative approach. The focus was on conceptions of how to cope with major depression, with the help of professional and lay support.

Participants

The studies presented in this thesis were conducted over a period of eight years and included 84 participants. Characteristics of the participants are presented in Table 4.

Patient group with treatment-refractory major depression (Papers I, II)

In Paper I (n=27) and Paper II (n=40) depressed patients were recruited among patients who were undergoing a 5-day comprehensive investigation protocol for a Treatment-Refractory Affective Disorder Program at the Sahlgrenska University Hospital in Mölndal, Sweden. All patients met the DSM-IV (American Psychiatric Association, 1994) criteria for major depression. The patients were originally recruited for participation in the Treatment-Refractory Affective Disorder Program at the Sahlgrenska University Hospital in Mölndal, Sweden. The patients had been referred to this research unit by open-care psychiatrists from an area in the southwest of Sweden due to severe treatment problems and were defined as treatment-refractory depressed. The definition of treatment-refractory depression used in these studies was two or more full-dose pharmacological antidepressants with different pharmacodynamic profiles, in adequate dosages generally associated with treatment response, and with a treatment duration of at least six weeks for each drug. The investigation included medical history, physical, neurological, and psychiatric examinations, as well as laboratory tests and a psychosocial examination. In Papers I and II, special attention was paid to social support, social networks and stressful life events. The degree of severity of depression was evaluated by Hamilton Depression Rating Scale scores (Endicott, Cohen, Fleiss, & Sarantakos, 1981) and was diagnosed by the same board-certified psychiatrist (HÅ). The patients were included consecutively in the studies. Twenty-seven of the 40 patients in Paper II were included in Paper I.

Criteria for inclusion

- Patients meeting the criteria for major depression in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994)
- Age ≥ 18
- Understanding of written Swedish
- Patients neuroleptics- or antidepressant-free for at least two weeks prior to examination

Criteria for exclusion

- Patients suffering from diabetes, multiple sclerosis, Parkinson's disease, stroke or other neurological diseases (such as dementia), paralysis, brain infections, alcohol or narcotics dependence within the previous 6 month-period, cramps, epilepsy, episodes of unconsciousness, shivers, tremors, disturbance of balance, confusion or psychiatric disorders other than depression.

Healthy volunteers (Paper II)

The adult volunteers lived in the community and were recruited by means of newspaper advertisements. They were screened for depression using the DSM-IV criteria for depression. Nineteen volunteers were included and underwent a two-hour comprehensive assessment protocol including neuropsychological tests (Degl'Innocenti, Ågren, & Bäckman, 1998) as well as assessments in relation to social support, social network and stressful life events.

Criteria for inclusion

- Age ≥ 18
- Understanding of written Swedish
- Patients neuroleptics- or antidepressant-free for at least two weeks prior to examination

Criteria for exclusion

- Patients suffering from diabetes, multiple sclerosis, Parkinson's disease, stroke or other neurological diseases (such as dementia), paralysis, brain infections, abuse of alcohol or narcotics dependence within the previous 6-month period, cramps, epilepsy, episodes of unconsciousness, shivers, tremors, disturbance of balance, confusion or psychiatric disorders (such as depression).

Informants who had been hospitalised for major depression (Papers III, IV)

The informants consisted of men (N=12) and women (N=13), who lived in the community and who were strategically chosen in order to obtain a variation (Fridlund, 1998; (Patton, 2002) with regard to age, cohabiting, living in a rural or an urban area, education, number of children, and number of admissions to psychiatric departments for treatment of major depression (Table 5). The degree of severity of depression was evaluated by the Montgomery Åsberg Depression Rating Scale (MADRS) (Montgomery & Åsberg, 1979) and was diagnosed by board-certified psychiatrists in the psychiatric departments involved.

Criteria for inclusion

- Patients diagnosed as suffering from major depression in accordance with DSM-IV (American Psychiatric Association, 1994)
- Hospitalisation at some point in time between 1997-1998 in either of two psychiatric departments serving a geographical area with about 275 000 inhabitants in a county in the southwest of Sweden.
- Age ≥ 18
- Able to understand and speak Swedish

Criteria for exclusion

- Hospitalisation for less than two twenty-four-hour periods
- Diagnosed psychiatric disorders coexisting with major depression in accordance with Axis I or II diagnosis within DSM-IV (American Psychiatric Association, 1994).

Table 4. Gender, mean age and cohabiting (expressed as a percentage) of the participants appearing in the papers included in this thesis

	Men/Women N	Mean age (range)	Co-habiting %
Study I	14/13	48 (22-71)	59
Study II	18/22 9/10	48 (22-75 51 (21-70)	60 79
Study III	0/13	42 (28-63)	62
Study IV	12/0	48 (28-65)	59

Table 5. Sociodemographic data and number of previous admissions to hospital due to major depression, of informants in Paper III and IV

Variables	Paper III Female	Paper IV Male
Age (years)		
mean (range)	42(28-63)	48(28-65)
18-34	2	2
35-44	6	2
45-65	5	8
Marital status		
partner	8	7
no partner	5	5
Place of residence		
urban	9	8
rural	4	4
Education		
elementary school	4	3
upper secondary school	3	2
college/university	6	7
Number of children		
none	0	4
1-2	10	5
≥3	3	3
Number of previous admissions		
1	4	6
2	6	4
≥3	3	2
Occupation at the time of the interview		
paid employment	11	10
pension	2	2

Data collection

The quantitative studies (Papers I, II)

The data collection methods used in Papers I and II were face-to-face semi-structured interviews in order to measure the patient's social support, social network, and stressful life events.

Interviews

The interviews were conducted in a quiet room or office, and sufficient time was allowed for the uninterrupted completion of questionnaires. The interviews with the patients lasted 1 to 2 hours and were conducted by a mental health nurse (KD) on the ward on the afternoon of the patient's third day at the diagnostic unit. The interviews with the volunteers in Paper II lasted 15 to 30 minutes and were carried out at the psychiatric research unit. The volunteers received monetary compensation for their time.

Instruments

Depression measure

The degree of severity of depression was measured with the clinician-administered Hamilton Depression Rate Scale (HDRS) (Endicott, Cohen, Fleiss, & Sarantakos, 1981). The HDRS was extracted from the Schedule for Affective Disorders and Schizophrenia (Endicott & Spitzer, 1978). In all, 17 items were rated, with a total score of 52. A HDRS score of 6 or less may be considered to define non-depression or recovery, a score of 17 is used as a cut-off point for admission to out-patient drug studies, and over 25 is used for in-patient drug studies (Endicott et al., 1981). The instrument was designed for use with patients already diagnosed as suffering from affective depressive disorders.

Social support and social network

An 11-item semi-structured instrument was used to estimate the person's social support and social network. The instrument was extracted from The Support-Q (Fridlund, 1997; Fridlund, Stener-Bengtsson, & Wännman, 1993), originally designed as a 24-item questionnaire about social support, social networks and progressive heart disease. The four components of social support (emotional, instrumental, information, or appraisal) were described to the patients, and they were then asked if they felt that they had received sufficient social support. Those who answered in the negative were asked to state what types of support they lacked, and what type of support they valued most. To determine a patient's social network, the interviewer asked whether the person considered that they received social support from a sufficient number of people. Further questions included the number of family members (partner, parents, children, siblings, and grandparents) and other significant persons (other relatives, friends, and professionals) who provided social support. The frequency of face-to-face or telephone contact was recorded. The final questions identified the person offering the best support (family member or other person), and whether the person had a confidant or not. Content and construct validity of the original instrument was satisfactory (Fridlund et al., 1993). As the instrument includes different types of scales, the number of observations in this study is too small for reliably testing the instrument.

Stressful Life Events

The Life Event Checklist adopted from Paykel & Brown and published in the Life Chart Method and Manual (Leverich & Post, 1993) was used as the basis for a semi-structured interview. The instrument was translated and tested in Swedish (Dencker, unpublished data). The checklist contains 20 life events, which were grouped into the three categories recommended by Paykel (1983); independent life events (4 items), dependent life events (15 items), and personal illness (1 item). An independent life event occurred without the person's possible complicity and was unlikely to have been brought about by any illness. In this questionnaire the independent SLE included the death of spouse, close family member, close relative, and close friend; as well as serious illness among close family members. A dependent life event was caused by the behaviour of the individual, or might be a consequence of the depression. In the questionnaire, the dependent life event included major financial problems, business failure, loss of job, unemployed > 1 month, retirement, negative change in work situation, new type of work, demotion, separation and/or divorce from spouse or partner, increased arguments with spouse (or partner), increased arguments with resident family member (other than spouse), separation from significant other, lawsuit, and change of residence. Personal illness includes the recurrence of the depression or some other illness, that impairs the capacity and function.

For each undesirable life event during the past 12 months, the following questions, to be answered with a yes/no, were asked: Was the event unanticipated, uncontrollable and perceived as a long-term threat, and did it lower his/her self-esteem. The yes-scores on each item were used to form a *subjective* measure of the negative/stressful impact of the life event, with scores ranging from 0 (no impact) to 4 (severe impact). To form an *objective* measure, ratings were made by the interviewer with scores from 0 (no impact) to 4 (severe impact), as suggested in the Life Events Checklist Manual. In an attempt to quantify a measure of the subjective impact, we selected the patient's subjective measure that equalled his/her highest score on one single life event. The same applied to the objective measure. The internal consistency of the Life Event Checklist measured by Cronbach´s alpha, was 0.65 (Paper I) and 0.76 (Paper II).

