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EXPLORING THE LIVED EXPERIENCES AND MEANINGS OF THE BODY DURING DEPRESSION

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A research report submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Arts in Community-based Counselling Psychology.

University of the Witwatersrand, Johannesburg, 2009

DECLARATION

I declare that this thesis, entitled 'Exploring the lived experiences and meanings of the body during depression' is my own unaided work. It is submitted for the degree of Master of Arts in Community-based Counselling Psychology, at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination at any other university.

Signed this _____ day of _____ 2009

_____

Althea Sherry

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ABSTRACT

Depression is predicted to be one of the largest global health burdens in the future. As such, it is important to expand the current understanding of this disorder, so as to develop more effective treatments. While somatic symptoms are being increasingly recognised as important, one area that has received little attention, is that of the lived somatic experiences in depression and the psychological meanings behind these. This study aimed to contribute to this by utilising a qualitative approach. Interviews were conducted with individuals who had recovered from depression. These interviews focused on experiences at the time of depression, with an emphasis on day-to-day physical aspects. Thematic content analysis of participants' narratives revealed central themes of disconnection from the body, and a sense of lack and deprivation in relation to the body. These themes were evident in both emotional and physical experiences of depression, indicating a link between these two aspects of self. The psychological meanings behind physical experiences were explored utilising psychodynamic etiological theories of depression. These theories included Freud's theory of object loss, the theory of unmet oral dependency needs, as well as Winnicott's understanding of psyche-soma indwelling. Finally, the possibility of the body as symbolic of etiological processes in depression, was discussed in relation to existing psychodynamic literature on the mind-body relationship. The results of this research imply that there may be a relevant relationship between the experiences of the mind and the body in depression, and that physical experiences during depression may potentially be understood as symbolic of underlying etiological processes.

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LIST OF ABBREVIATIONS

Abbreviation	Full terminology
APA	American Psychiatric Association
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, 3rd edition
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision
SSRI	Selective Serotonin Reuptake Inhibitor
US	United States of America
WHO	World Heath Organisation

CHAPTER 1: INTRODUCTION

This research report focuses on experiences of the body during depression, and some of the possible psychological meanings underlying these experiences. While a large amount of research can be found on both the emotional and somatic aspects of depression, little is written on the actual lived experiences of the body, nor on the potential meanings and processes behind these experiences. This research attempts to address this area of inquiry using a qualitative study that focuses on participants' accounts of how they experienced their bodies in periods of depression. These accounts are then analysed and discussed from a psychodynamic perspective. A specific focus on experiences of the body and their link to etiological theories of depression is taken. The concept of the body as symbolically representing these etiological processes is then discussed.

This introductory chapter serves to provide background information on this study. Initially a rationale for conducting the research is discussed, and aims of this study are set out. Following this, a brief overview of the structure of the research report is presented.

RATIONALE

Depression is one of the most frequently diagnosed mental disorders, and places a large burden on both health care systems and the quality of life of the individuals who suffer from depression. The large extent of this impact indicates that further study into this group of disorders is of high relevance. Depression has global lifetime prevalence rates of around 20-25% across the full unipolar spectrum, with major depressive disorder having the highest lifetime prevalence rates (around 17%) in comparison to any other psychiatric disorder (Sadock & Sadock, 2007). A recent national health survey study in the US found that in any two week period between 2005 and 2006, 5.4% of the American population over 12 years of age experienced depression, indicating that prevalence rates may be higher than estimated (Pratt & Brody, 2008). Obtaining accurate statistics for South Africa is problematic due to a paucity of reliable sources (Tomlinson, Swartz, Kruger & Gureje, 2007) and sources seem to differ in estimated prevalence rates. Recent statistics based on data collected according to WHO guidelines indicate that lifetime prevalence of depression in South Africa to be 9.8 % (Stein et al., 2008). Previous estimated annual prevalence rates in

rural areas have been found to be as high as 17% in community epidemiological studies (Rumble, Swartz, Parry & Zwarenstein, 1996). However, it is generally agreed that depression is an area of concern within the South African context (Tomlinson et al., 2007).

Various factors in the South African context are associated with increased rates of depression, including HIV/AIDS, discrimination and social inequality, as well as poverty. HIV/AIDS is conceptualised as having a large impact on the mental health of South Africans (Freeman, 2004) and depression is often observed in relation to dealing with diagnosis (Freeman, 2004), stigmatisation (Simbayi et al., 2007), living with illness, failing health and impending death (Freeman, 2004). Those close to the sufferer are also affected by depression (Freeman, 2004), as are children orphaned by AIDS (Cluver, Gardner & Operario, 2007). South Africa's policy of apartheid and the accompanying social inequality and racial discrimination has negatively impacted on the psychological well-being of South Africans (Naidoo, 2002). Social history in South Africa can also be seen as contributing to depression, as social inequality is associated with low self-esteem and affects quality of life (Belle & Doucet, 2003). According to Chakraborty and McKenzie (2002), racism is an additional predisposing factor in the etiology of depression, as it results in psychological distress and can elicit feelings of inferiority. The widespread poverty evident in South African is also associated with depression (Havenaar, Geerlings, Vivian, Collinson & Robertson, 2008), and the relationship between poverty and depression has also been verified at an international level (Lorant et al., 2007). Due to the existence of numerous factors that trigger or exacerbate depression, this research area can be seen as valuable in the South African context.

Depression is noted to have a negative impact on individuals' lives in numerous ways. According to Murray and Lopez (1997) in a study conducted by the WHO and Harvard University, predictions of the burden of disease indicate that by the year 2020, unipolar depression will be the second highest contributor to disability adjusted life years. This implies that depression will be one of the largest contributors to a category that incorporates both years of life spent with a disability and years of life lost to premature death. According to Sadock and Sadock (2007), mood disorders are those most commonly associated with suicide, which may occur during depressive episodes. Depression is also considered to be extremely debilitating and is associated

with increased levels of physical illness (Balon, 2006) and can severely impact on recovery from illness (Simon, 2006). Pratt and Brody's (2008) survey of depression in the US found that, of those who reported experiencing depression, approximately 80% reported finding difficulty with work, maintaining a home and being socially active, thus indicating the extent to which depression impacts on individuals' daily lives. Therefore, it would appear that due to the relative impact in the future that depression is likely to have on both the quality and length of life, continuing research into depression is becoming increasingly necessary.

Within the field of depression research, somatic symptoms are coming into focus as gaining in importance within mainstream psychiatric discourses in relation to diagnosing and understanding depression (e.g. Demyttenaere, De Fruyt & Stahl, 2004; Simon, 2006). According to Henningsen, Zimmerman and Satel (2003) various reasons have been proposed for the strong link between somatic symptoms and depression. These include increased attention to somatic symptoms, as well as similar biological processes in depression. In addition to this, the conceptualisation that both emotional and physical processes may share a common underlying psychological factor, is also becoming increasingly accepted (Henningsen et al., 2003). However, this is not frequently discussed in psychiatric literature on depression (e.g. Demyttenaere et al., 2004).

The link between somatic and emotional processes has historically been part of psychoanalytic conceptualisations of the body (Meissner, 2006). An understanding of the relationship between mind and body was a central concept in early psychoanalytic literature, in relation to phenomena such as hysteria and conversion disorders (Aron, 1998). The processes of the body were also utilised to provide an understanding of psychological development, as is evidenced in Freud's (1977) stage theory. However, the focus on the body seems to have become less prevalent over time (Taylor, 2008b).

While authors such as Balamuth (1998) and Turp (1999) focus on the importance of the body in understanding and working therapeutically with clients from a psychodynamic perspective, the importance of the interrelation between mind and body seems to have been largely overlooked, and has been decreasing since the 1970's (Taylor, 2008b). Taylor (2008b) discusses how the psychological aspects of the body are again being recognised as valid in current literature, and describes how this approach is contributing to a more holistic understanding of health and illness. This

increasingly holistic viewpoint, as discussed by Taylor (2008b), appears to be leading to an upsurge of interest in the interrelations between mind and body. This approach could also have implications for disorders such as depression. However, to date, the relationship between mind and body in depression still seems to be largely neglected. Gaining an understanding of this interrelation from a psychodynamic perspective may assist in providing insight into the psychological meanings behind experiences of the body during depression.

AIMS

This research aimed to explore subjective experiences of the body during depression, and to gain an understanding of the meanings behind these experiences. Viewed within the framework of their overall experiences during depression, the intention of the research was to gain an in-depth understanding of what it was like for participants to live in their bodies at that time. Thus, the aim was to capture participants' predominant day-to-day somatic experiences relating to everyday activities, such as waking up and moving, as well as to gain an overall sense of how their bodies felt during depression. It was also intended to capture the responses to these somatic experiences in order to understand the emotional experiences in relation to the body. The study then aimed to make sense of these experiences by ascertaining what thematic concepts emerged from these experiences, and how various concepts related to one another, as well as differences and similarities across participants.

Further to this, the study intended to discern whether constructs from a psychodynamic etiological framework were present in participants' narratives of the body. Utilising psychodynamic etiological theories of depression (such as those related to object loss and unmet oral dependency needs), the study aimed to gain a more in-depth understanding of the body during depression by applying these concepts to participants' somatic experiences. A further aim was to discuss whether or not physical experiences could be seen as symbolically representing underlying psychodynamic etiological processes during depression. Given the psychodynamic understanding of the body as a symbolic expression of unconscious processes, as is seen in relation to certain somatoform disorders, this study aimed to engage in a discussion suggesting that this concept could be extended to include experiences of the body as symbolic during depression.

STRUCTURE OF THE REPORT

This research report consists of six chapters, including the literature review, research method, presentation of findings and overall discussion. The structure of this report is discussed in more detail below.

The current chapter provides an introduction to the report, and introduces the rationale behind the research and the aims of the study, in addition to detailing the structure of the report. This chapter serves to provide a brief overview of the reasons for the study and its intentions, so as to present the reader with an overall understanding of the focus of this research.

Relevant literature related to the experiences and meanings of the body during depression is covered in *Chapter 2*. The purpose of this review is to provide an overview of existing knowledge, ideas and research related to depression, and to the nature of the body during depression. The existing literature related to this topic is examined and critiqued, and existing trends are identified.

At the start of the literature review, a brief overview of depression is presented, comprising of definitions, diagnostic criteria, epidemiological information and information on comorbidity and course. Qualitative studies on the lived experiences of depression and recovery are then covered in order to give an understanding of what it is like for individuals to live with depression. Following this, psychodynamic etiological theories on depression are discussed, and existing studies relating to some of these theories are examined. Literature on the mind-body relationship is then explored within philosophical and psychodynamic contexts. The chapter then proceeds to examine depression-specific information on the mind-body relationship in both the broader field of psychology and from a psychodynamic perspective. The chapter concludes with a focus on existing trends and gaps in the literature and an identification of potential areas for further exploration.

Following on from a discussion of omissions in existing literature, the research questions that guide this study are presented at the beginning of *Chapter 3*. The methodological approach employed in this research is then elucidated so as to provide an understanding of the qualitative and interpretive methodological approach that was taken in order to answer the research questions. The procedures followed in conducting the research are then described. Details are provided about the sample, procedures followed and the use of thematic content analysis to gain an understanding of the results. Finally, ethical issues pertaining to the study are discussed, and ways in

which these issues were managed is explained.

Chapter 4 contains a presentation and discussion of the research findings. This chapter serves to present the data, utilising quotes from interview transcripts in order to provide an understanding of participants' experiences of their bodies during depression. These experiences are then interpreted and discussed so that a deeper level of understanding can be obtained. Findings are then related to existing literature to identify areas of correlation and differences. Within this chapter, findings are divided into two sections. The first covers background information on emotional experiences of depression, followed by the major section on experiences of the body during depression. In order to capture lived experiences of depression, within each of these sections, data has further been separated into central thematic categories of disconnection and lack.

A discussion of the parallels between emotional and physical experiences of depression is presented in *Chapter 5* in order to ascertain the relationship between these aspects of self. Following this, a theoretical examination of experiences of the body during depression is attempted, which aims to provide an in-depth understanding by relating these experiences to psychodynamic etiological processes during depression. A short discussion of the symbolic nature of the body in depression then concludes this chapter.

Chapter 6 is the concluding section of the report. In addition to final comments, various limitations of the study are addressed. Possible directions for future research are discussed in relation to gaining an increased understanding of the phenomenon, as well as suggestions for research into the possible application of these concepts within a psychotherapeutic context.

This chapter has provided an overview of the aims and rationale of the research, as well as providing an overview of the report. The following chapter will discuss the existing literature relating to depression and the body, in order to identify trends and omissions in existing literature.

CHAPTER 2: LITERATURE REVIEW

This review aims to provide an understanding and overview of the relevant literature relating to experiences and meanings of the body during depression. Initially, definitions, as well as diagnostic categorisations and criteria of depression are covered in order to provide a basic introduction to the field. Epidemiological information, as well as mental disorders commonly co-occurring with depression, are presented. Following this quantitative information, qualitative studies on general experiences of depression are explored in order to gain an understanding of what it is like to live with depression. The course of depression, as well as experiences of recovery are then discussed.

Psychodynamic etiological theories on depression, and their central constructs, are examined in order to provide a framework that will ultimately be utilised to provide an increased understanding of the body during depression. The central theories covered are Freud's theory on object loss (Freud, 1917), oral fixation (Freud, 1917) and unmet oral dependency needs (Fenichel, 1946) and their contributions to depression. Melanie Klein (1986) and Andre Green (1986)'s theories are also briefly reviewed.

The existence and importance of the mind-body relationship is then discussed. Initially, the general concept is considered from a philosophical perspective, followed by psychodynamic conceptualisations of how the link between mind and body functions, and how this emerges from a developmental perspective. Expressions of unconscious emotional processes via the body, as seen in some of the somatoform disorders, are then discussed.

Finally, the nature of the mind-body relationship with regard to depression-specific research is reviewed. Topics relating to the body and depression, including body image, the role of exercise and movement in treatment, somatic symptoms and somatisation are explored. This is followed by the few existing specific explorations of the relationship between the mind and body in depression from a psychodynamic perspective.

AN OVERVIEW OF DEPRESSION

Depression is a term that is utilised to refer to a mood disorder characterised by pathological feelings of sadness, despondency, and a loss of interest or pleasure in

daily life (Sadock & Sadock, 2007). Historically, instances of depression have frequently been referred to and have been acknowledged as affecting individuals over the centuries, with examples of depressive mood and behaviour being found in ancient writings such as Homer's Iliad (Sadock & Sadock, 2007). The term melancholia, which originally referred to any "madness", became associated with a habitual state of sadness in the 1800s (Berrios, 1988). The term "depression" became more common around the 1860s and referred to "a lowness of spirits" (Berrios, 1988). In the early 1900s, a recognition of melancholia as a disease of the nervous system became increasingly prevalent (Parker, 2000). During the 20th century, major debates on depression involved the differences, from a psychoanalytic perspective, between psychotic and neurotic types of depression (Parker, 2000) and distinguishing depression from schizophrenia and from bipolar disorder (Glas, 2003). With the advent of the DSM-III in the 1980s, the classification of mental disorders became increasingly based on symptoms, rather than on psychoanalytic theoretical understandings. These understandings were refined over time to the existing diagnostic categories of depression found in the DSM-IV-TR (Mayes & Horwitz, 2005). More recent diagnostic changes have included a further demarcation of unipolar from bipolar depression, and the distinction between dysthymic disorder and less chronic types of depression (Glas, 2003). Critiques indicate that current conceptualisations are still neither clear nor universal (Glas, 2003).

The DSM-IV-TR provides the commonly accepted current conceptualisation of unipolar depression that will be utilised in this study. According to the DSM-IV-TR, unipolar depression is further categorised into the major subtypes of major depressive disorder, dysthymic disorder and depressive disorder not otherwise specified (APA, 2000). Other disorders which capture a depressed mood include adjustment disorder with depressed mood, or adjustment disorder with mixed anxiety and depressed mood (APA, 2000).

A diagnosis of major depressive disorder must include the presence of at least one major depressive episode (APA, 2000). Criteria for a major depressive episode are met if the individual's mood change lasts for at least two weeks, is characterised by either depressed mood or loss of interest or pleasure and five or more diagnostic symptoms are present. These symptoms include the presence of a depressed mood for most of the day; markedly diminished interest or pleasure in activities; significant

weight loss, weight gain, decrease or increase in appetite; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or guilt; diminished ability to think or concentrate, or indecisiveness; recurrent thoughts of death, suicidal ideation or suicide attempt (APA, 2000).

Dysthymic disorder refers to a more chronic condition distinguished by a depressed mood for most of the day, for more days than not, that lasts for at least two years. Two of the following symptoms also need to be present during the depression: poor appetite or overeating; insomnia or hypersomnia; low energy or fatigue; low self-esteem; poor concentration or difficulty making decisions; feelings of hopelessness.

Depressive disorder not otherwise specified refers to disorders with features of depression that do not meet the criteria for major depressive disorder, dysthymic disorder or an adjustment disorder with depressed mood, or an adjustment disorder with depressed mood and anxiety. Some of the more common examples include premenstrual dysphoric disorder, minor depressive disorder and recurrent brief depressive episode (APA, 2000). Adjustment disorder with depressed mood or adjustment disorder with mixed anxiety and depressed mood occur, in response to a stressor that elicits distress that is in excess of what would be expected in the situation (APA, 2000).

While the DSM-IV-TR criteria provide a useful benchmark, Gotlib and Hammen (2002) discuss that the line between meeting diagnostic criteria (and not) is often arbitrary, and is not necessarily reflective of an individual's situation. In addition to this, depression may be experienced in different ways in different cultures, making diagnostic criteria controversial within these contexts (Gotlib & Hammen, 2002). Gotlib and Hammen (2002) also discuss the possibility that the concept of depression is over-simplified, and does not necessarily capture the heterogeneity of depression in reality.

Postpartum depression is a controversial topic (Gjerdingen & Yawn, 2007), as this disorder is not distinguished by a separate diagnostic category within the DSM-IV-TR. Rather, postpartum depression is captured under a diagnosis of major depressive disorder or depressive disorder not otherwise specified, and identified by an onset indicator (APA, 2000). Controversy exists in the fact that there is debate as to whether this type of depression can be differentiated from major and minor depressive

episodes (Gjerdingen & Yawn, 2007). Studies appear to reveal different perspectives, with some finding a three-fold higher rate of depression in the months following birth, indicating the need for a separate category, and other studies finding no factors to suggest that postpartum depression is different from minor or major depression. Fluctuations in hormone levels have thus far not proven any definite link between oestrogen, progesterone and postpartum onset depression (Gjerdingen & Yawn, 2007). General symptoms are the same as in other depressive disorders (Gjerdingen & Yawn, 2007) but fluctuations in mood, mood lability and a preoccupation with infant well-being are most common (APA, 2000). Currently, postpartum depression is captured in relation to depressed mood as an onset specifier for diagnosis of major depressive disorder, bipolar I or bipolar II disorder (APA, 2000).

In addition to the diagnostic criteria, other patterns of feelings, thoughts, behaviour and physical symptoms are present in depression. Feelings of tearfulness, irritability and obsessive rumination are common (APA, 2000) as are those of helplessness and/or hopelessness (Mays & Croake, 1997). Feelings of emptiness, low self-esteem, guilt and worthlessness are also prevalent (Sue, Sue & Sue, 2002). Anxiety frequently emerges, and panic attacks are common. Less satisfying social interactions are prevalent (APA, 2000), as is social isolation (Johnson, 2000), partly due to the fact that depressed individuals have emotional difficulties accessing and utilising social support (Maher, Mora & Leventhal, 2006). Problems may occur with respect to relationships, occupational problems or academic problems. Lowered work productivity is also common (Sue et al., 2002). Attempted or completed suicide is also associated with depressive episodes, and can be a significant risk (APA, 2000). A decrease in basic self-care may be present ranging from sloppy dress to a lack of basic hygiene (Sue et al., 2002).

Epidemiology and comorbidity

Depression is one of the most commonly diagnosed mental disorders (Gotlib & Hammen, 2002). Global lifetime prevalence rates for all unipolar depressive disorders is in the range of approximately 20-25% according to recent studies (Sadock & Sadock, 2007), with a 9.8% global lifetime prevalence being estimated in South Africa (Stein et al., 2008). The discrepancies between South African and global figures, as seen above, may be related to the difficulty in obtaining accurate statistics

within the South African context as discussed by Tomlinson et al. (2007). Rates of depression are generally acknowledged to be far higher in women than men, with an almost twofold higher rate in women (Marcus et al., 2005). This difference is hypothesised to be associated with differing psychosocial and biological factors (Sadock & Sadock, 2007).

Comorbidity is a common occurrence in depression, with around three quarters of those diagnosed with major depressive disorder also meeting the criteria for another disorder at some point in their lifetime (Gotlib & Hammen, 2002). Depression is frequently related to anxiety disorders, as well as substance abuse disorders (particularly alcoholism) and impulse control disorders (Gotlib & Hammen, 2002). Other areas of comorbidity that are frequently studied include personality disorders and eating disorders (Mann & Kupfer, 1993).

The course of depression

The course of depression tends to be long and to have a pattern of relapses and recovery (Sadock & Sadock, 2007). For major depressive disorder, the duration of an untreated depression is about 6 to 13 months, with the duration of a treated depressive disorder being about three months. As the course of the illness continues, more frequent episodes that last increasingly longer are commonly found, with an average of five or six episodes occurring over a 20-year period (Sadock & Sadock, 2007). According to Judd et al. (2000), depression is more likely to reoccur if there are remaining sub-threshold symptoms of depression after a first episode of major depressive disorder. Gollan, Raffety, Gortner and Dobson (2005) also note that early onset is associated with a shorter time to relapse and the experience of more residual symptoms on follow-up.

The course of major depressive disorder tends to be chronic, with recurrence in approximately 80% of individuals diagnosed with this disorder (Gotlib & Hammen, 2002). Dysthymic disorder may also emerge in people who have been diagnosed with major depressive disorder and the course of this disorder is also typically chronic, with high instances of relapse in a ten-year naturalistic follow up study (Klein, Shankman & Rose, 2006). Fava, Ruini and Belaise (2007) note that many individuals who have supposedly had successful treatment still experience remaining residual symptoms, which may be seen as indications that further relapses are imminent.

Fava et al. (2007) also examined the concept of recovery in depression. In a review of literature, they discuss that recovery is generally seen as remission of symptoms without continuing treatment. However, Fava et al. (2007) described this as an inadequate concept and included the concept of an experience of psychological well-being as an integral part of recovery from depression. Schreiber (1998) points out that much research on recovery still remains unclear, which seems relevant in light of the literature reviewed. An overall trend can be seen in the literature presented above whereby rates of recovery are discussed (Klein et al., 2006; Sadock & Sadock, 2007) and conceptualisations of the concept of recovery are discussed (Fava et al., 2007), but a clear understanding of the concept of recovery and the factors involved still appear to be lacking. Lived experiences of recovery are also frequently overlooked (Schreiber, 1998).

While figures such as those on epidemiology and recovery indicate the statistical realities of depression, they fail to incorporate any real sense of what it is like to live with depression (Karp, 1994) or to recover from it (Schreiber, 1998). To this end, lived experiences of depression and of recovery will be covered in the next section.

EXPERIENCES OF DEPRESSION

Karp (1994) and Lewis (1995) discuss the fact that although there is a great deal of information on the causes and statistics related to depression, little can be found on the experiences of living with depression.

Karp (1994) explores the transition through various phases of depression from the perspective of individuals who suffered from long-term depression and who had a history of hospitalisation. He differentiated the following phases of depression: an experience of distress; crisis; the adoption of depression as an aspect of identity; and ultimately the conceptualisation of depression as something that can be overcome (Karp, 1994). Karp (1994) attempted to provide one of the first studies which focused on gaining an understanding of what it is actually like to live with depression, and is acknowledged to have succeeded in these aims (Lewis, 1995). However, critiques of the study include its focus only on participants who had been hospitalised. This limits the generalisability of this study as it provides insight only on severe depression (Lewis, 1995).

Cornford, Hill and Reilly (2007) focused on patients' views on the significant

symptoms of depression and contrasted this to a medical model of depression symptoms. Patients focused on experiences of a loss of control and a loss of self-identity as significant symptoms from their perspective. Corford et al. (2007) discuss how this is divergent from the disease management model, which is commonly adopted in treatment of depression.

Lewis (1995) focused on experiences and meaning making in depression, with a specific focus on the impact of diagnosis on self. Receiving a diagnosis was experienced as being both liberating and pathologising for participants. Identifying a reason for depression was seen as helping individuals to understand and come to terms with their depression. Participants' reasons for depression were seen as contradictory and widely varying. These ranged from personal experiences, biological factors, hormonal issues in women, and social explanations for depression (Lewis, 1995).

A great deal of studies on the experiences of depression focused on specific groups rather than providing a broader overview. Wisdom and Green (2004) discussed teenagers' experiences of the process of depression and the various transition phases, in a similar way to Karp's (1994) study as discussed above, although without taking the process of recovery into account. They described a slow growth of distress, followed by what teens referred to as “being in a funk”. This was followed by teens' consideration of whether or not they were depressed followed by help-seeking and responses to diagnosis (Wisdom & Green, 2004).

Knudsen, Hansen, Traulsen, Eskildsen (2002) explored the impact of anti-depressant medication on experiences of self in depression in young women. Within this topic, the focus is on the career stages of taking anti-depressant medication. These centre around feelings of distress and needing help, internal conflicts about taking medication, and experiences of improvement in the condition and problems with discontinuing the medication. Knudsen et al (2002) felt that these stages largely centred around changes in self-concept surrounding issues of treatment and medication. As can be seen, a number of studies on experiences of depression focus on dividing experiences of a period of time into specific “career stages” of acceptance and change.