The qualitative studies (Papers III, IV)

To obtain a complementary knowledge of how men and women cope with major depression in daily life with the help of professional and lay support, an inductive, qualitative, and phenomenographic approach was chosen, using interviews as the data collection method.

Description of qualitative approach

Phenomenography is a process of describing various specific phenomena as they appear to and create meaning for individuals. Its area of application has been applied within healthcare issues (Barnard, McCosker, & Gerber, 1999; Hansson Scherman, 1994; Mårtensson, Karlsson, & Fridlund, 1997; Mårtensson, Karlsson, & Fridlund, 1998; Sjöström, 1995). The approach has been described by Marton (1981) as "research which aims at descriptions, analysis, and understanding of experiences" (p.180). Phenomenography is a distinct approach to qualitative research and is different from phenomenology, even though they both aim to make human experiences and awareness an object of research. Phenomenography is less interested in individual experiences than in emphasising collective meaning.

The phenomenographic research approach emphasises the reflective rather than the prereflective experience, and instead of a first-order perspective, in which the world is described as it is, phenomenography aims to describe the world as people experience, explain and understand it, i.e. from a second-order perspective. Phenomenographers seek to discern patterns of experiences in nonnumeric language and to describe similarities and differences in the way people understand or ascribe meaning to them as well as their conceptions of the surrounding world (Svensson, 1997). The emphasis is on how things appear to people in their world, the way in which people explain to themselves and others what is going on around them, and how these explanations change.

When seeking to describe experiences, an informant will express two levels of understanding (Marton, DallÁlba, & Beaty, 1993). These levels of understanding are referred to as the informant's internal and external horizons. The internal horizon consists of the characteristics of phenomena, which are based on conceptions that are both clear and accepted and which are delimited in relation to related parts of a concept. The external horizon is on the periphery, where explanation and ideas become unclear or vague and understanding is often pre-reflective. The goal of phenomenographic analysis is to distinguish separate vital categories based on a number of observers' dissimilar conceptions of the same phenomenon. The final categories should optimally not overlap each other.

Interviews and procedure

The interview was reflective and emphasised the need for sensitivity to the way in which each informant delimits the study object, yet it was both explorative and directive in its approach and ambition. The researcher wants the interviewee to reflect on his or her experience of the phenomenon under study, in order to understand the individual meaning of his or her experience of a phenomenon (Entwistle, 1997). One test interview was conducted to probe the relevance of the interview as well as the concordance in relation to the aim of the study. A letter was sent to each potential informant, including a brief account of the study and the information that participation was voluntary, that they could withdraw at any time without giving any reason and that this would not affect their future nursing and/or medical care. It was emphasised that the informants could express their views freely and that no one, with the exception of the author, would have access to the audio-taped interviews. The informants were then contacted within a week (IS) to agree a convenient time and place for the interview. The interviews were performed in a place chosen by the informants themselves, and the author of this thesis conducted all the interviews.

Interviews were undertaken with the assistance of predetermined entry questions, which were included in order to assist the informant in reflecting on how to cope with major depression based on his or her experiences. The interview guide consisted of the following questions, which were asked in a conversational style: What does being "free of depression" mean to you? What helped you recover from the depression? How do you view your chances of remaining well in the future? How would you like your family and friends to support you to stay well? How would you like the healthcare professionals to support you to stay well? Where appropriate, each person was invited to explain further his or her understanding, and examples were requested in order to clarify the language and intent of the informant. Questions such as, Could you explain this in more detail? or Could you give an example? were necessary and useful prompts when the explanation was unclear or when the interviewer did not understand what the informant was trying to say. To achieve the goal of the interview, the interviewer was required to adopt a relaxed and friendly interview style and to show a genuine interest in what the person had to say.

All the interviews in Papers III and IV were conducted from November 1999 to April 2000. The interviewer had never met any of the informants previously. The interviews were alternated between the twenty-five men and women, and all the data collection was performed before the analysis started. The interviews were audio-taped and transcribed verbatim by the author and two secretaries. Each interview in Paper III lasted between 29 and 85 minutes (mean 55 minutes), and the total transcribed text amounted to 208 double-spaced pages. The interviews in Paper IV lasted between 20 and 75 minutes (mean 50 minutes), and the total data amounted to 208 double-spaced pages.

Depression measure

The degree of severity of the depression was evaluated with The Montgomery Åsberg Depression Rating Scale (MADRS) (Montgomery & Åsberg, 1979). The MADRS was constructed to measure depression and to be particularly sensitive to treatment effects. It consists of 10 items and its range is between 0-60. A MADRS score of 8 or less may be considered to define non-depressed or recovered individuals; 18-22, mild depression; 22-28, moderate depression; and >28 severe depression. The interrater reliability ranged between 0.89-0.97 (Montgomery & Åsberg, 1979). A validation of the MADRS against HDRS showed a correlation of 0.70 (Montgomery & Åsberg, 1979).

Analysis

Statistical analysis (Papers I, II)

Non-parametric methods were used when analysing nominal or ordinal data, as the samples were small and not considered to be normally distributed (Altman, 1996). The Wilcoxon rank sum test was used for comparisons within (sub)groups, comparisons of age, HDRS, number of SLEs, number of independent SLEs, number of dependent SLEs, number of SLEs that included personal illness, number of family members in the network, and number of others in the network. Fisher's exact test was used to test cross tabulation statistics for group comparisons regarding gender, having a partner, having a confidant, perception of having a sufficient number of persons in one's network, and being best supported by family members. To test differences in proportions, for example on single items, Chi-square tests were used to compare the subjective and objective negative/stressful impact of SLEs, and frequency of contacts. Consistently, a p-value of less than 0.05 was regarded as statistically significant, and all p-values were two-tailed. The statistical software used for this thesis was SPSS 7.5.

Analysis of the interview texts (Papers III, IV)

The analysis was carried out in a gender-specific way, in Paper III for the women and in Paper IV for the men. The analysis followed the guidelines by Marton et al. (1994; 1993) in its description of the experiences of the phenomenon in terms of qualitative variations. Initially, the author and one of the supervisors (BF) read each transcribed interview text as open-mindedly as possible, in order to acquire an understanding of the texts in their entirety. The texts were reread several times, in order to identify statements describing each informant's salutogenic statements. After having worked through each interview individually, the descriptions from the different interviews were compared with each other. After careful analysis, a total of 188 descriptions, which were directly related to the aim of the studies, were obtained from the female informants in Paper III and 267 descriptions from the males in Paper IV. Saturation of the conceptions was reached following analysis of 10-11 (Paper III) and 9-10 (Paper IV) interviews.

In the second phase, the descriptions were analysed and categorised into conceptions of similarities and differences between the ways in which the phenomenon appeared to the informants and, in the third phase, they were grouped into adequate patterns in order to obtain an overall picture of the conceptions. In the fourth phase, the focus of attention was shifted from the relations within the conceptions to the relations between the categories, in order to establish the critical attributes of each category as well as the features distinguishing the categories. In this way, through the interaction between the whole and the parts, a set of descriptive categories was developed and formed a part of a further whole, which is related in the form of a common structure, called the outcome space.

The transitional analysis

In order to describe the movement experienced by men and women, when recovering from major depression (Papers III, IV), a deductive reasoning was developed, based on the interviews with the men and women. A transition perspective inspired by Meleis et al.'s (2000) theoretical framework facilitated the development and reflected the gender diversity in the movement from illness to health as well as other patterns of transition based on the informants' experiences.

Ethical considerations

The ethical issues in this thesis have been considered in the light of the guiding principles of the World Medical Association's Helsinki Declaration 2000 (WMA, 2000) and through following the guiding ethical principles of the Swedish Medical Research Council, which comprise the principles of respect for autonomy, beneficence, nonmaleficience and justice (The Swedish Medical Research Council, 1996). The studies reported in Papers I and II were approved by The Ethics Committee of the Medical Faculty of Göteborg University, Sweden (GU 46-94), and in Papers III and IV by the Ethics Committee of the Medical Faculty, Lund University, Sweden (LU 395-97).

FINDINGS

The most important results from the various studies are presented in the following section, and the overall results are presented in Papers I-IV respectively.

Perceived social support, social networks, and stressful life events in patients with major depression (Papers I, II)

Nearly every other patient ($p<0.04$) (Paper II) and one out of every three patients in Paper I ($p <0.001$), the majority of whom were women, felt that they had insufficient social support. Among the volunteers (Paper II), one man and two women out of 19 persons reported that their level of social support was insufficient. Among those who perceived that they received insufficient social support (ISS), the component of emotional support was most often lacking (Papers I, II).

Patients who experienced insufficient social support reported that the number of persons in their network was insufficient ($p<0.003$) and that they were females ($p<0.02$) (Paper I). The analysis showed significant differences with respect to having a confidant, as all members of the healthy volunteer group had a confidant, while in the patient group this figure was 55 % ($p>0.001$) (Paper II).

An interesting result was that the perceived ideal number of people in one's network did not differ between the depressed group and the healthy volunteers, whereas the actual number of people in the network did (Paper II). The patients had fewer people, especially relatives, in their networks ($p<0.001$) as well as less frequent telephone contact with these people compared to the healthy volunteers ($p<0.01$). The patients had the same number of family members, although they had less frequent face-to-face contact with them compared to the volunteers ($p<0.006$) (Paper II) (see Table 6).