Studies on qualitative experiences of women's postpartum depression are becoming increasingly prevalent (Beck, 2002). In a synthesis of 18 articles, Beck

(2002) found that an incongruity between expectations and reality of motherhood were common, as well as feelings of spiralling downward, pervasive loss and difficulties experienced in making gains towards recovery. Nicolson (1999) also explored qualitative experiences of postpartum depression and found that a loss of autonomy, time, femininity, sexuality and occupational identity following the birth of a child are implicated in postpartum depression. More specific cultural experiences were explored in relation to Chinese postpartum experiences in Hong Kong, where women commonly described feeling trapped, hopeless, helpless and feeling a loss of control over their lives (Chan, Levy, Chung & Lee, 2002). In addition to this, particular cultural factors such as an uncaring partner and in-laws, which were viewed as highly relevant to Chinese culture, were explored (Chan et al., 2002).

Research on the lived experiences of depression as reviewed above, tends to focus on identity, the specific stages of the course of depression or to focus on a specific population group's experiences (such as Chinese women, teenagers etc.). Within the journal articles on these groups' experiences of depression, authors frequently mentioned that there was a great deal of study on general experiences of depression and yet simply referred to quantitative studies that do not appear to capture the subjective experiences of those suffering from depression (e.g. Wisdom & Green, 2004; Chan et al., 2002). However, the studies above did focus on participants' experiences, although they can be seen to be limited in their generalisability. There was also a strong focus on cognitive and emotional aspects of depression, with a tendency to overlook somatic experiences. While studies on lived experiences of depression are more common, fewer studies were found on experiences of recovery from depression.

Lived experiences of recovery

The few studies on the lived experiences of recovery that were found highlighted the role of self-awareness in recovery - a factor that is not mentioned quantitative studies (Ridge & Ziebland, 2006). Ridge and Ziebland (2006) explored participants' lived experiences of overcoming depression in interviews with 38 men and women who had previously experienced depression. They identified authenticity, taking responsibility and the acceptance of depression as an aspect of self-identity to have been important in participants' experiences of recovery. Participants' understandings

of the causes of their depression were also seen as relevant and varied from chemical imbalances to life events or personal attributes. Ridge and Ziebland (2006) noted that identifications of causes were often contradictory and varied widely across participants. However, coming to an understanding was experienced as important to participants (Ridge & Ziebland, 2006).

Schreiber (1998) interviewed 21 women and analysed the data using grounded theory. From this she came to the conclusion that from these women's perspective, gaining emotional and cognitive insight was significant, as was the process of self-discovery (Schreiber, 1998). However, it should be noted that Schreiber's study did not refer to any physical aspects of the self. Lafrance (2009) compiled a number of qualitative papers on women and recovery from depression, in which she highlighted the necessity of women focusing on themselves and learning to engage in self-care behaviours in order to facilitate recovery, rather than always caring for others. Overall, the studies described above can be seen as having qualitatively captured the experience of recovering from depression, which can be seen as adding to knowledge about how this process works from the perspective of those who have lived through it.

This section has provided basic information on the diagnostic criteria, prevalence rates, comorbidity and course of depression. Research regarding qualitative lived experiences has also been reviewed with regard to the lived experiences and recovery from depression. Etiological theories are covered in the next section in order to gain an understanding of how the disorder, as outlined above, comes into being.

ETIOLOGICAL PERSPECTIVES OF DEPRESSION

Etiology serves as a means of understanding how specific psychopathologies develop (McWilliams, 1994), and can therefore be seen as useful in providing a framework for understanding various aspects of depression. Within a psychodynamic/psychoanalytic framework, various etiological understandings of depression exist. The concept of unmet oral dependency needs and its impact on depression is discussed as this contains more physical elements (such as the role of the mouth and the need for physical holding and nurturance) in the understanding of depression, which can be seen as closer in nature to the experiences of the body. A focus on object loss is primary in this literature review, as it is one of the more accepted etiological understandings from within a psychodynamic framework. Other key theories that are

engaged with include Melanie Klein's theory of the depressive position, Andre Green's perspective of an emotionally absent mother and an integrative psychodynamic model of depression.

Oral dependency

The concept of unmet oral dependency needs refers to an infant's unmet needs that arise during the earliest stage of development. The term arose due to the fact that the infant is entirely dependent on others for emotional and physical nurturance at this point in its development (Cameron & Carmichael, 1963) and because oral needs predominate at this point in terms of developmental stages (Freud, 1977). The concept of unmet oral dependency needs has been developed over time (Huprich, 1998), and initial contributions were made by Freud (1917; 1977), Abraham (1927) and Fenichel (1946), as described by Bornstein (1996).

Freud, in conjunction with Abraham, concluded that depression is associated with fixation in the oral stage of development (Freud, 1917). During the oral stage, the mouth predominates in the infant's interactions with the world, and suckling is the infant's primary activity (Freud, 1977). Any difficulties experienced at this stage of development are seen as having far-reaching impacts on character formation and adult personality (Abraham, 1927). While Freud's conceptualisations focused on the sexualised aspects of the infant in relation to feeding (Freud, 1977) this idea has been expanded on over time to incorporate not just feeding, but emotional nurturance needs (including caring, love and physical holding) as described by Huprich (1998), which are seen to be the primary needs at this developmental stage (Cameron & Carmichael, 1963).

The concept of orality can be seen as having intuitive appeal (McWilliams, 1994) and the expression of this can be seen in commonly observed behaviours by depressed individuals, such as excessive eating or a refusal to eat, drinking and kissing (Abraham, 1983). The emotional experiences of those with depression are also often associated with food-related analogies, confirming the existence of an oral link (McWilliams, 1994). In addition to this, disturbances of eating and appetite were one of the first symptoms utilised to link depression to the oral stage of development (Abraham, 1983; Freud, 1917).

In depression, it is postulated that oral needs (Freud, 1917), with a focus on the

dependent nature of these, have not been fully gratified (Fenichel, 1946). An infant requires nurturance and emotional mirroring in order to internalise a sense of caring within him/herself (Fenichel, 1946). If this does not occur, the infant is unable to gain sufficient narcissistic supplies (defined as emotional support, reassurance, praise, reward and esteem), which results in the poor self-esteem later in life that characterises depression (Fenichel, 1946). Due to a lack of narcissistic supplies, as a result of insufficient early mirroring, seeking out narcissistic supplies from external sources continues in later life (Fenichel, 1946; Rado, 1983). The individual attempts to meet such needs by either complaining to generate sympathy (as is frequently seen in depression), or by appearing attractive and successful in order to generate admiration from others (Cameron & Rychlak, 1985). The individual is reliant on others to maintain their self-esteem (Rado, 1983) and a depressive state emerges when self-esteem supplies needed by the orally dependent individual are not available externally (Fenichel, 1946). This means that the individual is dependent on others during later life, and as such, can be characterised as a "love addict" who is constantly seeking out reassurance and nurturance (Fenichel, 1946).

As oral dependency needs have not been adequately met in infancy, the individual will become fixated in the oral stage of development, and carry characteristics and defence mechanisms from this phase of development into later life (Abraham, 1927). Defence mechanisms of the oral stage of development characterise eating and regurgitation, such as introjection and projection (Abraham, 1927). Introjection (or taking in) can often be seen when depressed people take in and internalise the wishes of others, and projection frequently occurs when the depressed person sees others as needy, when the sense of need is really experienced in relation to the self (McWilliams, 1994). The oral defence mechanism of identification, linked to the concept of introjection, is strongly related to the oral origin of depression by Freud (1917).

While psychodynamic theory links oral dependency to depression, there is a paucity of formal research to verify this link (Bornstein, Poynton & Masling, 1985). A few of the studies conducted to verify or disprove this link have been outlined below.

Studies on oral dependency and depression frequently utilise Rorschach tests of oral dependency to ascertain the link between oral dependency factors and the presence of depression. Bornstein et al.'s (1985) study revealed that in an empirical

study of oral dependency and depression utilising the Rorschach test and Depression Experiences Questionnaire, that there was no strong correlation between oral dependency, as recorded by the Rorschach, and depression. However a more recent study by Sprohge, Handler, Plant and Wicker (2002) found high correlations between oral dependency and depression in depressives and alcoholics using a different Rorschach rating scale.

Lewis (1993) and Maltby (1997) utilised a combination of the Oral Pessimism Questionnaire and the Beck Depression Inventory, receiving data that they viewed as confirming the link between oral fixation due to restrictive and harsh oral experiences, and depression. This data was viewed as being more objective, as less subjective interpretation was involved than in Rorschach tests. Lewis' 1993 study found that depression was more closely associated with oral traits than anal traits, providing limited support for the link between depression and oral-stage development.

Abela, McIntyre-Smith and Dechef (2003) compared cognitive behavioural and psychodynamic understandings of the etiology of depression. Dependency was one of the personality traits investigated, and was found to be positively correlated with depression (Abela et al., 2003). While this is not directly linked to oral dependency, the presence of dependency can be linked to the oral stage of development, and therefore this study provides increased credibility between the link of oral dependency needs and the etiology of depression. However, it should be noted that according to Bornstein et al. (1985) as well as Lewis (1993), and Abela et al. (2003), other factors aside from orality and dependence are important in understanding the etiology of depression.

In spite of criticisms against stage-based developmental issues being linked to psychopathology, such concepts are frequently utilised by clinicians when formulating clients (McWilliams, 1994). McWilliams (1994) further points out that the concept of oral dependency has been carried over to Erikson's (1977) often well-received work on basic trust and its association with the gratification or deprivation of oral needs. The concept of object loss is often combined with oral dependency to provide a more complete understanding of depression from a psychodynamic perspective.

Object loss and depression

The relationship between the loss of a love-object and melancholia was first discussed by Karl Abrahams (1983), and the discovery of this link is generally credited to him (Gaylin, 1983). Freud built on this concept and produced his paper on “Mourning and Melancholia”, published in 1917, which is cited as central to the psychodynamic understanding of depression (e.g. Klein, 1986; Rado, 1983). Based on this understanding, depression is viewed as similar to mourning, as both states are characterised by similar feelings of loss and loss of interest in the external world. However, depression is distinguished by a disturbance of self-regard that is absent in the process of mourning (Freud, 1917). In mourning, it is the world that is seen as empty, whereas in depression, it is the ego that is experienced as empty and therefore worthless (Freud, 1917).

While actual loss due to death results in mourning, the loss that precedes depression is related to a perceived loss of a love-object and need not necessarily be concrete in nature (Freud, 1917). In depression, the knowledge of 'what' has been lost, even if the 'whom' is known, remains unconscious (Freud, 1917).

During the process of mourning, the ego is absorbed in the work of processing and letting go of the object. In depression, similar internal work is needed, leading to the inhibited behaviour characteristics of depression (Freud, 1917). However, in depression, this internal process is not as evident to the observer, and yet similar internal processes are involved.

Prior to the loss, the infant is deeply attached to the object, following which the relationship is shattered due to a slight or disappointment (Freud, 1917). In a normal situation, the libidinal energy is withdrawn from the lost object and invested in a new object (Freud, 1917). In the case of depressive individuals, the energy is not displaced onto a new object and is instead withdrawn into the ego (Freud, 1917). As a result, there is a regression from a libidinal position of object-choice to one of narcissism. This internalised energy is utilised to establish an identification of the ego with the abandoned object (Freud, 1917). Using the oral defence mechanism of introjection, aspects of the lost object are identified with and the characteristics of the lost object are internalised in order to emotionally retain the object (Freud, 1917). Therefore the object loss that has been experienced is now transformed into ego-loss, with the ego being seen as if it were the lost object (Fenichel, 1946). While this introjection can be

seen as an attempt to preserve the lost object, it can ultimately become pathogenic, particularly if the original relationship to the lost object was ambivalent (Fenichel, 1946) and the lost object was punitive in nature (Cameron & Rychlak, 1985). If this is the case, the introject then becomes sadistic, resulting in guilt feelings in the depressed individual (Fenichel, 1946) and lays the groundwork for the creation of a punitive archaic superego (Cameron & Rychlak, 1985).

Due to the loss, the individual experiences both love and anger towards the object following experiences of being abandoned by it (Freud, 1917). Anger towards the object can now no longer be expressed openly as it is already prohibited by the internalised punitive introject (Cameron & Rychlak, 1985) and may damage the remaining relationship with the object (McWilliams, 1994). Instead, the anger is turned towards the self, and the original love-object is idealised (Freud, 1917). The anger felt towards the love-object due to the loss is therefore turned against the self (Rado, 1983), resulting in the self-recriminations frequently found in depression (Freud, 1917). Ambivalent feelings of both love and hate for the lost object result in pathology as the infant feels responsible for driving the object away resulting in feelings of unworthiness (Freud, 1917).

Connections between object loss and oral dependency needs are visible in psychodynamic literature. Fenichel (1946) describes how individuals with increased ambivalence, orality and increased narcissistic needs are more likely to succumb to depression in the face of difficult life events. A lack of narcissistic needs, as is likely to emerge due to oral dependency deprivation, means that the individual relies on the love-object for their narcissistic supplies, leading to the object loss being harder to bear (Fenichel, 1946). According to Abraham (1983), the combination of unmet dependency needs and object loss result in a vulnerability to depression which can be precipitated by events that threaten the individual's sense of self, such as by loss of love, personal security or self-esteem.

The application of object loss to depression can be seen both implicitly and explicitly in existing literature. The association between depression and object loss can be seen in the DSM-IV-TR, where attention is drawn to the differences between normal bereavement and major depressive disorder (APA, 2000). Depressive symptoms are seen as a normal aspect of bereavement, and are considered to be part of a depressive diagnosis once they have persisted for longer than two months. It is

evident from this that the relationship between “mourning” and “melancholia”, as described by Freud (1917), is generally recognised within the fields of psychology and psychiatry.

Horesh, Ratner, Laor and Toren (2008) examined the various types of life events associated with depression and borderline personality disorder. Major depressive disorder was associated more highly with the death of a close family member than either Borderline Personality Disorder or the control group, providing evidence for the strong link between concrete loss and depression. According to Kendler, Hettema, Butera, Gardner and Prescott (2003), a comparison of life events associated with depression and anxiety indicated that loss and humiliation were more strongly associated with depression. This provides support for the influence of both loss and narcissistic injury as etiological factors associated with depression. Kessing, Agerbo and Mortensen (2003) found that in a sample of 13 006 patients, recent divorce, unemployment and suicide of a relative were associated with severe depression requiring admission to a psychiatric ward. As these are all forms of loss, the strong link between loss and depression can be seen.

While concrete loss, as opposed to object loss, is the focus of the majority of the studies, this may well be due to the fact that object loss is far harder to study and verify. According to Bifulco, Bernazzani, Moran and Ball (2000), stressful life phase changes are likely to result in depression, particularly if negative early childhood circumstances were reported. Life phase changes can be conceptualised as a form of abstract loss and the association with depression can therefore be conceptualised as arising from this experience of abstract loss. Stressful life events are also commonly associated with depression (Kessler, 1997) and specific life events such as unemployment (Stankunas, Kalediene, Starkuviene & Kapustinskiene, 2006) are also strongly linked to the onset and course of depression, and can be seen as involving an element of abstract loss. However it should also be noted that prior personality characteristics, coupled with a stressful life event, are the most likely to produce an instance of depression (Kessler, 1997).

Feelings of a loss of self are commonly experienced in depression (Cornford et al., 2007; Lewis, 1995). In Cornford et al.'s (2007) study on patients' perception of important symptoms, a loss of self-identity was reported. Lewis (1995) found that in relation to experiences of depression, a sense of a loss of self was central to

participants' experiences of depression. These examples of loss of self in depression are possibly associated with an object loss that is internalised, leading to an experience of a loss of self as is implicated in the etiology of depression.

Huprich's (2001) study on the link between object loss and depressive personality indicated that those who were considered to be highly depressed at a personality level reported more experiences of object loss in their early history. Thomas and Siller (1999) found that the concept of object loss from a psychoanalytic perspective was helpful in gaining understanding of the process of adjusting to disability and its concomitant depression, and the ways in which the loss of mobility was linked to an internal process of mourning, similar to that described by Freud in his paper on "Mourning and Melancholia". In a study of 183 patients in Japan, effects of childhood parental separation lead to an increase in depressive symptoms later in life. The authors concluded that the experience of early object loss makes depression in later life more severe (Takeuchi et al., 2002).

Theoretical and empirical literature indicates that the relationship between depression and loss is generally accepted to some extent. The majority of studies focus on explicit events, such as death of a loved one, rather than on more abstract features of loss. Some studies from a psychoanalytic perspective link depression to object loss, but these are far fewer in number. In addition to oral dependency and object loss, the role of internalised objects, overcoming the depressive position and the role of the emotionally withdrawn mother are central to psychodynamic conceptualisations of depression and are reviewed below.

Melanie Klein's theory of object relations and depression

One of Melanie Klein's largest contributions to the understanding of psychology and psychopathology is her concept of internal objects (Greenberg & Mitchell, 1983). In infancy, the infant is understood as internalising objects from the external world, creating an inner world which corresponds to the child's actual impressions and experiences, but which is altered by their own phantasies and impulses (Klein, 1986). The child confirms or disconfirms this inner world by paying attention to internal and external stimuli. If this inner world, affected by the child's own anxieties and fears, is so strong that external objects cannot affect it, then the child is likely to experience difficulties with mental health (Klein, 1986). The individual then interacts with the

external world as if it is his/her own inner template, even though the internal objects may differ from the real person with whom the individual is interacting (Greenberg & Mitchell, 1983).

These internal objects are seen as being strongly related to later depression, with this internal world of the infant having more influence than the external interactions with caregivers (Mitchell & Greenberg, 1983). Internal developmental stages also play a key role, from a Kleinian perspective. According to Melanie Klein (1986), two phases of object-relating exist with the oral stage of development, namely the paranoid-schizoid position and the depressive position. During the paranoid-schizoid position, the infant has no concept of a whole person and relates only to part-objects. The object is split into ideal and persecutory aspects that are experienced as separate. The infant aims to idealise and possess the good breast, and then fears attack from the bad breast (Segal, 1973).

During the depressive position, which occurs at around the time of weaning, the infant begins to recognise the mother as a whole object, who is responsible for both good and bad experiences (Klein, 1986). The infant experiences the ambivalence of feeling both love and hatred towards the mother. The infant fears persecution and experiences pining for the good object. The angry attacks against the mother that occurred during the paranoid-schizoid position now generate feelings of guilt in the infant for having damaged the primary love object (Klein, 1986), which result in depression if reparation is not possible (Segal, 1973). In optimal development, the infant's experiences of joy in relation to others should help in overcoming this natural depressive phase of development and establish secure internal objects. Depression is seen as occurring in later life if the individual is unable to establish good internal objects and to feel safe and secure in the world (Klein, 1986).

Andre Green's theory of depression

Andre Green discusses the dead mother complex of depression, which he sees as containing elements of Klein's depressive position with Freud's theory of object loss (Green, 1986). This complex, which is generally identified by its emergence in the transference, is experienced as cold and unfeeling in the countertransference. The dead mother complex emerges in response to a maternal decathexis, in which energy is rapidly withdrawn by the mother, leaving the child feeling abandoned and in the

company of only a “dead presence” of the mother (Green, 1986). According to Green (1986), based on readings of Freudian and Kleinian theory and case studies, this decathexis is particularly pathogenic if it occurs during the child's Oedipal stage of development, and at the time he/she is resolving the depressive position (Green, 1986).

On the mother’s side, this withdrawal is frequently related to her own internal mourning, with a result that she withdraws from all her own affects, which in turn negatively impacts on the child (Bollas, 1999). For the child there is a brutal loss of an alive and present mother, and the child’s energy is then decathected (Bollas, 1999), making it difficult for relationships with others to be established in later life (Green, 1986). Green indicates that decathexis is a central concept in depression, and that a withdrawal of energy from the world leaves individuals unable to carry out day-to-day tasks (Kohon, 1999). The child is unable to understand the reasons for the sudden loss, leading to feelings of guilt in the child (Green, 1986). Anger cannot be expressed against the mother due to a fear of further maternal detachment, leading to the child responding to this by turning anger against the self, in a pattern similar to the Freudian description of object loss (Bollas, 1999). The loss of the mother's love leads to a loss of meaning in the child's life, and resultant depression. In addition to this, the child's attempts at reparation are unsuccessful, leading to an unresolved depressive position (Green, 1986) all of which combine to result in depression later in life.

Combined core dynamics model of depression

Busch, Rudden and Shapiro (2004) have recently proposed a model that intends to integrate the various core dynamics behind the etiology of depression from a psychodynamic perspective. In this model, a narcissistic vulnerability due to loss, rejection or biochemical imbalances is seen as a predisposing factor. As a result of this, low self-esteem exists, making the individual vulnerable to experiences of narcissistic injury following feelings of anger at perceived rejection. This leads to anger, which is then self-directed, leading to guilt, shame and the experience of depression (Busch et al., 2004). Low self-esteem in such individuals is dealt with by idealisation and devaluation of self and others. Others are likely to be idealised and a high ego ideal strived for by the individual. However, as the self cannot meet such standards, disappointment and devaluation of the self then occur. Alternatively, the

self may be idealised, which is responded to with aggression from a harsh superego (Busch et al., 2004). The defence mechanisms associated with depression then emerge to protect the self from intolerable feelings of self-esteem and anger, giving rise to the commonly known depressive picture seen in clinical settings (Busch et al., 2004).

Common themes of loss and deprivation in relationship to others can be seen in theories of oral dependency, object loss and Green's theory of the depressed mother. Klein's theory, however, focuses more on the internal world of the infant and less on real experiences in relation to others, although the depressive position and weaning can be seen as related to loss in the oral stage. The cross-over in these theories indicates that these concepts have relevancy in understanding the development of depression. Literature supporting these studies is often related to projective testing (such as in relation to oral dependency and object loss) and some in relation to individual experiences (e.g. Takeuchi et al., 2002). While these concepts are frequently utilised by therapists (McWilliams, 1994), it would appear that external verification is still not necessarily sufficient to be conclusive. While the oral dependency theory is focused on some of the infants' somatic experiences, the role of and effects of developmental issues such as object loss on the body are lacking in the literature reviewed. However, the existence of somatic symptoms in the DSM-IV-TR diagnostic criteria indicates that the body is of importance in depression. To this end, the existence of the mind-body relationship in general will now be discussed, as well as how this relationship is specifically linked to depression.

PHILOSOPHICAL PERSPECTIVES ON THE MIND-BODY RELATIONSHIP

The relationship between the mind and the body has been long viewed as a contentious issue (Damasio, 1994). The concept of mind-body duality espoused by Plato, Augustine and Descartes consists of the viewpoint that human existence is split into two realms, with the mind or spirit as separate from the physical aspects of the self (Bordo, 1997). Historically this idea was adopted, with the result that the body was conceptualised as an alien object to which the self was attached. This body was viewed as confinement and limitation from which the mind struggled to escape (Bordo, 1997). However, although this concept is viewed as historical, these same beliefs appear to be embedded in much of day-to-day cultural understandings (Bordo, 1997). Capra (1983, p.45) describes how this history and continuation of dualistic thinking has negatively impacted on society:

> The Cartesian division between mind and matter has had a profound effect on Western thought. It has taught us to be aware of ourselves as isolated egos existing “inside our bodies”; ... it has kept doctors from seriously considering the psychological dimensions of illness, and psychotherapists from dealing with their patients' bodies.

Here it can be seen that such dualistic thinking has impacted on both fields of medicine and psychology, with the result that both have become exclusionary of aspects of mind or body. Over time, a scientific understanding of the link between mind and body has become more strongly recognised. For example, Damasio (1994) wrote on Descartes' error of seeing the mind and body as separate units by describing how brain injuries affected an individual's mind or personality.

Dualistic conceptualisations of body and mind as separate are not universal. Both African and Eastern perspectives focus on a more holistic worldview, in which the body, mind and spirit are conceptualised as one (Dwairy, 1997). According to Chan, How and Chow (2002), body, mind and spirit are treated as integrated in various Eastern cultures and belief systems, including Buddhism, Taoism and Confucianism. Integration of these three aspects of the self are regarded as optimal, and healing practices from these worldviews typically treat the person in totality. African worldviews differ across different tribes and regions, and yet share commonalities. One of these is a holistic view of the world, self and others, with an emphasis on the oneness of mind, body and spirit (Bojuwoye, 2005). Ill health is seen to result when there is a break between mind and body, and is treated accordingly (Bojuwoye, 2005). However, Patel (1995) cautions that viewing African worldviews as completely holistic is not truly accurate, and explains that a distinctive concept of the mind does exist, although it is seen to interact with other aspects of self and community.

Westernised psychiatric views of mental health problems in non-Western communities frequently refer to high levels of somatisation in Eastern and Western cultures (e.g. Sadock & Sadock, 2007). This can be seen as related to the mind-body unity conceptualised by these cultures, leading to greater interrelation between mind and body symptoms. Dwairy (1997) raises the idea that there is less emphasis on the self in these cultures, leading to less psychological approaches to health. She therefore contends that within these cultures there is a “depsychologization” rather than somatisation, and describes how this approach is equally valid, in contradiction to

psychiatric discourses.

From these differing perspectives within and between cultures, it can be seen that the relationship between mind and body remains a central question, and therefore further exploration of this concept would be of benefit. Views on the relationship between mind and body from a psychodynamic perspective will be explored in the following section, in order to gain an increased understanding of how this contentious issue is viewed within this framework.