Table 6. Social support and social network in patients with major depression (n=40) and in healthy volunteers (N=19) (paper II)

	Patients (n=40)		Volunteers (n=19)		
	n	%	n	%	p-value
Perceived sufficient social support	22	55	16	84	**0.041**
Perceived sufficient number of people in the network	21	53	15	79	0.085
Best support from family members	31	78	14	74	0.753
Having a partner	24	60	15	79	0.239
Having a confidant	22	55	19	100	**0.000**
Females	22	55	10	53	1.000
	Mean	SD	Mean	SD	p-value
Number of family members in the network	4.2	2.2	5.0	2.0	0.203
Number of others in the network	11.4	8.1	24.3	10.4	**0.000**
Age	47.0	13	51	14.4	0.372
Depr score*	17	6.5			

* Hamilton Depression Rating Scale (Endicott, 1981)

Patients with major depression had experienced a larger number of both dependent SLEs and life events, including personal illness, compared to the healthy volunteer group ($p<0.001$) (Paper II). However, there were no differences in the number of independent SLEs. The level of stress measured both subjectively and objectively also differentiated the two groups. The patient group had experienced a higher level of stress due to dependent SLEs ($p<0.01$) as well as personal illness ($p<0.001$) than the volunteer group (Paper II). As can be seen in Table 7, the most significant dependent SLEs in the patient group were an increased number of arguments with one's partner ($p<0.02$) and with family members ($p<0.05$) (Paper II).

Table 7. Stressful Life Events in patients with major depression (n=40) and healthy volunteers (n=19) (paper II)

	Patients (n=40)		**Healthy volunteers (n=19)**		
Independent events	n	%	n	%	p-value
Death of a spouse	0	0.0	0	0	
Death of a close family member	4	10	3	15.8	0.553
Serious illness among close family members	9	22.5	2	10.5	0.255
Death among close friends	6	15	1	5.3	0.325
	Mean	SD	Mean	SD	p-value
Total number of independent SLEs	0.5	0.6	0.3	0.5	0.306
Subjective negative impact of independent SLEs	0.2	0.6	0.2	0.4	0.908
Objective negative impact of independent SLEs	0.0	0.3	0.0	0.2	0.752
Dependent events	n	%	n	%	p-value
Major financial problems	6	15	0	0	**0.077**
Business failure	9	22.5	1	5.3	0.102
Loss of job	4	10	0	0	0.224
Divorce	0	0	0	0	1.000
Separation from spouse	2	5	0	0	0.326
Unemployment longer than 1 month	1	2.5	0	0	0.491
Demotion	1	2.5	0	0	0.491
Lawsuit	0	0	0	0	
Increased arguments with partner	9	22.5	0	0	**0.026**
Increased arguments with family members	7	17.5	0	0	**0.054**
Separation from significant other	10	25	1	5.3	0.071
Retirement	4	10	2	10.5	0.491
Detrimental change in work condition	2	5	0	0	0.326
Starting a new type of job	4	10	1	5.3	0.491
Change in residence	5	12.5	1	5.3	0.224
	Mean	SD	Mean	SD	p-value
Total number of dependent SLEs	1.4	1.4	0.2	0.4	**0.001**
Subjective negative impact of dependent SLEs	1.2	1.7	0.2	0.6	**0.014**
Objective negative impact of dependent SLEs	0.8	1.2	0.1	0.5	**0.021**
Personal illness	n	%	n	%	p-value
Personal illness	26	65	1	5.3	**0.001**
	Mean	SD	Mean	SD	p-value
Total number of personal illnesses	0.7	0.5	0.0	0.2	**0.001**
Subjective negative impact of personal illness	1.7	1.9	0.1	0.5	**0.001**
Objective negative impact of personal illness	1.1	1.3	0.0	0.0	**0.001**

Men's and women's conceptions of being free from major depression (Papers III, IV)

Two aspects of a conception are often distinguished within phenomenographic analysis, namely a what-aspect and a how-aspect. The what-aspect is a prerequisite for the meaning that is the basis of the conception, that is the how-aspect. The what-aspect and the how-aspect are mutually dependent upon each other and cannot be separated. One cannot precede the other. In Papers III and IV, the question: "What does being free from depression mean to you?" was asked during every interview session. Analysis of the answers to this question in relation to the whole context dealing with what the women meant by being free from depression, resulted in three categories: *to be independent, to interact with one's surroundings* and *to be present* (Paper III). The same procedure was carried out for the men. Three categories were created: *to take responsibility, to be free to make choices* and *to express oneself* (Paper IV).

Women´s conceptions of coping with major depression in daily life, with the help of professional and lay support (Paper III)

Four descriptive categories were created from the interviews with the women. The category *to heal oneself* described how the women needed space to recover and to obtain that which they had previously denied themselves. They made themselves and their needs visible, which boosted their self-reliance. In the category *to manage,* the women perceived that having their own strategies would help them to become healthy and to find new resources within themselves during the process of transition. The movement towards transition gave them the power to use their inner strength to make new choices, in turn resulting in enhanced self-reliance. The category of *receiving social support* described how the women perceived the encounter with other people as vital. Having somebody in whom them could confide and talk to about their feelings was perceived as a support, helping them to better understand themselves. Through this support, the women experienced being unburdened, and it also increased their knowledge about the disease and how to deal with it. The category of *finding a meaning* described how the women were able to place their experiences of being depressed into a further perspective, resulting in an increased sense of meaning in their future life. This led to personal growth, enabling them to face the future with confidence as well as having strategies for how best to make use of their resources in the future. It was concluded that the women needed to undergo a process in order to gain both a cognitive and an emotional understanding of how to cope with their lives in order to avoid depression. This knowledge was subsequently translated into health-related actions. The process of development or growth guided the change for the woman, and both family and friends were important for the woman's reintegration into her social environment.

How men cope with major depression in daily life with the help of professional and lay support (Paper IV)

Four descriptive categories were created from the interviews with the men. The category of *being unburdened* described how the men had reached a point when they were no longer able to manage their lives by themselves and needed to be unburdened. They experienced a feeling of relief and safety when admitted to hospital, where they were allowed to rest and obtain help. The men needed active support from other people, from their family as well as from healthcare professionals, to have the strength to overcome their passive state. *To restore one's health* described how the men's reassessment of their life gave them new insights, which led to changes in their lifestyle, sometimes through their own efforts and sometimes thanks to the support of others. The category *to feel involved* described how the men placed a value on themselves in relation to their professional life. To do one's full share and take responsibility meant being involved in society and having a feeling of adequacy. In their encounters with healthcare professionals, the men valued concordance in the relationship, which had a positive influence on their trust in the treatment and care they received. The category *to find a meaning* described how the men tried to find a meaning in and accept the life they now lived. They also tried to see and reflect upon their previous life events from a new life perspective and on any restrictions in their future plans. It was concluded that the salutary benefits received from the healthcare professionals were security and continuous information provided on an individual basis. The men who had regained their health prioritised changed lifestyle goals, and they needed lay support to feel that others had faith in them and their ability to solve problems. While the men received help and support from healthcare professionals to restore their health, their *own* path to health was to regain their position in the public domain. In these efforts, it was primarily lay support (family, friends, colleagues) that was important.

DISCUSSION

Methodological considerations about the quantitative studies (Papers I, II)

In this concluding section, the strength and weaknesses of the study will be briefly commented upon. As the overall purpose of the thesis was to describe the social support, social network, and stressful life events as well as the patients' own experiences of how they used social support when trying to recover from the depressive episode, it was deemed appropriate to use both a quantitative and a qualitative approach. The research questions in each of the studies decided which method was appropriate. Both the quantitative and the qualitative approach have their strengths and limitations (Polit & Hungler, 1999; Ruth, 1991), as both approaches have different epistemological foundations. For example, quantitative studies reduce complex human experiences and capture only a limited range of such experiences. There is also a requirement for generalisation. Qualitative studies, on the other hand, emphasise the understanding of human lived experiences and involve the researcher in the interpretation and analysis of data, and thus may be regarded as subjective. While there is no "truth", there must be a balance in scientific dialogue (Ruth, 1991). In addition, each study has its limitations and weaknesses, which will be discussed below.

Papers I and II consist of interviews with semi-structured questionnaires. Within psychiatric mental health care, it has been emphasised that interviews rather than self-rating instruments are preferable due to the consequences of the illness. Interviews can be more informative and precise than self-report questionnaires, because interviewers can use probes, feedback, and cues to facilitate the respondent's recollections (Callaghan and Morrissey, 1993). Within the interview, there is also interaction between the researcher and the patient, which, if the interaction is of good quality, makes it possible to capture data more precisely. In Papers I and II, a mental health nurse (KD), familiar with interview techniques, interviewed all the patients. Two persons interviewed the volunteers, and to avoid differences in the ratings, they rated five persons together (Paper II). These inter-ratings were made in an attempt to strengthen the reliability of the data (Bowling, 1995; Paykel, 1994).

The internal consistency of the Life Event Checklist measured by Cronbach´s alpha must be seen as acceptable, as the minimum target value was 0.70 (Polit & Hungler, 1999). The reliability of the items can therefore be said to be good. As the Support-Q instrument comprised three different types of scales, there were so few observations that no reliability-test on this instrument was needed, which must be seen as a weakness of the study. However, the Support-Q instrument can be said to have construct validity, as it measured those theoretical constructs for which it was intended. The patients who agreed to complete the instrument found it comprehensible, which can be due to their perception that it measured the information that they had agreed to provide (Thomas, 1992).