PSYCHODYNAMIC PERSPECTIVES ON THE MIND-BODY RELATIONSHIP

According to Meissner (2006, p.259), from within a psychodynamic perspective, "dualistic impressions of mind and body have given way to more integrated perspectives in which psychic and bodily processes are conceived of as operating within the same conceptual framework." While this statement implies an overall unity, conceptualisation of the relationship between mind and body are occasionally contradictory, although the link between them is reasonably acknowledged. This topic will be explored in relation to developmental issues, somatoform disorders and Winnicott's view of the relationship between psyche and soma.

Development of the self and the body

The link between the physical and psychological sense of self from a developmental perspective can be seen in some psychodynamic literature. According to Freud, (1950, pp. 25-26), “the ego is first and foremost a bodily ego [and] the ego is ultimately derived from bodily sensations”. Aron (1998) discusses how the most common interpretation of this statement indicates that the psychological self developmentally arises from bodily sensations.

Mahler and McDevitt (1982) analyse this concept further and link the infant’s earliest sense of self as being conveyed through bodily sensations, with a particular emphasis on proprioception. According to Mahler and McDevitt (1982), the self emerges as separate from the mother-child symbiotic unit by means of sensoriperceptive stimuli, which facilitate the infant’s ability to delimit the sense of self and self-image from those around him/her. Similarly, Winnicott focuses on the body as formative in creating a sense of self and describes how the infant's first sense of self originates from being physically held by the mother (Winnicott, 2007).

Anna Freud (in Meissner, 2006, p.305) describes the interrelation between mind

and body in early development:

> During the whole of the first year, while psychological life expands, the access between body and mind remains an easy one. Every upheaval in the bodily sphere causes mental distress, crying, etc., while every mental upset such as shock, frustration, anxiety causes physical upheaval.

From this it can be seen that developmentally, infants are seen as having a close link between mind and body, with one affecting the other. Based on Sigmund Freud, Anna Freud, Mahler's and Winnicott's mention of a link between the development of a psychological sense of self and the experiences of the body, it would appear, based on this early developmental process, that the sense of the self and the sense of the physical body may be inter-related later in life. This interrelation can be seen in psychodynamic understandings of somatoform disorders.

Somatoform disorders

Somatoform disorders are a group of disorders that are defined by presence of predominant bodily signs and symptoms (Sadock & Sadock, 2007). Recent psychodynamic and historical psychoanalytic literature provides insight into this group of disorders.

Traditionally, psychoanalytic literature has discussed the link between mind and body in relation to hysteria and conversion reactions. The concepts of hysteria and conversion reactions, developed at the time of Freud, are seen to be at the root of the psychoanalytic understanding of the relationship between mind and body (Beutel, Michal & Subic-Wrana, 2008). At the time, these understandings were considered to be revolutionary, as they opposed the concepts of Cartesian duality that were dominant at that time (Meissner, 2006).

Conversion reactions (or conversion disorders) are defined as a disturbance of physical functioning that is not correlated to current concepts of anatomy or physiology of the central or peripheral nervous system (Sadock & Sadock, 2007). Historically, conversion symptoms were incorporated into the concept of hysteria. At the time of Freud, hysteria referred to a disorder characterised by emotional outbursts, fainting, suggestibility and conversion symptoms (Colman, 2001). Conversion symptoms are viewed as an early conceptualisation of the existence of the link

between mind and body in which both the wish and the defence against the wish (Beutel et al., 2008) are replaced by a specific physical symptom (Freud, 2004). Here the body can be seen as communicating things that cannot be expressed verbally (Beutel et al., 2008) and are therefore made evident via the symbolic communication of the body (Freud, 2004).

In current day psychodynamic and psychoanalytic literature, the concepts found in original studies of conversion disorders are utilised to explain other non-medical symptoms captured under the category of "somatoform disorders" in the DSM-IV-TR. The categories of disorders which appear to the most studied include somatisation disorder, conversion disorder and pain disorder. From a general psychodynamic perspective, somatoform disorders, such as those listed above, are seen as means by which the physical self serves as a means of expression for, and symbol of, the unconscious wishes and fantasies of the emotional self (Taylor, 2002).

In a case study on chronic pain, Taylor (2008a) explores how the chronic pelvic pain symptoms of his client represented her attachment with her parents, as well as an early trauma, that could not be verbalised. He noted that once she was able to explore such relationships in therapy, her pain symptoms reduced, as well as her presentation of depression and anxiety (Taylor, 2008a). Sklar's (2008) case study focused on the use of a physical tic to express early loss that could not be symbolised. Sklar describes how this enactment by the body can be seen as an unconscious means of drawing attention to emotions and conflicts that cannot be expressed (Sklar, 2008).

Meissner's (2006) recent work on psychosomatic illness indicates a definite link between mind and body emerging in these disorders. Meissner draws on the work of Winnicottt to indicate that psychosomatic illness results from an inadequate attachment to a parental figure and subsequent inadequate dwelling of the psyche in the soma, or connection between the psychological and physical. Winnicott's viewpoint will be explained in more detail later in this chapter.

Based on this understanding, it would appear that, from a psychodynamic/psychoanalytic perspective, the body serves as a means of unconscious communication (McWilliams, 1994) therefore making an understanding of the internal conflicts expressed via the body useful in understanding psychopathology (Cameron & Carmichael, 1963).

Symbolic meanings of the body can be useful in the context of psychotherapy,

even if no explicit somatoform disorder is evident. Psychoanalyst, Hopenwasser (1998), discusses the neurobiology linked to the highly controversial topic of recovered memories, and discusses how forgotten memories are often somatically represented, prior to being remembered. In the cases discussed by Hopenwasser (1998), the symbolic symptoms were no longer experienced following the patient gaining an understanding of her physical symptoms and their relationship to repressed memories. As understandings of somatoform disorders are often linked to Winnicott (e.g. Meissner, 2006), his view of the relationship between psyche and soma is presented below.

Posture as expressing unconscious processes

Following on from the understanding of the body as symbolising unconscious conflicts and processes, the body may also reflect these processes at a more subtle level. As discussed by Cameron and Carmichael (1963) early developmental experiences can result in subtle postural and movement changes in the individual. Posture can be seen as conveying common personality variables, such as rigidity or stooping.

Esther Bick (1988) also related everyday posture to developmental experiences, with a specific focus on whether or not the infant was sufficiently emotionally contained during early development. In her conceptualisation, adequate handling of the infant is needed during the feeding (or oral) stage of development (Willoughby, 2001). This experience serves to help the infant to feel contained within a skin that is a combination of the infant's own skin, as well as the skin of the mother (Willoughby, 2001). This concept is known as integration of the “first skin” (Bick, 1988).

If this containing skin formation does not happen due to an interruption in the feeding stage, general psychic fragility is likely to occur later in life, and lead to posture and mobility that appears to be unintegrated. Bick provided examples, such as a client who had a hunched posture and stiff joints (Bick, 1988). Without the formation of the containing skin from the mother-infant relationship, the infant develops a “second skin” of pseudo-independence as a way of managing the fact that he/she cannot fully depend on their primary maternal object. This was described as forming a protective shell, such as aggression, a muscular stiffness or verbal protection of the self (Bick, 1988). Early experiences are therefore seen as being

related to later postural developments. Turp also utilises this conceptualisation in relation to the body, as will be discussed further in the section relating to Winnicott's views.

Donald Winnicott's view of psyche and soma

Winnicott explored the concept of the mind and body as related in his theory of psyche-soma indwelling. His concept of the mind and body as related is one of the more commonly used theoretical understandings of this relationship, as can be seen from a variety of literature (e.g. Aron, 1998; Meissner, 2006). According to Winnicott (1987), if the infant experiences good enough handling from the mother, the infant is able to be more present in his or her body, which Winnicott termed "psyche-soma indwelling". Without good enough handling (which relates to the physical holding and caring of the child, which Winnicott described as the earliest form of nurturing) the infant experiences impingements, which result in a disconnection between psyche and soma (Winnicott, 1987).

Winnicott (1987) explored the fact that in order to understand the concept of the mind in relation to the body, the development of the whole individual must be taken into account. The infant is described as a "new psyche-soma", without a separate "mind". The soma refers to the body or physical experiencing, and the psyche is described as the "imaginative elaboration of somatic parts, feelings and functions… of physical aliveness" (Winnicott, 1987, p. 244).

In a state of optimal development, the infant's experience of psyche-soma should proceed along a continuity of being, with the caretaker actively meeting the infant's needs initially, so that no impingements are experienced by him/her. The mother also serves the function of confirming the infant's physical experiences, by attending to his/her needs appropriately (Winnicott, 2007). This leads to a continuing sense of going-on-being for the infant, and the continuation of a true self that is based on the experiencing body. In such circumstances, an integration of psyche and soma remains, forming the basis for the true self (Winnicott, 2007). As a result of good enough mothering, the infant feels that the body is the self, rather than something separate and disconnected from the self. The person of the baby becomes linked with the body, with the skin serving as a limiting membrane that acts as a boundary between the baby and the rest of the world (Winnicott, 2007). As the ego is derived

from the body, this process forms an essential part of the child's development and leads to personalisation, or development of the self as separate and alive (Winnicott, 2007).

In normal development, over time, appropriate failure is experienced and the infant develops the mental functioning to deal with this (Winnicott, 1987). However, if impingements are experienced too early, the only way the infant can cope with such experiences is to utilise mental functioning to assist him/her in dealing with these unmanageable feelings. Thus, the psyche is seduced into the mind and away from the soma, leading to a pathological mind-psyche that is separate from the body (Winnicott, 1987). As a result, the infant cannot experience the optimal state of psyche-soma indwelling, where psyche and soma are still connected and the infant is grounded in his/her body (Abram, Karnac & Hjulman, 2007). If the infant's bodily experiences are not confirmed by adequate handling provided by the mother or caregiver, the potential aliveness of the body is seen as being killed. If this is the case, the child must adapt to the meanings imposed by the external world, resulting in a development of a false experience of the body and a false self (Winnicott, 2007). As a result of a lack of being able to depend on the environment (including people) to meet the infant's needs at this critical time of development, the individual will continue to seek out this perfect environment through relationships and interactions in later life, so that the individual no longer has to rely on mental functioning for survival and can return to a state of psyche-soma integration (Winnicott, 1987).

Winnicott's theory has been frequently applied to psychodynamic understandings of the relationship between mind and body. Looker (1998) explores the concept of psyche-soma indwelling in relation to case studies, and discusses that if the infant's mother is unable to have this connection herself, her disconnect will passed on to her infant. As a result, Looker (1998) feels that it is particularly important for the therapist to be present in both psyche and soma in order for the client to be able to reconnect these aspects of the self.

Turp (1999) has applied Winnicott's understanding of the mind-body relationship in case study therapy research. Using the concept of a "body storyline" (which incorporates the client's history of experiences of touch, movement, sexual behaviour and eating from infancy to adulthood), Turp (1999) explores her clients' emotional processes. She believes that developmental experiences become inscribed

in the body and are then expressed in posture, physical style, avoidance or enthusiasm for physical experiences, terms used to describe the body, and physical responses evoked in others (Turp, 1999). These body storylines as expressed by clients in psychotherapy can then be utilised to gain an increased understanding of the client and used to achieve greater integration of mind and body as well as gain an understanding of and integrate emotional experiences (Turp, 1999).

Balamuth (1998) utilises Winnicott's concept of the relationship between psyche and soma to discuss the importance of focusing on the body as it is subjectively experienced in leading to self-awareness, and of the use of the body in psychotherapy. Balamuth views that a disjoint between psyche and soma arises, in later life, from the notion of inadequate care-giving in infancy leading to a lack of an "authentic and direct self grounded in the body" (Balamuth, 1998, p. 281). A disconnect between psyche and soma is seen as resulting from a loss or violation that cannot be acknowledged. Based on this assumption, if the individual is unaware of their body, this often indicates that they are unaware of important aspects of themselves (Balamuth, 1998). Therefore, increasing awareness of the body is seen as an important goal in psychotherapy and as leading to an enhanced integration of the individual.

Controversies regarding mind and body

From a psychodynamic perspective, it would appear that there has been a slow move towards integrating the concepts of mind and body (Meissner, 2006). While the majority of psychodynamic and psychoanalytic viewpoints acknowledge the inter-relation between mind and body, the nature of how this relationship is viewed varies to some extent across the different theoretical perspectives, with no apparent unified approach to this phenomenon.

Aron (1998) describes how for Freud, the self emerges out of the body, and emotional needs or drives are derived from the physical drives and needs of the body. Therefore, it is seen, that for Freud, all psychological needs are ultimately traced back to their somatic source (Aron, 1998). Gill (as cited Aron, 1998) discusses the fact that Freudian narratives may be too concrete and reductive to give a clear sense of the relationship between the mind and the body. This Freudian perspective can also be seen to be ignoring more interactive and relational meanings as expressed by the body

(Aron, 1998).