Although major depression is common today, the patient groups in Papers I and II were specially selected as a result of the inclusion criteria of the treatment-refractoriness. Despite this, these patients are often seen in psychiatric outpatient settings due to the episodic and chronic nature of the illness. The patients were selected consecutively, and there were no external or internal dropouts, which was a strength of the study. All diagnoses were established in accordance with DSM-IV (American Psychiatric Association, 1994) by one board-certified psychiatrist (HÅ).

In interpreting the results, one should take into consideration the fact that the study was conducted among a relatively small and specially selected sample. Thus, the result cannot be generalised. The risk of Type I error and more especially type II error is obvious in small samples. Type I (α) error refers to the risk of rejecting the null hypothesis i.e. the researcher concludes that a relationship exists when in fact it does not. To reduce the risk of Type I error, a significance level is set, usually at 5%, which in this thesis was used for all statistical analyses. Type II (β) error refers to the risk that a false null hypothesis is accepted, i.e. the researcher concludes that no connection exists even when in fact one does. To decrease the risk of Type II errors, the sample size can be determined in advance (Polit & Hungler, 1999). A type II (β) error was suspected in Paper I with regard to a result pertaining to confidants that contradicted previous research results.

Methodological considerations about the qualitative studies (Papers III, IV)

The phenomenographic approach was chosen in order to describe men's and women's conceptions of coping with major depression in daily life with the help of professional and lay support. Safety in the data collection and analysis in qualitative studies could be ensured by means of the concepts of identification, reasonableness, trustworthiness, and conscientiousness (Fridlund & Hildingh, 2000). In phenomenographic studies, the focus is on discovering patterns of conceptions, which can be used to identify different descriptive categories. A limitation of qualitative studies is the impracticality of using large, representative samples to obtain data. However, according to some methodologists, descriptive categories can be said to apply to a wider population to the extent that the sample represents the variation of the investigated population (Marton & Booth, 1997).

To ensure that the sample accurately represented individuals suffering from major depression, the informants in the studies were chosen from among those treated for major depression in specialist in-patient care and diagnosed in accordance with DSM-IV (American Psychiatric Association, 1994). The reason for choosing the interview as method of data collection was to gain an understanding by means of dialogue of how the phenomenon under study appeared to the informants and how they explained it to themselves. The informants were strategically selected in order to capture as wide a range of experiences as possible of coping with major depression. To obtain a gender-specific perspective, the analyses were performed separately (Papers III, IV). A salutogenic approach was applied in order to obtain knowledge about how the informants coped with and recovered from major depression. The informants who had managed to recover had more experience of helpful coping strategies, which is the reason these informants are cited more often in the quotations.

Reasonableness was ensured by means of the interview guide, which was jointly formulated by the author and supervisors with comprehensive knowledge of methodology, mental health nursing, and psychiatry. The interview guide was adjusted following a pilot interview. During the interviews, there were some informants who stated that they were prepared to talk about their depression, but not from a salutogenic perspective, and the issue could in some cases be unclear. One can safely state that the informants were in the outer boundaries of their understanding, the external horizon, where their understanding and experience were immature and prereflective (Marton et al., 1993). The author had to frequently ask these informants to give examples and to further explain how they had tried to regain health. In this way, the questions functioned as instruments for obtaining clear and more detailed information as well as allowing the interviewee to get a hint of how the interviewer had understood what he or she had said. This was also how the interviewer tried to confirm her interpretation of the informant's answers during the course of the interview. In the initial letter, which was sent by post to the informant, it was emphasised that the focus of the interview should be on the importance of the help and support they had received when being treated for depression. However, the health-related questions gave the patients a chance to reflect over what the help and support had meant to them, and they certainly provided very rich material. The interviews were all individually adjusted both to the informants' discourse and to their responses to the predetermined questions.

The trustworthiness of the data collection was achieved through the fact that the interviews were conducted by one person (IS), which minimised the risk of different focuses in the individual interviews. However, each interview must be adapted to the person and the situation. All the interviews were conducted in a place chosen by the informant. However, misinterpretation of the text could arise from the fact that the author herself did not transcribe 10 of the 25 interviews. In order to avoid such a risk, all transcripts were checked by listening to the recorded interviews. Trustworthiness was furthermore ensured by the fact that there was a positive, reflective and systematic discussion between the author and the supervisors, all of who participated in the interpretation process. The supervisors brought to bear the benefits of their different specific professional perspectives on the comparisons between conceptions, categories and quotations.

The systematic handling of data ensured conscientiousness from its beginning, through the different stages, to the presentation of a clear and complete account. All the interviews were conducted alternatively with men and women in order to prevent a systematic bias caused by the interviewer's technique. During the analysis process, a continuous movement back and forth between the whole and the parts confirmed the data, as exemplified by the quotations. The integrity of the informants has been respected through obtaining their written consent to participate in the study, through the interviews as such, through the storage of the study data, and through the presentation of findings.

General discussion of the findings

Social support and social network

Social support is one variable that has received increased attention as a possible factor contributing to the observed variances in health outcomes. Although models have been developed by nurse theorists and researchers (Norbeck, 1988; Stewart, 1993; Stewart & Tilden, 1995), almost all are based on and derived from theories advanced by sociologists and psychologists. There are no new social support theories that have been generated by nurse researchers. For nurses, the interpersonal relationships and the manner in which they influence the mental health of individuals and families constitute a key concept. However, it is important to be aware of the fact that social support is an ongoing daily process that can best be studied and understood through its appearance in personal relationships. Nursing has a longstanding association with the concept of caring by means of interpersonal relationships (Chambers, 1998a; Peplau, 1988; Watson, 1985; 1996). Criticism has been levelled at the fact that focus on interpersonal relationships has been concentrated on dependent family members and on nurses regulating the capability of patients, rather than on potentially supportive social networks and lay groups that surround the patient. Perhaps now is the right time to introduce a more holistic approach, thus highlighting the patient's perspective (the emic perspective) and their conceptions of a growth-producing relationship.

Patients with major depression reported experiences of a far weaker social support than the healthy volunteers. In the patients with treatment-refractory depression (Paper II), every other patient, for the most part women, felt that they had sufficient social support. This can be compared with the healthy volunteers, 84% of whom had sufficient support. Patients with sufficient social support perceived family members as offering the best support (Papers I, II), while patients with insufficient social support perceived that people outside the family gave the best support. Hupcey & Morse (1997) and Hupcey (1998) found that social support recipients consistently chose spouses, children, family, and close friends as providers of social support and that professionals and the community were placed at the bottom of the list. Those who perceived that they received insufficient social support often lacked the emotional component of the support (Papers I, II). In the Whitehall II Study, emotional support from one's closest friend or relative was a predictor of good mental health in men but not in women (Stansfeld, Fuhrer, & Shipley, 1998). On the other hand, for women, emotional support had a beneficial effect on mental health when support came from up to four close relatives and/or friends (Fuhrer, Stansfeld, Chemali, & Shipley, 1999).

An interesting result was that the perceived ideal number of people in one's network did not differentiate between the treatment-refractory patients and the healthy volunteers (Paper II), whereas the actual number of people in the network did. The patients had fewer people, especially relatives and friends, in their networks than the healthy volunteers, and the frequency of face-to-face contact as well as telephone contact was less than that enjoyed by the volunteers. This means that the patients were as content as the healthy volunteers with how their social network fulfilled their needs. This means that there was no difference between these patients and the healthy volunteers in terms of satisfaction with how their social network fulfilled their needs A large social network is often seen as conducive to acquiring a variety of coping strategies (Lugton, 1997). However, a social network may also be a source of additional strain and stress, because some people may cause more problems and conflict, thus outweighing the benefit of their support (Simmons, 1994). One should be aware that although the samples in these papers are small, they nevertheless allow one to hypothesise in several directions. One such direction may be that the consequences of the illness decreased the patients' ability to bond with other persons, which led to a reduction in their social network over time, especially in the case of the patients who did not fully recover. Another direction could be that the patients were sufficiently content with small networks, because they did not have the ability to obtain what they really needed. This direction is the same as that of Cornelis, Ameling, & de Jonge (1989), who described it as "a premorbid lack of social matters". This could reduce the patient's ability to cope with the illness in the most appropriate way, as a wider social network increases a person's ability to cope (Lugton, 1997). Some of the differences in the network size and characteristics may be explained by the depressed person's need for a less stimulating atmosphere and reduced levels of intimacy. Hence, for some people, certain features of limited social networks may be experienced as protective and as a way to adapt oneself to the circumstances. Furthermore, the male and female informants (Papers III, IV) who had recovered from the depressive episode were more aware of which persons they wished to be a part of their social network. The informants said "no" to persons that were not good for them and instead chose other individuals who could fulfil their needs. The informants described how, during the transition stages and as a result of their changed attitudes and values, they changed their relationships as they had become much more selective about whom to talk to and made choices that excluded some former friends. These processes were complex and accompanied by grief on the part of the informants at losing old friends. However, they needed the strength to extend their network by the inclusion of new persons whom they considered valuable. Although well intended, relatives and friends sometimes responded with intrusiveness, unsolicited advice and attempts to make contact and – particularly when these efforts failed – with criticism and rejection. Low scores on measures of perceived support may represent a retreat from such destructive and painful social network interaction, which can be part of a coping process.

An important source of support to the patients came from their fellow patients as well as friends and relatives who had similar experiences of the illness. They provided both informal and emotional support and gave the depressed patient the feeling of not being alone in their situation. It has also been shown that a friend who listens and is present has a significant positive effect upon remission of the depression (Harris, Brown, & Robinson, 1999a). Recognition and confirmation of the patient from others, who share their experiences, may provide external validation. Obtaining a picture of how other persons have managed their situation provided opportunities for comparison, both downwards and upwards (Stewart & Tilden, 1995) and gave information about how to manage the situation. This highlights the benefit of support groups, where the patients can share their experiences and empower themselves (Papers III, IV) thanks to the mutual caring support provided by the group members. An interesting finding was also the informants' satisfaction at being able to provide support to other persons in similar situations, which was a positive feeling for both the male and the female informants. According to Stansfeld (1999), what a person gives in a relationship is as important for their health as what they receive from someone else.

Relationships with healthcare professionals were valued if the quality of the relationship was good. Further, the need for a holistic approach was emphasised by the patients. They needed to be seen as whole human beings and not only as "the depression" (Papers III, IV). The informants were striving for a valid relationship to help them get through the situation, someone who would listen to their problems, help them to gain understanding and to put their worries and fears into perspective. This is in line with the main core of psychiatric mental health nursing, i.e. that the quality of the relation is of decisive value (Chambers, 1998a; Peplau, 1988; Watson, 1996). If the informants did not manage to establish such a relationship within the health care system, they had to obtain it elsewhere or do without it (Papers III, IV). Also other studies (Kadam, Croft, McLeod, & Hutchinson, 2001; Wakefield, 1998) have reported that the capacity to improve mental health was limited by the mental health team's inability to intervene effectively in personal and social problems and that those patients who did not receive help with their personal/social problems were less likely to report receiving help with their mental problems.

Of the treatment-refractory depressed patients (Papers I, II), about every second reported that they had a confidant, irrespective of having a partner or not. This can be compared to the healthy volunteer group, where all had a confidant. This lack of a confidant is well supported by recent studies (Dickinson et al., 2002; Goering et al., 1992; Dohrenwend et al., 1995). Alexander (2001) reported that none of the depressed men had a close, confiding relationship. The perception of having a confidant or at least one close, confiding relationship is a strong indicator of social support (Lin & Peck, 1999). The absence of a confidant may be an indication of loneliness in the midst of the acute illness and that these patients have grave difficulties finding someone in whom they can confide their innermost feelings and experiences. This was especially true of the male informants (Paper IV), who described it as a major problem. It was often their colleagues or boss who finally drove them to the hospital because they had reached a point where they were no longer capable of coping with their life as well as having difficulty expressing their feelings. Apparently, they had no one to confide in or turn to for help in their painful situation. Furthermore, the depressive episode had caused such a strain on their family life as well as on their relationship with colleagues and others that it had led to the patient being surrounded by a highly charged negative atmosphere (Badger, 1996).

The results from the studies of patients with treatment-refractory depression (Papers I, II) suggest that women have more of a tendency to perceive insufficient support. This was probably a result of feelings of vulnerability generated by the decrease in their social network at the onset of the depressive episode. The women (Paper III) benefited from several kinds of social support at different periods of time but their social network was not sufficient to support them. Chronic environmental stress, which might involve interpersonal difficulties (Riso, Miyatake, & Thase, 2002), may produce this effect, as many people under stress continually express their distress to others, thereby driving away those who could provide them with social support (Bolger, Foster, Vinokur, & Ng, 1996; McLeod, Kessler, & Landis, 1992). Although acute stressors may mobilise social support, at least in the short term, chronic stressors may impose a heavy burden on the social network and thus erode perceived and received support over time. While support was linked to the closeness of the relationship, it was also multi-faceted. Different types and levels of support were provided at different times by different people. It is unrealistic to expect one person to provide all the necessary support. Each type of support was seen as having a place in the scheme of things and being relevant within its own context.

Stressful life events

Paykel (1997; 2001) pointed out three of the most important methodological issues concerning stressful life events. The first challenge is to assess the reliability of retrospective information. We assessed stressful life events cross-sectionally (Papers I, II) and retrospectively over a period of one year. Most recent studies have used a one-year time frame for the occurrence of events, because of the assumption that the effects of stress will be obvious within that timeframe (Holmes, 1979). Evidence to support this assumption is actually limited, and very little is known about the time lag between the occurrence of the event and perceived illness (Herbert & Cohen, 1996). It is likely that the time lag varies between different individuals and different illnesses. The second challenge is the elimination of those events that are a consequence of the depressive episode, i.e. dependent life events. Illnesses may generate events, such as loss of work, family quarrels and instability. In this thesis, the life events are grouped into three categories in accordance with Paykel (1983). This would seem to be reliable (Paykel, 2001) but it also highlights the complex problem of what appears to be events generated by personality and life style. The third challenge according to Paykel (1997; 2001) is quantification of stress. Stressful life events vary in magnitude, and simply counting their number is a poor way in which to quantify the amount of stress. In this thesis, all events identified from the interviews have been included, but only undesirable events have been used in the statistical analyses. Furthermore, all undesirable events have been subjectively judged by the patient who experienced the event. The patient estimated the extent to which the event was unanticipated, uncontrollable, had the potential to lower self-esteem, or contained a perceived long-term threat. Based on this information, the interviewer then made an assessment of the severity of the negative/stressful impact for the patient, in order to establish the correlation between the patient's rating and the objective assessment. The degree of negative impact of objectively estimated SLE was found to correlate significantly with the patient's own ratings in all groups (Papers I, II) (Paykel, 1997). This indicates that there is a common concept of stress which underlies these ratings or that certain events can always be interpreted as stressful.

The results showed that the treatment-refractory patients (Papers I, II) experienced a larger number of both dependent SLEs and life events including personal illness in comparison with the volunteer group (although the number of independent SLEs was not increased). As the patients often perceived the origin of the depressive episode in an event of personal illness, it was quite obvious that there would be differences (Paper II). There were no differences in respect of perceived sufficient social support (Paper I). Recent researchers have raised the question of whether stressful life events actually have an impact on the course of depression or, more specifically, if depressed individuals generate more negative life events (Hammen, 1991) thus leading to a recurrence? The latter hypothesis has been confirmed for recurrent depression (Harkness, Monroe, Simons, & Thase, 1999) but there are no conclusive data for chronic depression (Spijker, Bijl, de Graaf, & Nolen, 2001). It is also noteworthy that multiple events may not be separate events, but rather a cascade of one event triggering several others, e.g. depression causing loss of one's job, thus leading to financial difficulties, which in turn cause marital tension. Thus, one event can have a domino effect, in turn giving rise to three subsequent events. It was also evident that an increased number of arguments with one's partner and family members increased the level of stress (Paper II). The patients also reported major financial problems as well as separation from the significant other as stressors.

The process of transition from depression towards health

The experiences of getting through an episode of major depression served as a trigger for the men and women to change their circumstances in their lifestyle as well as for their subsequent strive towards recovery and health. The transition itself was the affirmation of a change in their health status as well as the ramifications there on their own person, their families and others in their social network. The experience of living with major depression caused a break in the structure of the men's and women's lives and affected the forms of knowledge that underpinned and gave structure to their lives. The admission to hospital constituted an abrupt change of their environment but the transition was a long-term process, involving adaptation to new roles and situations, coming to terms with the diagnosis, eventually resulting in new meanings and a sense of mastery. In the conceptual model designed to guide the research in this thesis, the transition can be seen in Figure 3. For those informants who achieved health, it was apparent that they had started a movement towards a transition, which led to a reappraisal, in turn leading to personal growth, which predicted health. However, not all the informants achieved health in the transition. Some of them were only at the beginning of the transitional phase and some were still searching for ways to start the transition. These patients expressed the need for change in their life but had no idea how to bring it about.

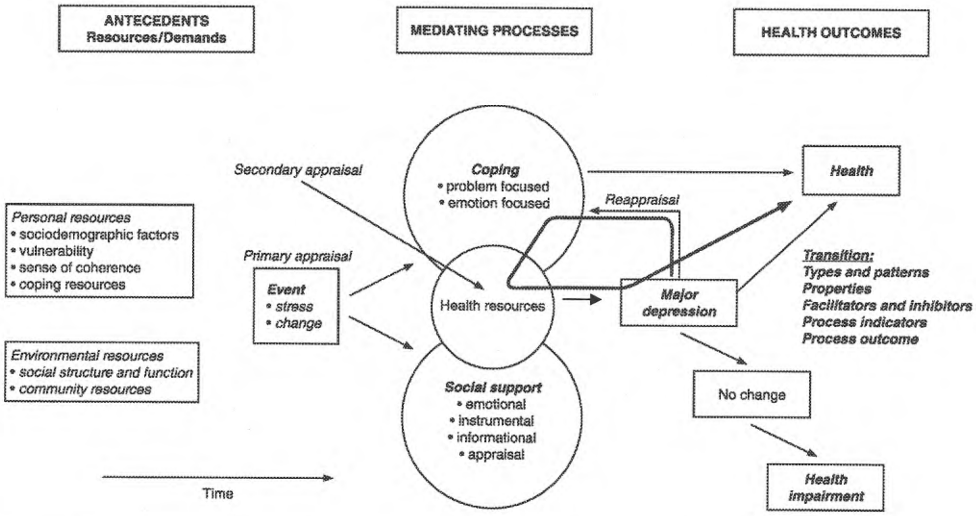

Figure 3. A conceptual model about suggested assumptions between antecedents, mediating processes and the transition in the health outcomes

Types and patterns of transition. For the informants, the interrelationships and connections of multiple transitions were interwoven throughout their conceptions. The health-illness transitions provided different experiences, such as whether it was the first time or a subsequent episode. Independently of this, they were forced to deal with the personal development and their life situation related to both their employment situation and personal relationships. Both men and women expressed that the transition comprising the relationships with significant others cost them more effort than the episode of depression itself. The care-giving transition was related to the health-illness transition for the informants, as some of them had children living at home. The male informants expressed uncertainty about their role as fathers, as they feared losing this role. The female informants struggled to maintain their role as mothers but did not express any fear of losing it. The parental role was an important incentive for recovery. Transitions are both the result of and result in changes in lives, health, relationships and environments (Meleis et al., 2000).