It is unclear to what extent Freud valued either an integrated or dualistic view of mind and body, and both opposing positions are accredited to him (e.g. Aron, 1998; Gunsberg & Tylim, 1998; Meissner, 2006). Winnicott seems to have a holistic view, in which the psyche is seen as a construct that is not truly separate from the body, and emerges from physical experience (Aron, 1998). His theories also seem to be the most utilised in relation to the connection between mind and body. Work on hysteria and some somatoform disorders indicates that the body symbolically represents emotional processes, which seems to indicate a reversal of what is described in relation to development, in that the body comes to represent the mind, rather than the mind developing to represent the body. However, it seems plausible that both options are likely, and that the mind and body can be seen as interrelated in various ways.

Winnicott, Sigmund Freud and Anna Freud in particular explore the developmental link between the mind and the body, which can also be seen in psychopathology such as certain somatoform disorders. Cameron and Carmichael (1963) broadly discuss the fact that early developmental influences may often interfere with the way the body is seen and experienced. Based on this, it may be useful to continue to explore this developmental influence in more specific ways in order to gain an increased understanding of the developmental influence of this on the body as it emerges in psychopathology.

Literature on the psychodynamic view of the relationship between mind and body is largely based on case material and individual psychotherapeutic work. This type of research utilises the insight and experiences of the therapist and can be seen as valid in relation to experiences of patients and therapists in their therapeutic work. The strong point of this research is the depth of understanding of specific cases and trends from a highly personalised perspective. However, it should be noted that the writings on this topic are lacking in objective, observable measures and controlled studies.

The importance of the body in therapy

According to Miller (2000) and Turp (1999), focusing on experiences of the body in therapy can provide a useful understanding of the individual's emotional experiences and processes. While this information is often ignored or avoided in many

psychotherapeutic contexts (Miller, 2000), it has proven beneficial in various therapeutic modalities (such as Gestalt therapy). According to Gunsberg and Tylim (1998), mind and body need to be integrated via the therapeutic process and Lombardi (2008) discusses how incorporating the physical aspects of self into psychotherapy may be particularly useful when working with difficult patients.

Wrye (1998) focuses on the importance of the therapist being aware of their own body, and describes how the body is often utilised to gain an understanding of transference and countertransference in analytic settings. She explores how an increased awareness of the therapist's body can assist in understanding both the body and mind of the client. This concept is also supported by Balamuth (1998) who discusses the need to integrate psyche and soma from the perspective of Winnicott. In order to bring the body into therapy, the therapist should be aware of their own body during sessions, paying attention to physiological factors such as breathing and experiences of pain; in addition to the feelings, fantasies and thoughts that therapists are frequently attuned to (Balamuth, 1998). Balamuth (1998) describes how therapists often miss their own physical experiences in a session. This means that potentially useful information is being overlooked and Balamuth therefore advocates for increased physical awareness on the part of the therapist.

According to Meissner (1997), an increased understanding of how the body self and the psychological self develop is an important understanding within developmental theory. As the mind-body relationship can be seen as important from a therapeutic and developmental perspective, literature concerning the mind-body relationship as it emerges in depression will now be reviewed.

MIND AND BODY IN DEPRESSION

While few studies cover the explicit relationship between mind and body in depression, literature does indicate the importance of the body in depression. Studies of the body in depression typically focus on somatic symptoms of depression, on exercise as a treatment for depression, and on body image.

Somatic symptoms of depression

Depression is a multidimensional problem with symptoms occurring on emotional, cognitive, behavioural and somatic levels (McIntyre et al., 2006). Somatic symptoms are being viewed as increasingly important within the field, particularly as they are

the reason for many individuals with depression seeking help (Demyttenaere et al., 2004) and their use for the diagnosis of depression is frequently utilised in non-westernised countries (Simon, Gater, Kisely & Piccinelli, 1996). According to Dowrick, Katona, Peveler and Lloyd (2005), physical and psychological symptoms share a complex relationship in depression. While depression may be thought of as a more emotional disorder, physical symptoms are frequently prevalent and may serve as indicators of emotional disorders. Somatic symptoms are used as diagnostic criteria for depression, and those commonly associated with depression include appetite and weight disturbances, lack of energy and fatigue, general aches and pains (Tylee & Gandhi, 2005), sexual dysfunction (Dobkin, Leiblum, Rosen, Menza & Marin, 2006) and a number of medically unexplainable illnesses and syndromes (Henningsen et al., 2003).

According to Vaccarino, Sills, Evans and Kalali (2008) somatic symptoms are frequently associated with depression and this link has been verified in various quantitative studies over time. An extensive WHO survey published in 1999 indicated that around 69% of individuals with depression displayed somatic symptoms (Vaccarino et al., 2008). Somatic symptoms have also been discovered to be predictors of depression, with certain somatic symptoms, such as low back pain, dizziness and abdominal pain, being present a year prior to the diagnosis of depression (Nako & Yano, 2006). Wenzel, Steer and Beck (2005) ascertained that higher rates of somatic symptoms in depression are most commonly associated with women. However, Middeldorp, Wray, Andrews, Martin and Boomsma (2006) asserted that based on a large sample, the symptom profile of both and women was not significantly different.

Changes in appetite, including either an increase or decrease, are commonly associated with depression. Weight changes, which may be related, are also common somatic indicators (Sadock & Sadock, 2007). Middeldorp et al.'s (2006) large European and Australian study found that a decrease in appetite was found in over half of non-related participants, with an increased appetite being found in around 20% of participants. Correspondingly, decreased weight was found in over half of participants, and increased weight in the range of 10% of participants. Wenzel et al. (2005) concluded that appetite disturbances were found to be more prevalent in men than in women. However, these findings were not replicated in the study by

Middeldorp et al. (2006), which found that no significant weight or appetite changes could be observed across genders.

Sexual dysfunction and depression often co-occur and this relationship is well documented and accepted. Findings also indicate that this co-occurrence is particularly prevalent in relation to women (Dobkin et al., 2006). Existing sexual dysfunction may also be affected by anti-depressant medication, although the extent of this effect cannot be clearly determined as sexual dysfunction is already at a high level within the depressed population (Kennedy, Dickens, Eisfield & Bagby, 1999). The experience of sexual dysfunction may also decrease quality of life and therefore contribute to feelings of low mood in those who are already experiencing depression, thus serving as a contributing factor to the continuation of depressive disorders and symptomology (Dobkin et al., 2006).

Sleep disturbances are frequently associated with depression and include initial and terminal insomnia, multiple awakenings and hypersomnia (Sadock & Sadock, 2007). Sleep disturbance is often considered to be the single most common symptom of depression, with 60% to 90% of people being recorded as having sleep disturbances during a major depressive episode (Szuba, 2001). Sleep disturbances such as insomnia are considered to be highly unpleasant and may be the reason for the individual seeking help (Ford & Cooper-Patrick, 2001). However, the cause and effect relationship between sleep disturbance and depression is unclear. Sleep disorders often precede depression, and many of the symptoms of depression, such as inability to concentrate and a lack of energy and fatigue can be linked to sleep disruption (Szuba, 2001).

The symptom of fatigue or loss of energy is associated with a number of psychiatric disorders and is found in about 97% of depressed individuals (Sadock & Sadock, 2007) and viewed as a central component of depression in recent literature (Arnold, 2008). In addition to this, it is a diagnostic criterion in both the DSM-IV-TR and ICD-10, and evidence indicates that it is one of the most common symptoms of depression (Arnold, 2008). The importance of fatigue as a symptom often goes unnoticed, particularly in association with the DSM-IV-TR, although it has been shown to be a significant predictor of depressive disorders (Arnold, 2008). Fatigue is both a prodromal and residual symptom, and experience of fatigue in the general population has been associated with an increased risk of being diagnosed with a

depressive disorder (Demyttenaere et al., 2004).

Looking beyond the DSM-IV-TR criteria, various medically unexplained disorders are also associated with depression (Henningsen et al., 2003). Digestive and bowel problems are also common symptoms in depression with disorders such as irritable bowel syndrome being often associated with depression (Visser et al., 2008). Henningsen et al. (2003), compared and analysed 244 studies and found that disorders such as irritable bowel syndrome, nonulcer dyspepsia, fibromyalgia and chronic fatigue syndrome were strongly related, but not dependent on, the presence of depression and anxiety.

Demyttenaere et al. (2004) explored the presence of painful physical symptoms in individuals suffering from a major depressive episode. In a quantitative study including 21 425 participants, painful physical symptoms were established to be present in 50% of those experiencing a major depressive episode.

Vaccarino et al.'s (2008) study covered the overall incidence of somatic symptoms, with a focus on which type of painful and non-painful symptoms were most reported in depression. Using a sample of over 2000 participants, they found that over 78% of respondents agreed that they were “feeling fatigued, weak, or tired all over” at a moderate or higher level. They concluded that fatigue was the most common physical experience and discussed that it has both somatic and psychic elements. Feeling unwell and not in good health was also a prominent finding. Over half of the participants indicated that they agreed that they were “feeling not in as good physical health as most of your friends” and “not feeling well most of the time in the past few years”. Participants indicated that these experiences were present at moderate or higher levels in over half the respondents (Vaccarino et al., 2008).

Jacobsen, Lassen, Friis, Videbech and Licht (2006) examined the nature of physical symptoms in depressed individuals with no physical illnesses, and contrasted these to normal controls. This study was conducted from the perspective of a physical therapy background, and hence different types of somatic symptoms were recorded than are found in most psychological or psychiatric studies. They found evidence of increased muscular tension, pain complaints, restricted breathing, negative attitudes towards physical appearance and ability, and less flexibility and stability in movements. As improvements in depression were measured, so bodily symptoms improved at a similar rate (Jacobsen et al., 2006). The study also indicated that

depressed participants were measured as having a generally poorer overall physical ability, reduced co-ordination, and movement that is described as lacking in freedom and disharmonious. These symptoms, as described in this study, fall outside of what is usually included in psychiatric concepts of the physical symptoms of depression (Jacobsen et al., 2006). As this research is done from a psychiatric physical therapy perspective, it provides a sense of physical movement and ability that is objectively observable, and yet also provides a greater overall sense of the physical picture of the somatic realities of depression, giving a sense of a reduced and restricted physical presentation.

This high instance of somatic symptoms and experiences associated with depression, as described above, can be seen as being closely related to somatoform disorders. There are frequently recorded co-occurrences of somatoform disorders, such as pain disorders, co-occurring with depression (Hennginsen & Lowe, 2006). In some cases, this may lead to dispute over which diagnostic category an individual should be placed in, as these disorders are frequently comorbid (Henningsen & Lowe, 2006). Disorders such as body dysmorphic disorder (Phillips, Siniscalchi & McElroy, 2004) and hypochondriasis are also associated with depression (Noyes, Woodman, Bodkin & Yagla, 2004).

Henningsen at al. (2003) discuss various reasons for the possible high occurrence of somatic experiences in depression. They mentioned that somatic symptoms may result from increased physical sensitivities during depression, and that depression may have arisen due to the physical symptoms. Another predominant concept is that psychological and somatic symptoms may be different forms of expression of the same underlying psychological problems that results in depression (Henningsen et al., 2003). Vaccarino et al. (2008) also discuss that a preoccupation and concern with physical health is elevated in major depressive disorder and may therefore account for some of the symptoms, and can also be related to hypochondriasis. They also postulated that pain and depression may share a common underlying neurochemical process, leading to a high co-occurrence of these two phenomena (Vaccarino et al., 2008).

While the majority of these studies focus on quantitative aspects of somatic symptoms, Wilson (2007) explores narratives of depression in her PhD thesis, and briefly discusses her women participants' somatic experiences. She further indicates

that her participants felt these experiences to be important. Being curled up in a foetal position was an important theme, changes to either experiences of a slower or faster body, feeling like a robot or zombie, being physically immobilised, disturbed sleeping patterns and an increase in physical illness (such as irritable bowel syndrome) and physical pains (such as headaches and neck pain) were reported by her participants (Wilson, 2007).

Overall, studies regarding the existence of somatic symptoms of depression form the bulk of literature on this topic. Most focus on a single explicit symptom, and explore topics such as prevalence rates, comorbidity and predictive value. Vaccarino et al. (2008) focused on more general feelings, such as a sense of unwellness, in addition to specific symptoms. From the literature reviewed in this section, it is clear that somatic symptoms are both prevalent and important in relation to depression, and at times it is hard to distinguish physical symptoms from somatoform disorders. However, while studies focusing on prevalence rates, prediction and comorbidity are undoubtedly of value, it appears that the majority of such research fails to capture the day-to-day experiences of individuals living with these symptoms or deal with the value that these symptoms may have for understanding the psychological processes underpinning depression. Wilson's (2007) dissertation did focus on experiences of living with symptoms, although somatic experiences were not predominant in her exploration of narratives of depression and no focus on the meanings behind these was engaged with. While the body is often omitted in experiences of depression, the usefulness of exercise in the treatment of depression is well established, and the use of movement and dance therapies are becoming recognised, and will be discussed in the following section.