Characteristics of transition. For both the male and female informants, the transition involved changes in their mode of life. The male and female informants began to observe their own behaviour and to understand how it had contributed to the depression. They challenged their old values and ingrained role expectations and, when successful, this process led to increased manageability of their life. Recovering from depression was a question of making changes in one's life and in oneself as a person. To make both the transition and the change, the female informants had to take risks in trying new activities. This required a kind of *empowerment,* where the women could see themselves succeed in changing their view of their own person and their future direction. The women made choices, which they thought would improve their health, as well as set boundaries, something they had not done before, which can be seen as a statement of assertiveness and self-reliance (Peden, 1993). The men changed their work environment and could in this way *try another road*, which enabled them to avoid or minimise some of the demands made upon them. Thus, from a health perspective, both men and women could set their own health agenda, which they could implement as they saw fit (Meleis et al., 2000; Roswell, 1996).

Transition conditions: facilitators and inhibitors. For the informants, a personal transition occurred within themselves. The female informants believed in their own ability to heal themselves, and to do so they needed a *space of their own*. This space required a place as well as temporal continuity. The women had cared for other people for a long time without thinking of themselves. In her own space, the woman was allowed to be herself and had the opportunity to think about how best to meet her own needs. Although the women needed time-out, one essential goal was to return to work, as it was important to them as human beings. Even as the transition occurred within them, it was obvious that it was not an isolated, personal experience that impacted on the informants' physical and psychological health, but one that also touched the lives of their families and friends. The overall goal for the male informants in restoring their health was to find a platform where they could resume their place *in society*. They valued themselves in relation to their role in their workplace or in society. This helped them to exhibit similar behaviours to the rest of society, served as a means of reducing their uncertainty about their own self-concept, and was beneficial to family life. This was also the role that they considered a man should have in society, i.e. "making you a man" (Faludi, 1999). It was obvious that gender differences in the informants' way of thinking helped them during the recovery phases. The women wanted "a space for themselves" in order to heal themselves in their own way while the men wanted to "regain their place in society", because it made them feel valued as a human being. RaskEriksen (1996) studied how men and women managed their lives after the diagnosis of cancer and found gender differences. The men intended to stay at work as long as possible and to return to work as soon as they could and focused on "home life" only when they were incapable of working. The women in RaskEriksen's (1996) study had much longer sick leave than the men and were much more oriented towards relations and family life. Studies based on sick leave figures in Sweden for patients with depressive disorders have found that men's sick leave lasted longer compared to women, although women had a higher frequency of sick leave (Hensing, Alexanderson, & Bjurulf, 1996; Hensing, Brage, Nygård, & Sandanger, 2000). Looking back at the informants' process of recovery in this thesis, there may be different ways for men and woman to facilitate the recovery process.

The informants' perception of the quality of the support they had received appeared to be contingent on the relationship that the informant had with the nurse/doctor. Seeking professional help was often a reluctant act, frequently done as a result of spousal/family pressure as well as encouragement from their colleagues and superiors at work. As the male informants reported that they suffered from a lack of initiative while in hospital, they needed much more *active* help and support from family and most especially from healthcare professionals in order to become motivated. It is important that nurses meet patients in such a way that they feel welcome, invited by the nurse to participate in a caring relationship. Otherwise the healing process may be delayed or aborted (Eriksson, 1997a; Roach, 1992). Severinsson and Lützén (1999) emphasised that nurses should take the responsibility for creating a deeper relationship with patients in order to obtain in-depth knowledge about the individual patient's wishes and needs. Lindström (1995) points out that patients wish to encounter carers, who clearly invite them into a relationship, and who articulate their caring by actively, seeking out the patient and being present in the most difficult situations.

A sense of participation was achieved when the male informants had a feeling of *concordance in the encounter* with the healthcare professionals, which gave them confidence in the treatment. The women wished *to be seen* and to be acknowledged as a whole person and not just as a medical case. When the women were treated as a whole person, they dared to trust themselves more, which, in turn, increased their self-reliance. For both the male and female informants, it was important that their illness or symptoms were taken seriously and that they were treated as equals, whose needs were considered important, that they were involved in decision making, choices and able to talk freely about their wishes as individuals. This is highlighted in Herbert and Erikssons's (1995) study, which found that patients had much wider and holistic concepts of health than the nurses who were caring for them. Liaschenko (1998) argued that the focus on the whole person involves recognition that patients are more than the mere disease or illness. To be seen as a whole person also meant that the women requested treatment methods not always available in the Swedish healthcare system. Olfson, Zarin, Mittman & McIntyre (2001) reported that depressed women had less opportunity than men to discuss their treatment preferences with their psychiatrists, and they also received less adequate help to select an effective treatment method.

To have and to establish *confirming* relations were valuable for both male and female informants. Being told by the healthcare professionals that they were not crazy and that they would recover gave them the strength to struggle through their pain and predicted an end to their suffering, which inspired a sense of hope. The informants believed in their capacity to recover if they gained the strength to struggle through their pain and if they were able to enter into a caring relationship (Kasén, 2002), which allowed them the possibility of being confirmed. The importance of being confirmed has been described as "the greatest single factor ensuring mental development and stability" (Watzlawick, Bavelas, & Jackson, 1967, p.84). The confirming relationships helped to develop skills and behaviours necessary to manage the new situation. Nurses could, through communication and dialogue, enter the world of the patients or the relative in order to understand their suffering. It is through communication that nurses convey confirmation or disconfirmation to the patient (Killingmo, 1994). A person develops through a good relationship, in which the patient is allowed to be as he/she feels at the moment. The characteristic of expert caring is to be able to create a healing power through engagement and confirmation (Benner, Tanner, & Chesla, 1996). What was important was the quality of the contact. Numerous research findings have stressed the importance of a well-functioning relationship to create qualitative care (cf. Benner, 1984; Benner et al., 1996; Watson, 1985). Such a relationship allows the patient to recover and to be a part of, as well as co-operate in, the process, and to strive towards health (Watson, 1979).

It was obvious that the informants needed support during the transition phase. The women approached friends or relatives, who helped them by providing guidance and *support.* Social support could consist of practical help until the woman was ready to resume command of her own life. If the female informants did not get the required help from the healthcare professionals, they approached other people, such as the family physician, counsellors, or even staff at the Job Centre. These findings are consistent with Steen (1995), where the women nurtured themselves and shored up their support systems in order to obtain the support they required to recover. Other important support came from their fellow patients and from support groups, who could share their experiences with them. Confirmation from others with similar experiences may provide external validation of these experiences.

Adequate *information* about the depression and its consequences helped the male informants to distance themselves from a feeling of personal failure. Information provided to their family about the illness helped to alleviate the confusing situation. The information also inspired hope, which gave the informants a sense of reassurance throughout the rehabilitation. Hope is an active component of coping, since it comprises two alternatives of handling the loss of health; restored or compensated health (Lazarus, 1991). The importance of access to information from healthcare professionals as well as from newspapers, brochures and books is well established in the literature (Peden, 1994; Schreiber, 1996; Steen, 1995). Information promotes identification, validation, and insight into important aspects of a person's life. For the vast majority of lay people, the media constitute one of the most important sources of information about health and illness (Lupton, 1999).

Process indicators. *Being part of a fellowship* with other people was one way to create a platform in one's life for testing new roles. This necessitated an examination of their closest relationships, which could be a complex process. The intra-psychic changes brought about the need to reflect on life goals, existential meaning and the nature of one's roles and attachments, which had consequences for the informant's social network and prevented them from maintaining some of their previous relationships. During this process, they felt sad at losing some of their old friends. The process also led to an extension of their social network, in order to fulfil their new needs. The re-examination and alteration of interpersonal roles can foster more creative, valued and engaged relationships (Aldwin & Sutton, 1998). The informants' *own resources* and *personal strategies* helped them to manage the depression. They paid greater attention to their mood, analysed why they felt in a particular way and made conscious choices to change their situation, often through some kind of activity such as walking, jogging, meditation etc. It is well-known that such strategies reduce physical reactions to stress as well as creating a sense of well-being (Babyak et al., 2000; Bagby et al., 1999; Benner & Wrubel, 1989; Murphy, Carney, Knesevich, Wetzel, & Whitworth, 1995). The women talked about their situation with other people in whom they had confidence, such as healthcare professionals and/or lay persons. For the women, one benefit of talking to healthcare professionals was not having to burden their friends with their problems to the same extent and receiving honest feedback, which is a prerequisite of self-development.

Much of the power of talking may lie in helping or supporting the informant to express their experiences verbally, as putting experiences into words has the effect of containing or shaping an otherwise diffuse experience. Talking about distressing experiences had several positive effects on the informants, such as having the opportunity to express their feelings and alleviation of their suffering (Pennebaker, Mayne, & Francis, 1997; Rehnsfeldt, 1999). If the nurse has the ability to contain the informant's emotions, it is likely that the person will feel 'held' and accepted as he/she is. The experience of suffering that is shared and contained by another is probably less frightening. The 'containing ability' promotes the nurse's ability to actually see the other person as they are, which is of great importance (Åström, 1995).

Process outcome. The informants tried to discern how the suffering they had endured could give some meaning to their present life. The women described how they recovered from the depression by *regaining command over the everyday structure.* The informants felt confident that they could use their new skills to avoid slipping back into depression. Both male and female informants *reflected* upon former events in their lives, mostly losses, from their childhood as well as in what way these events and current stress had influenced their life. The looking back and summing up could also be about the previous possibilities they had had to realise personal and vital life goals and the ability to interact with other persons to reach those goals (cf. Nordenfelt, 1991; Tengland, 1998). They had in some way reached a consciousness (Eriksson et al., 1995) over their own inner capacity and, although the suffering was hard to handle, the informants recognised that they were, in many ways, different persons (cf. identity reformulation) (Chick & Meleis, 1986; Schreiber, 1998). The female informants were increasingly able to see themselves as a whole person, complete with inconsistencies, strengths, and shortcomings as well as able to nurture themselves without having to apologise. The male informants who had regained their health had *reassessed* their lives and adopted a changed way of appraisal in an effort to deal with their stressful condition. They had redefined their goals based on a new way of looking at themselves and others. The male and female informants had *accepted* their way of living and were able to see that the depression also had broadened their life. They had to come to terms with the vulnerable situation, and this resulted in new meanings and a sense of control (Antonovsky, 1987; Meleis, 2000). The perspective of seeking a meaning in life experiences is consistent in nursing theories (Parse, 1991; Neuman, 1995; Newman, 1994; Watson, 1985), whereby nurses listen to and validate patient stories in order to promote them on their journey towards the healing process. The male informants' *plans for the future* were rather short-term, which was their way of dealing with the fear of suffering a relapse. They tried to live in the present and took one day at a time, which can be a potent indicator of the presence of an inhibition to participation and engagement in the transition (Selder, 1989). The female informants were confident that they were capable of influencing their own future. They realised that their world had changed and accepted that it was impossible to turn back.

IMPLICATIONS

Determining what keeps people healthy and how they regain perceived health as well as how to enhance those skills is extremely relevant to health care today. In order to obtain increased knowledge of the essence of perceived illness and its social consequences, there is a need for a more holistic approach to the human being than that of detailed analysis. Supporting and guiding a person in respect of strategies to cope with the disabilities, suffering and loss that a depressive episode involves is a central part of psychiatric mental health nursing. The healthcare system is seldom the first source of help for an individual. Family and close friends are often sought out initially for advice and support. It is only when this source of help is unavailable, interrupted, or exhausted that health professionals enter the support scene.

When the patients seek help, it is vital to be on the same wavelength. This means that the nurses must create opportunities by means of mutual participation and by acknowledging the potential of the patient. It is also important that nurses communicate the fact that they have knowledge about some of the consequences of depressive illness and that they are willing to share it by responding to patients' questions and queries. It is possible to identify particular characteristics of the social networks of people with long-term psychiatric illness, characteristics that indicate limited networks and reduced access to social support. Nurses could identify signs of deficits and intervene in a timely manner to enhance the support system. It is important that the depressed person can be helped to explore and strengthen social relationships outside the therapeutic context. Support should be directed towards helping people improve their social networks and learning to cope with other social difficulties. Improved access to this kind of support requires that information regarding local self-help organisations, friendship groups, advice centres and counselling services is improved upon and made available. The way this information is given to patients is crucial. Patients need information, but they must be allowed to make their own choices about what to do with it. The findings point to the need for the psychiatric mental healthcare services to develop and use information methods that can empower the patients to make and participate in appropriate decisions.

Caring can be seen as a process that facilitates successful transition by focusing on the quality of the patient's interactive relationships with individuals who are important to them. The nurses can also help patients to recognise that stressful or relapse-inducing life situations inevitably occur and to find coping resources and strategies that help them to deal with these situations. New ways of caring can assist the rebuilding of the shattered assumptive world by providing a safe context in which individuals can reassess the world, their position and condition within it and their self-worth. It is likely that for many people, empathetic social support is a key context in which they can integrate recent events into their assumptive world (for instance for women to talk about their experiences and feelings). This process stresses the need for continuity of care, with an organisational framework that is longitudinal and multidimensional. Therefore, interventions that enhance the provision of social support are likely to aid the transition process in major depression.

It is of decisive value to involve the family and the closest friends, where appropriate, in the acutely depressive phase by giving them information and support. Attention should be paid to depressed patients' self-critical attitudes and their partners' understanding of depression, as both may contribute to the course of the recovery process. To involve and support the patient's closest social network is also a part of the recovery process for the patient. It is of decisive value that healthcare professionals inform the family, not least the children, of how to handle the situation and to allow them to participate in the care planning together with the patient. There needs to be a clinical approach that supports people in articulating their wishes, making choices about treatment, and evaluating the quality and relevance of the services they receive. It is of decisive value that the goal setting should involve a holistic view of the patient and the patient's world. The patient's participation in setting these goals can be a significant first step in regaining mastery over his or her life.

There is a need for healthcare professionals to understand the impact of gender within the mental health system and that this requires consideration of male as well as female needs. Looking back to the recovery process of the informants in this thesis, a recommendation to women is to take time-out for as long as necessary in order to fulfil their own needs and to have their "own space". In so doing, the women will probably require support from family and people around them to really benefit from their leave of absence as opposed to merely being free from their employment. For men, it would seem important to recommend a return to work as soon as possible, but not necessarily their ordinary work. Instead, they could have an important task that can be done at any time during the day and with no deadlines in order to get back on track again. In this case, the man needs support from bosses and colleagues as well as from his family to help him discover the level of demands that suits him.

Further research

There is a need for more research to identify which supporting processes motivate a person to enter the transition phase. There is a lack of knowledge about how positive events impact on health and recovery, and it would be interesting to explore positive and desirable events as reported by patients, which could facilitate the process of transition.

Furthermore, there is a need for evaluation of intervention programmes that include both psycho-educational and cognitive strategies of patient education on the subject of how to cope with major depression. Longitudinal studies are needed in order to follow the effects of such interventions on outcome of major depression over time.

CONCLUSIONS

The stages of clinically relevant depression extend from onset of depressed feelings through a depressive episode to recovery or possibly relapse and recurrence. Relationships, grounded in social processes, may be relevant, not only for the onset of depression, but also for the transition to regaining health. The findings of this thesis show that:

- Men and women with major depression perceived insufficient social support, an insufficient number of people in their network, and lacked the most valued component, emotional support.
- Men and women with major depression had fewer relatives and friends and less frequent telephone contact with them compared to healthy volunteers.
- Women were prone to perceive insufficient social support.
- One out of two men and women with major depression had a confidant compared to the healthy volunteers, all of whom had a confidant.
- Men and women with major depression were exposed to more stressful life events, especially increased arguments with their partner and family members, than the healthy volunteers.
- There are gender differences in the recovery phase, which need to be taken into account in addition to the individual treatment given to each patient.
- Women with major depression needed to undergo a process in order to gain both a cognitive and an emotional understanding of how to cope successfully with their lives. This process led to an inner re-evaluation, which changed their views of themselves and those around them. It also led to a more health-conscious use of their inner resources. The process of development or growth guided the change in the woman, and both family and friends were important for the woman's reintegration into her social environment.
- For men with major depression, the salutary benefits received from the healthcare professionals were security and continuous information provided on an individual basis. The men who had regained their health prioritised changed life style goals, and they needed lay support to feel that others had faith in them and their ability to solve problems. In order to restore their health, the men received help and support from healthcare professionals, although their own path to health was to regain their place in the public domain, and for this they needed primarily lay support.
- The transition that both men and women went through served as a trigger to change their lifestyle as well as in the subsequent strive towards health and recovery. The transition was a long-term process, which involved adaptation to new roles and situations and eventually resulted in new meanings and a sense of mastery.

Populärvetenskaplig sammanfattning

Det sociala stödets betydelse för män och kvinnor med egentlig depression. En beskrivande och utforskande studie.

Världshälsoorganisationen (WHO) beräknar att depressionssjukdomarna, jämte hjärt-kärl sjukdomar, är de stora hälsoproblemen under 2000 - talet. Egentlig depression (DSM-IV) är den största källan till arbetsoförmåga och funktionsnedsättning bland vuxna personer. Depression medför stort lidande och omfattar sociala och ekonomiska konsekvenser för både den drabbade personen, dennes familj och samhället. Varannan kvinna och var fjärde man riskerar att drabbas av depression någon gång under livet. Vanliga symtom kan vara oro, nedstämdhet, självförebråelser, sömn- och matstörningar samt kroppsliga besvär. Med adekvata behandlingsinsatser blir ca 80 % av alla insjuknande symtomfria. Dock kommer tre av fyra personer med förstagångsdepression någon gång senare under livet att drabbas av en ny depressiv episod. En del av dessa personer får allt tätare återfall och 20 procent av alla som insjuknar i egentlig depression riskerar att få leva i ett ständigt pågående depressivt tillstånd. På senare år har flera forskare kommit fram med forskningsresultat som belyser könsskillnader vid depressionssjukdomar. Detta gäller t ex skillnad i ålder för insjuknande, symtombilden, tillgång och behov av socialt stöd, rollfördelning, osv.