Exercise and movement in treatment of depression

The efficacy of utilising exercise as a means of treating depression is becoming increasingly recognised (Foley et al., 2008). Various types of exercise have been advocated, from stretching to aerobic exercise, and an overall link between exercise and depression has become acknowledged in recent literature (Foley et al., 2008; Sadock & Sadock, 2007). Exercise in depression has been noted to improve psychological aspects of self such as self-efficacy, situation specific self-confidence and may improve impaired episodic memory and lower cortisol levels (Foley et al.,

2008). The use of exercise to impact on emotional aspects of the self, such as self-efficacy, indicates a further instance of the interrelation between mind and body in depression.

The link between mind and body in depression has also been focused in therapeutic approaches that utilise awareness of the body in treatment. Dance and movement therapy is sometimes applied to depression, and has been proven to be effective as part of a treatment programmes in certain studies, and implies a link between mind and body (Koch & Brauninger, 2006). The use of yoga to facilitate physical and spiritual awareness has also been used to treat depression (Miller, 2005). Further explorations of the body in depression can be seen in body image studies as will be discussed in the following section.

Body image and depression

Body image is defined as perceptions, thoughts and feelings towards the body (Bergstrom & Neighbors, 2006). However, according to Cash and Pruzinsky (2002), the concept of body image is notoriously difficult to define. Body image disturbances are frequently studied and refer to either dissatisfaction with the body or size distortion (as frequently emerges in eating disorders).

Studies on body image and body perception indicate that depression and poor body image appear to be correlated, and the onset of a depressed mood can be seen as likely to trigger negative views about the body (Cash & Pruzinsky, 2002). According to Noles, Cash and Winstead (1985), individuals with depression are less satisfied with their bodies and see themselves as less attractive than non-depressed people. In Biby's (1998) study, lower body-esteem scores were associated with increased levels of depression and obsessive-compulsive disorder. Body image and its association with suicidal ideation in adolescents has been researched by Brausch and Muehlenkamp (2007). They found that negative attitudes and feelings towards the body predicted suicidal ideation to a greater extent than other variables such as past suicidal behaviour. This can be seen as indicating that negative attitudes towards the body are indicative of destructiveness and therefore linked to suicidal ideation. Poor body image can also therefore be seen as a component of the destructive picture of anger expressed towards the self that constitutes depression.

The temporal link between body image and depression was examined in a

longitudinal study by Pimenta, Sanchez-Villegas, Bes-Rastrollo, Lopez and Martinez-Gonzalez (2009). In this case, no evidence was found to indicate that poor body image preceded depression. It should be noted that Pimenta et al. (2009) appeared to utilise only a measure of estimated versus real body size to determine body image, and did not seem to take other body perception factors into account, which can be seen as a weakness of this study. However, the large sample (over 10 000) and the longitudinal nature do provide strength to these results, showing that body image cannot be used to predict the onset of depression.

It should be noted that in general, body image studies tend to quantitatively measure aspects such as views on body weight, body size and attractiveness. Factors such as global dissatisfaction, anxiety, cognitive distortions and behavioural avoidance are also typically studied (Thompson, Altabe, Johnson & Stormer, 1994). Overall impressions of the body as liked or disliked are also covered (Thompson et al., 1994). Emotional experiences of the body, however, are frequently overlooked, with more of an emphasis being placed on simply how the body looks in the mirror. This focus on observable attributes of the body can be seen as related to cultural norms of beauty and evaluation (Bordo, 1997), which may explain the prevalence of these conceptualisations. Subtle experiences and feelings in relation to the body are frequently overlooked in studies, however they are slightly more prevalent in some of the psychodynamic discussions on mind and body in depression.

Psychodynamic approaches to mind and body in depression

Few studies can be found focusing on the more emotional-based link between the mind and body in depression, incorporating a psychodynamic perspective. Miller (2005) discusses the usefulness of combining psychodynamic psychotherapy with yoga in order to increase physical awareness of emotions in both depression and anxiety. However, she has provided no theoretical reason for the usefulness of such an implementation.

Turp's research (1999) explores the relationship between mind and body, utilising her idea of “body storylines” (as described earlier) to explore the emotional aspects of the mind-body relationship in a specific case study of depression. Turp (1999) utilises the client's body storyline to gain an understanding of her relationship to her body and how this mirrors the client's internal world . She describes how her

client felt as though her body were a “machine”, which she later linked to an experience of being treated as a machine as a child. During the process of therapy, Turp (1999) describes how the client moved to a point where she was able to become more connected to her body, and described herself as enjoying her body and feeling more physically graceful and alive. This mimicked her emotional changes towards being more caring towards and understanding of herself (Turp, 1999).

While Turp's research is limited in its applicability, it nonetheless is one of the few examples of how the developmental relationship to the body emerges in the context of psychopathology in general, and depression in particular. Turp's linking of a developmental perspective seems to provide a greater understanding of a particular client in her case-study research. Therefore it appears that etiological perspectives enhance understanding of lived experience of the body and therefore utilising a psychodynamic etiology may assist in understanding the relevance of physical experiences in depression.

OVERVIEW OF LITERATURE

The concept of depression was briefly defined at the start of this review. Basic basic information on epidemiology was provided, which indicated the high prevalence rates of depression. Comorbidity was examined, with the relationship between anxiety and depression identified as one of the most common (Gotlib & Hammen, 2002). While this provided quantitative information on depression, lived experiences of depression were also explored, which frequently focused on phases of depression and identity (Cornford et al., 2007; Karp, 1994; Knudsen, 2002). Experiences of loss and hopelessness were also identified. Literature regarding experiences of specific population groups, such as teenagers (Wisdom & Green, 2004), Chinese women (Chan et al., 2002) and women with postpartum depression (Beck, 2002) were explored. The course of depression was investigated, with literature indicating that a chronic course with high levels of relapse as typical. Qualitative studies on recovery indicated that participants found it to be a slow process, but that the role of insight into their disorder was important (Ridge & Ziebland, 2006; Schreiber, 1998).

The etiology of depression from a psychodynamic perspective was included in this review as it can be seen as providing a useful theoretical framework to ultimately gain an increased understanding of the relationship between mind and body in depression. The focus was predominantly on Freud's (1917) theory of object loss,

which postulates that an abstract experience of loss ultimately becomes internalised, with anger towards the lost object being directed against the self. The overlap between this and oral dependency theories of depression was covered, with a lack of oral dependency needs being seen as a possible risk factor, and regression in object loss often leading to a return to the oral stage of development (Freud, 1917). A lack of care and nurturance, if needs of this stage are not met, were discussed as leading to increased vulnerability to loss, as well as to a lack of self-esteem. Klein (1986) and Green's (Green, 1986; Kohon, 1999) work was also briefly reviewed. While Klein focuses more on the internal world of the infant, Green describes infants' experiences of deprivation following a depression in the primary caregiver. This can be seen as related to Freudian theories of object loss and possibly oral dependency.

The importance and controversy surrounding the relationship between mind and body was explored. Theories of the interrelation between mind and body from a psychodynamic perspective were focused on, with Freud's (1923) view of the self as arising from the body, and Winnicott's (1987) view of the early and interrelated nature of psyche and soma being discussed. The relationship between mind and body was examined as it is related to certain somatoform disorders and hysteria in literature, with the view that the body expressing unconscious thoughts and feelings (McWilliams, 1994) being observed as the most common understanding.

The nature of the mind-body relationship with regards to depression was then discussed. While somatic symptoms and somatisation were found to be commonly occurring (e.g. Vaccarino et al., 2008), research on lived experiences was far less common, although this was briefly discussed by Wilson (2007). However, the importance of somatic symptoms was identified (Dymettenaere et al., 2004) as well as the proven role of exercise in the treatment of depression. Studies on body image indicated that poor body image was frequently associated with depression (Biby, 1998; Thompson et al., 1994). Additional literature that focuses on the body, such as body image studies and the use of movement and dance therapy (Koch & Brauninger, 2006) and yoga (Miller, 2000) have been briefly surveyed, but were not covered in depth, as they are not central to the focus of this study.

While it is evident that somatic aspects of the self are of importance in depression, little research could be found that discussed the nature of the relationship between emotional and somatic aspects of the self in depression, or provided an

understanding of the body in relation to etiological theories.

GAPS IN THE LITERATURE

While diagnostic and epidemiological information is frequently found in the literature, research on the lived experiences of depression were less common. Research on self-perceived phases of being depressed and adjusting to depression were frequently referred to (e.g. Karp, 1994). Identity was also included in several studies (Cornford et al., 2007; Karp, 1994; Knudsen et al., 2002; Lewis, 1995), with a particular focus on the impact of depression on a sense of identity. While Cornford et al. (2007) focused on the difference between participants' and the medical professions' view of important symptoms in depression, there is little emphasis on what it is like to live with depression in these studies. A focus on specific population groups' experiences provided a more in-depth focus on experiences (Beck, 2002; Chat et al., 2002), yet similar studies were not found in relation to a more generalised population. Research on recovery experiences explored meanings and struggles of recovery from depression (Ridge & Ziebland, 2006; Schreiber, 1998). However, little information on the somatic aspects of recovery was found.

Information on the existence and prevalence of somatic symptoms was adequate (e.g. Demyttenaere et al., 2004; Ford & Cooper-Patrick, 2001) with additional information on aspects such as restricted movement being provided by Jacobsen et al. (2006). Yet again, few studies engaged with what it is like to live with these somatic experiences. Vaccarino et al. (2008) covered more generalised and experiential factors in their study, such as not feeling well. However, as this study was based on rating items, no input on lived experiences was obtained from participants. Wilson (2007) and Turp (1999) were an exception to this as both focused on lived experiences of the body. However, a focus on the body was only a minor aspect of Wilson's work, and Turp's case study can be seen as quite limited in terms of its generalisability. While body image studies may be seen as relating cognitive experiences, these focused more on the body's appearance (as reviewed by Cash & Pruzinsky, 2002), rather than more subtle experiences of the body.

Links between mind and body are covered to a certain extent in psychodynamic literature, particularly in disorders that are explicitly physical in their manifestation (Meissner, 2006). For example, some somatoform disorders are seen to be a symbolic expression of emotional conflicts and processes (Meissner, 2006). As

depression is generally conceptualised as an emotionally rather than physically oriented disorder (Dowrick et al., 2005), links between mind and body, as described above, are seldom engaged with. While somatic symptoms, somatisation and body image are all researched, little attention is paid to the lived experiences of the body in depression, and the possible meanings behind these experiences. However, this area of study may provide an enhanced understanding of the physical aspects of depression. While theories on hysteria and some somatoform disorders link the ways in which the physical self reflects the emotional self in psychoanalytic and psychodynamic literature, the way in which the body serves as a representation (or symbol) of the emotional self in less physically-manifested disorders has not been sufficiently explored. While Turp (1999) provides an understanding of this relationship in her case-study research, further exploration is needed to gain an increased understanding of this phenomenon in which the body mirrors emotional processes in the context of depression.

In terms of the link between developmental theory and the etiology of depression, while Sigmund Freud (1923), Anna Freud (in Meissner, 2006) and Winnicott (1949) explicitly (although briefly) point out the mind-body link in early development, this does not appear to be directly explored in the etiological theory of depression. Winnicott does generally relate the split of psyche and soma to insufficient mothering and views this as present in a generalised view of psychopathology. Etiological theories of depression may mention physical aspects, such as the mouth and physical holding (e.g. in Freud's oral phase development), yet the impact of these physical developmental experiences are not focused on in the understanding of depression. While many theorists indicate that the body self and the psychological self develop in tandem (e.g. Sigmund Freud, Anna Freud and Donald Winnicott), this area has been insufficiently explored. At times it also appears that theories and/or interpretations contradict one another, and the nature of the mind-body relationship still remains unclear in psychodynamic literature.

Further understanding of the mind-body link in etiology of depression may help to provide increased knowledge of both mind-body relationships and the link between the body and self in the etiology of depression.

OPERATIONAL DEFINITIONS

The terminology as outlined below will be utilised in this study, and operational

definitions have been provided to clarify the meanings of these terms.

Depression is defined in accordance with the DSM-IV TR (APA, 2000), as described above.

Perceived depression refers to subjective perceptions of the self as being depressed. This term has been utilised as it is difficult to retrospectively measure the presence of psychopathology. Used in this study, this term may refer to experiences of a major depressive disorder, dysthymic disorder, depressive disorder not otherwise specified or an adjustment disorder with depressed or depressed and anxious mood, or to sub-clinical levels of depression.

Experiences of the body refers to subjective perceptions of the body with regard to what it is like to live in the body, somatic feelings, the view of the relationship to the body, emotions experienced in relation to the body and the way the body is made sense of and understood by the individual.

Symbolic representation refers to the process by which the internal mental image of one object comes to stand for the mental image of another object, as found in psychoanalytic literature. Therefore the first mental image serves as a symbol for the second (Rycroft, 1995).