Orsaken till depression uppfattas idag som mångfaldig. Genetisk och biologisk sårbarhet samspelar med psykologiska och psykosociala stressfaktorer och enligt till exempel stress - sårbarhetsmodellen är depression orsakad av en kombination av individens sårbarhet, känslighet för stress och förekomst av skyddande faktorer. På senare år har man alltmer börjat intressera sig för sådana skyddsfaktorer, som hjälper personer i riskzonen att förbli friska. Det är allmänt känt att socialt nätverk och tillgång till socialt stöd är betydelsefulla komponenter för hälsa och tillfrisknande i de allra flesta fall. Socialt stöd syftar till att ge människor möjligheter till kontroll över de faktorer som befrämjar hälsa och reducerar de faktorer som orsakar sociala påfrestningar.

För personer som insjuknar i depression innebär det en förlust av hälsa och det dagliga livets skiftande krav kan vara svåra att hantera. När människor utsätts för påfrestningar försöker de med hjälp av tankar och handlingar hantera och bemästra situationen (coping). Sättet att tänka och handla är mycket individuellt eftersom det formas av personens livshistoria och påverkas av den aktuella situationen. Hur en individ hanterar sådana situationer anses ha betydelse för hälsa och välbefinnande. Individer kan ha olika förutsättningar för att hantera en påfrestande situation. En person kan förfoga över ”allmänna motståndsresurser” som kan utgöras av biologiska, materiella och psykosociala faktorer och som kan göra det lättare för människan att se på sin tillvaro utifrån ett förhållningssätt att det kommer att klara av de påfrestningar de möter.

Depressionens förlopp gör att kraven på en effektiv och holistisk professionell insats ökar samtidigt som de korta vårdtiderna gör att det sociala nätverket blir involverade i allt högre grad, både inom familjen och i arbetslivet. Det är därför viktigt att få fram kunskap som kan underlätta för den drabbade individen såväl som för dennes familj och det sociala nätverket som finns omkring. Det saknas kunskap om på vilket sätt det sociala stödet kan bidra till tillfrisknande på bästa sätt, liksom om män och kvinnor använder sig av socialt stöd på samma sätt. Det behövs också mer kunskap om på vilket sätt omvårdnad vid depressions tillstånd kan underlätta en persons tillfrisknande från depression.

Syftet med avhandlingen var att beskriva i vilken utsträckning personer med egentlig depression hade ett fungerande socialt stöd och socialt nätverk, samt vad som kännetecknade de personer som upplevde ett otillräckligt socialt stöd. Vidare har målet varit att beskriva i hur stor omfattning de har varit utsatta för stressfulla livshändelser under en 12-månaders period. Slutligen har syftet varit att beskriva hur kvinnor och män som har behandlats för depression har använt sitt sociala stöd från hälso- och sjukvården och familj och närstående vid tillfrisknandet från depression.

Personer med svårbehandlad depression (n=27; studie I); (n=40; studie II) och 19 personer (studie II) som var en kontrollgrupp, intervjuades med hjälp av frågeformulär om i vilken utsträckning de hade socialt stöd och socialt nätverk, samt i vilken omfattning de varit utsatta för stressfulla livshändelser. Resultatet visade att nära hälften av personer med svårbehandlad egentlig depression hade otillräckligt socialt stöd. Framför allt saknades den emotionella komponenten av det sociala stödet. Drygt hälften av patienterna hade en nära förtrogen att dela sina innersta tankar och känslor med, medan alla personer i kontrollgruppen hade en nära förtrogen. Patientgruppen hade färre antal personer i sitt sociala nätverk än kontrollgruppen och det gällde framförallt personer i det sociala nätverket som fanns utanför familjen. Trots att patientgruppen hade färre personer i sitt sociala nätverk var de lika nöjda som kontrollgruppen om antalet personer de hade i sitt sociala nätverk. Detta tyder på att patienterna nöjde sig med ett mindre omfattande socialt nätverk, vilket kan vara en risk då de har färre personer omkring sig som kan stödja dem att hantera livets påfrestningar. I patientgruppen jämfördes de 45 % som uppgav att de hade otillräckligt socialt stöd med de patienter som hade tillräckligt socialt stöd. De som hade otillräckligt stöd kännetecknades av att de var kvinnor, de hade för få personer i deras sociala nätverk, samt att det sociala stödet i högre grad gavs från personer utanför familjen än från familjemedlemmar. Patientgruppen hade upplevt fler stressfulla livshändelser under det gångna året i jämförelse med kontrollgruppen, framförallt hade det skett en ökning av dispyter med partnern och med övriga familjemedlemmar. Detta kan visa vilken påfrestning som depressionen ger utifrån ett familjeperspektiv.

I delstudie III och IV intervjuades 13 kvinnor och 12 män som tidigare vårdats för egentlig depression, om hur de hade använt sitt sociala stöd vid tillfrisknandet från depressionen. I intervjuerna med kvinnorna (studie III) framkom att de trodde på sin egen förmåga till att *läka sig själv*. Kvinnorna behövde utrymme för återhämtning och gjorde sig själva och sina behov synliga. Kvinnorna beskrev *egna strategier* för att hantera konsekvenserna av sjukdomen, men de kunde också hitta nya resurser inom sig själva i den förändring som de gick igenom. En viktig strategi var samtalet med både vänner och professionella. Förändringen gav dem styrkan att göra nya val vilket ledde till en ökad självkänsla. Kvinnorna kämpade för att hålla kvar sina vardagsrutiner vilket var ett sätt för dem att återfå kontrollen. *Mötet med andra männis*kor var livgivande och känslan att ha någon förtrogen att vända sig till för att få uttrycka sina känslor var ett stöd som hjälpte dem att bättre förstå sig själva. Det informativa stödet ledde till avlastning och ökad kunskap för kvinnan och hennes familj. Kvinnorna reflekterade över hur de hade levt sina liv och vad de hade förändrat och vad de ville förändra. Den erfarenhet som depressionen gav kunde sättas in i ett större sammanhang i deras liv, vilket medförde en ökad känsla av *mening* i det fortsatta livet. Detta ledde till en personlig växt som gjorde att de såg på framtiden med tillförsikt och planerade hur de skulle disponera sina resurser i framtiden. Familj och vänner, men också professionella, var viktiga vid kvinnornas tillfrisknande. Stödet fungerade både direkt i kvinnornas vardag, men var också indirekt stödjande i den utvecklingsprocess som kvinnorna gick igenom.

I intervjuerna med männen (studie IV) framkom vikten av att *bli avlastad* i den akuta situationen. Männen hade kommit till en punkt då de inte längre klarade av att hantera sitt liv själv och var i behov av att få vila och avlastning. De behövde aktivt stöd av andra personer – både inom familjen och hälso- och sjukvården - för att orka ta sig ur sitt passiva tillstånd. Stödet kunde bestå i de fick information om sjukdomen – både till sig själv och anhöriga – så att de kunde sätta sin situation i ett större sammanhang och få hopp om att tillståndet kunde gå över. För att *återställa sin hälsa* hade männen omvärderat sin syn på sig själva och sin omvärld, vilket lett till ett förändrat tänkande och nya insikter, något som också omsatts i vardagen. Detta innebar tydliga omställningar i livsföringen, ibland av egen kraft och ibland med stöd av andra. Männen gav sig själva ett värde i förhållande till sin roll i det offentliga livet. Det var viktigt för dem att göra rätt för sig och ta ansvar. Detta innebar *delaktighet* i samhället och en känsla av fullvärdighet. Männen värderade sina relationer mer kritiskt, både privat och inom vården. I behandlingen var det graden av samstämmighet i relationen som värderades. Männens tillfrisknande handlade om (strävade efter) att *finna mening* och acceptera det liv som männen nu levde i. De försökte sätta in sin egen person, samt traumatiska och andra påfrestande händelser i livet, i ett större sammanhang. Männens planer för framtiden var ganska kortsiktiga, de tog en dag i taget och försökte lyssna mer på sig själva och ägna sig mer åt det som kändes viktigt i livet. Männen behövde stödet från hälso- och sjukvårdens personal för att tillfriskna, men männens egen beskrivning av att bli frisk var att bli delaktig i samhället igen. Familj och vänner hade en viktig uppgift i att stödja detta.

För både männen och kvinnorna hade tillfrisknandet från en depression lett till förändringar och utveckling i deras liv, både på ett inre och på ett yttre plan. På ett yttre plan ändrade de sina praktiska dagliga sysselsättningar, både inom familjen och på arbetet. Men för att göra det krävdes det en inre förändring (övergång ” transition”) som innebar att de t ex förändrade sina värderingar i sitt liv. Värderingarna kunde vara existentiella till sin karaktär eller funderingar på hur de ville leva sitt liv. Konsekvenserna av att ha en depression krackelerar strukturen i vardagslivet och för att få livet att fungera igen behövdes ny kunskap som männen och kvinnorna prövade sig fram till. Övergången var en lång process, där de fick anpassa sig till sin nya roll och till nya situationer. Detta ledde så småningom fram till en känsla av mening i livet och en känsla av sammanhang.

Det är viktigt att ta hänsyn till de olika behov av socialt stöd som män och kvinnor har vid tillfrisknade från depression. Familj och närstående har en viktig uppgift i att aktivt stödja och uppmuntra den deprimerade personen och att inte lämna personen åt sig själv. Hälso- och sjukvårdens stöd till män och kvinnor med depression kan vara att ta tillvara och understryka deras egna coping strategier, samt att involvera männens och kvinnornas sociala nätverk som en naturlig del i vården men också att upprätta och bevara vårdande relationer.

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