This literature review examined and discussed existing research and knowledge in relation to depression, the mind-body relationship and interactions between mind and body as they emerge in depression. Overall trends, such as a quantitative focus and a dearth of information regarding lived physical experiences were observed in relation to depression. Psychodynamic understandings of the relationship between mind and body were discussed, and a lack of application to this in relation to depression was observed. The existence of an interacting relationship between mind and body in depression was identified, although evidence of this tended to be quantitative in nature. Overall it was seen that more information on lived experiences of the body, and a psychdynamic understanding of this, could potentially be useful. The subsequent section will discuss the central research questions arising from the

literature reviewed, and discuss the research method chosen to examine these questions in this study.

CHAPTER 3: METHOD

In this chapter, research questions that have emerged from the literature, and which provide a central focus to this study, are presented. The research approach and methods that were utilised to answer these questions are then explained. Initially, the reasons behind the interpretive social science approach and qualitative research methodology used in this study are explored. The elements of phenomenological and case study research included in the design are then discussed and substantiated. The sampling approach is explained, and an overview of the sample is given. The procedures followed in conducting the research interviews and thematic content analysis of the data are also examined. Reflexivity is discussed and, finally, ethical concerns and the way in which these were managed are addressed.

RESEARCH QUESTIONS

The following research questions were drawn from the literature reviewed and served to guide the current study:

1. How do individuals experience their bodies during depression?
2. What central constructs emerge in the narratives of these experiences?
3. In what ways are these constructs related to psychodynamic etiologies of depression?
4. In what ways can the experiences of the body be seen as symbolic representations of the underlying etiological processes present in depression?

RESEARCH APPROACH

An interpretive social science approach has been utilised in this study. From an interpretive social research perspective, the social world is viewed as differing from the natural world (McLeod, 2001). Therefore, a move is intended away from the positivist approach, as utilised in the biological and physical sciences, and a focus on a research method more suited to the study of people and social phenomena is the focus (Babbie & Mouton, 2004). Interpretive social science is underpinned by the belief that internal, subjective experiences of reality are crucial (Neuman, 2000), with a view to gaining an understanding of the social world, as opposed to the focus on hypothesis testing found in positivist research (McLeod, 2001). As all research takes

place within a specific context, acknowledgement of the culture and context of the research is important (McLeod, 2001). Interpretive social science data collection methods provide in-depth accounts and rich descriptions (Neuman, 2000) in order to assist in gaining a deeper understanding of social experiences (Babbie & Mouton, 2004). An empathic understanding of people and social phenomena is attempted, with the aim of generating new conceptual and theoretical understandings (Pope, Mays & Popay, 2007). This approach was selected in order to gain in-depth understanding of the ways in which individuals experience their bodies during depression and explore the relationship between experiences of the body and emotional processes in depression.

Qualitative methodology focuses on gaining information that centres on thick description, the acquisition of meaning, as well as an understanding of specific phenomena within a certain context (Seale, 2004). A qualitative methodology was therefore chosen in order to meet the aims of the current study, and is in line with an interpretive social science approach (Babbie & Mouton, 2004). This qualitative approach allowed for an understanding of the individual's inner experiences, as well as gaining in-depth descriptions and accounts of the body during depression. During the process of this study, attention has been paid to the nature of a qualitative approach, and the researcher has focused on gaining an understanding of the participants' worldview and has attempted to elicit rich, descriptive information from participants where possible during the research process (Babbie & Mouton, 2004).

RESEARCH DESIGN

The research design underpinning this study incorporated elements of a phenomenological approach, as well as some elements of the case study approach. The phenomenological approach includes gaining an understanding of the whole of a lived experience of an individual person, as it understood by the individual (Giorgi, 1997). Thus utilising aspects of this approach has assisted in providing an enhanced understanding of the lived experience of the body in depression. However, although phenomenological studies are often extensive in terms of an individual's experiences, the research design incorporated elements of this, but did not incorporate the extensive depth often found in a phenomenological approach (Giorgi, 1997). Some elements of case study research were also incorporated in the design of this research, such as the use of theory to provide understanding into psychopathology (Ivey, 2008),

and gaining more in-depth data that is richer than that found in many interviews, as well as a deeper level of data analysis (Breakwell, Hammon, Fife-Schaw & Smith, 2006).

SAMPLE AND SAMPLING

This study employed a non-probability sampling method in which elements of convenience sampling, snowball sampling and purposive sampling were utilised. Convenience sampling refers to the inclusion of participants who are readily accessible. While this method limits the generalisability of the results, it is a practical method of selecting participants and was utilised in order to increase the feasibility of finding participants (Babbie & Mouton, 2004). Snowball sampling was also utilised, which involves asking participants who have been accessed to locate other potential participants (Babbie & Mouton, 2004). This method was chosen in order to increase the ease of accessing a sample of individuals from a population that is not easy to locate, and that consists of individuals who may not readily come forward due to the stigma associated with mental illness.

As participants were chosen on the basis that they met certain criteria that were needed to achieve the aims of the research, elements of purposive sampling were also present (Babbie & Mouton, 2004). Criteria required to include potential participants were that the individuals were over 18 years old, felt that they had suffered from depression in the past, and at the time of the study, did not perceive that they were suffering from major depressive disorder. In addition to this, participants needed to have not experienced major depressive disorder in the past year. In order to minimise risk to participants, only individuals who were receiving or had received psychotherapy at the time of the study were included. However, it was decided that participants could not be receiving psychotherapy from the researcher, as this would have impacted on the therapeutic process.

Five participants were included in this study. While this sample size cannot be seen as representative of other individuals who have suffered from depression, it has allowed for an in-depth understanding of participants' experiences, which is in line with the aims of qualitative research (Babbie & Mouton, 2004).

All five participants perceived that they had suffered from depression previously and no longer met the criteria for major depressive disorder at the time of the study. While no participants appeared to be experiencing a major depressive

episode at the time of the interview, some depressive processes were still described as being present, which is consistent with literature on recovery from depression (Sadock & Sadock, 2007). All participants had a tertiary level of education, and all had received psychotherapy for their depression, with three out of the five participants still in psychotherapy at the time of the research. In terms of the gender of participants, three were female and two were male. A gender criterion was not specified for inclusion in the sample, as this study was largely exploratory. The intention was to not foreclose potential information of interest because of the lack of research of this nature, and a specific gender focus was not included in the research questions. Most participants described their main depressive episode as having occurred in their mid to late twenties, with one participant having experienced depression in her late teens. Table 1. has been provided below to provide a descriptive overview of the sample included in this study.

Table 1. Sample Description

	Gender	*Age*	*Stated depression trigger*	*Current occupation*
Participant 1	Male	34	Unemployment	Architect
Participant 2	Female	35	Childbirth	Psychologist
Participant 3	Female	25	University	Student
Participant 4	Female	37	Abusive relationship	Teacher
Participant 5	Male	36	Changing job	Teacher

PROCEDURE

Participants were accessed via word of mouth, with the researcher making the study known to colleagues and requesting details of potential participants. Potential participants were also accessed via existing participants, some of whom referred people who would also be suitable for the study. Some participants contacted the researcher directly. For others, names and details of potential participants were passed on to the researcher, who contacted potential participants to confirm their willingness to participate in the study and to reiterate the objectives of the study. The majority of participants were then contacted again, and interview times and locations were

arranged, while some participants arranged times immediately.

Interviews lasted from between 50 to 120 minutes. The differences in interview times were due to the fact that some participants seemed wary of engaging on a personal level and were reluctant to divulge certain information, while others needed more time to get in touch with and explore their own experiences. Practical time constraints were also a factor, as some participants were interviewed during working hours and needed to return to work. The researcher allowed for the participants' individual differences to guide the research process. Three participants were interviewed in their own homes, and two were interviewed at their place of work.

DATA COLLECTION TOOL

A semi-structured interviewing guide (see Appendix A) was utilised to assist in eliciting information about participants' experiences. A semi-structured approach was used in order to ensure that exploration of individual issues regarding participants' experiences of their body during and following depression could be carried out, but still within the framework of the research (Bariball & White, 1994). An interview approach was selected as it provides more opportunity than a questionnaire format for exploration of issues and emotions relevant to each participant. Utilising an interview to collect data also means that non-verbal responses can be seen by the researcher and noted, providing additional material (Bariball & White, 1994). This was particularly relevant in for this study, as experiences of the body were being explored, meaning that non-verbal data such as posture were of high importance. This method of obtaining data is also in accordance with the needs of thematic content analysis, which requires the use of rich textual information for analysis, which was provided by the transcribed interviews.

Interviews were recorded using a digital audio recorder, in order to leave the researcher free to engage with the participant, without having to be pre-occupied with taking notes (Minichiello, Aroni, Timewell & Alexander, 1991). It should be noted that the method of audio recording data may, however, impact on participants responses. Audio recording could possibly lead to an increase in awareness of the research process and of the researcher's role, thus potentially influencing results, but does provide more accurate data than note taking (Minichiello et al., 1991). However, it was noted that none of the participants seemed to be concerned about the fact that they were being recorded, although their responses in this regard may have been

affected on a more unconscious level. During interviews, attempts were made to clarify the experiences of participants, in order to increase the internal validity of the data (Henning, Van Rensburg & Smit, 2004).

DATA ANALYSIS

Interviews were transcribed by the researcher in order to protect confidentiality, and to ensure an in-depth engagement with the data. Self-reflexive notes were also made for each interview immediately afterwards, and will be discussed in the section on reflexivity. Shortly after the interviews were conducted, the analysis of data was undertaken.

Analysis of this data was conducted using thematic content analysis in order to interpret and understand the data by identifying, analysing and reporting patterns (or themes) that emerged (Braun & Clarke, 2006). Themes were explored in both manifest and latent content (Eagle, 1998) in order to facilitate an in-depth understanding of the phenomenon being studied (VanManen, 1990). However, it should be noted that exploring themes is ultimately reductionist, and may therefore fail to fully capture the lived experience of participants (Van Manen, 1990).

Exploring themes in the context of this study provided a practical means of accessing the in-depth meaning present in the data. This helped to facilitate an increased understanding of people's experiences of their bodies during depression and ultimately relating these back to a psychodynamic theoretical understanding as conveyed in the research questions. Both interview material and the self-reflexive journal were utilised to provide data to be analysed as part of the study.

The process of analysing the themes that emerged from data was conducted as follows. Familiarisation and immersion in the data was undertaken in order to gain an overall understanding of the material, in order to guide the data analysis process (Terre Blanche & Kelly, 1999), via the researcher transcribing the interviews and reading through the interview transcripts several times. Initial codes were then generated by reading through the text and highlighting codes which indicated evidence of a potential theme (Braun & Clarke, 2006). Such codes included words, phrases or ideas that emerged from the data (Van Manen, 1990). This was followed by collating these codes into themes. These themes captured processes, functions, tensions and contradictions that emerged from the data, with a focus on those that

were related to the theoretical assumptions underpinning the research and associated with the research question, as described by Braun and Clarke (2006). Themes were then reviewed to ascertain relationships, contradictions and sub-themes (Van Manen, 1990). A process of ongoing analysis was then conducted in which themes were defined and named (Braun & Clarke, 2006) and the relationships between them were explored. Interpretation was then carried out, during which thematic categories were combined and then explored during a process of analysis, and ultimately used to answer the research questions (Terre Blanche & Kelly, 1999). This was then related back to literature (Braun & Clarke, 2006), and ultimately discussed in relation to the theoretical framework of psychodynamic etiological theory. During this process, the self-reflexive journal data was utilised to provide an increased understanding of the researcher's bias, and the possibility of the influence of this on the research (Smith, 1999).

REFLEXIVITY AND THE RESEARCH METHOD

Interpretive social research from a qualitative perspective focuses on understanding subjectively experienced social realities, with an acknowledgement of culture and context (McLeod, 2001). Due to an acknowledgement of these contextual factors, the importance of reflexively acknowledging the researcher's own subjective realities becomes important (Maso, 2003). The researcher's particular subjective experiences, culture and context impact on what is being researched. An awareness of this becomes vital within an interpretive framework, in order to avoid the error of the research being approached and viewed as the only true perspective (Alvesson & Skoldberg, 2005). In accordance with Alvesson and Skoldberg (2005), reflexivity was incorporated into the research process, and a reflexive journal was kept for this purpose. This journal captured the researcher's responses during the different stages of the research process, for both data collection (O'Callaghan, 2005) and to critically examine the research process and the researcher's impact and potential biases, in accordance with Alvesson and Skoldberg (2005) and Malacridia (2007).

The nature of the study and the research questions can be seen as being influenced by the researcher's personal perspective (Maso, 2003). In this case, the researcher's personal interest in mind-body connection and depression, combined with her clinical training as a psychologist and the preference for a psychodynamic orientation, can be seen as influencing the scope of the research and the nature of the

research questions, as well as the data collection and data analysis.

Interview schedules and the process of the research cannot be seen as neutral, as both are affected by the bias of the researcher (Maso, 2003). The construction of an interview schedule can contain bias, and can be seen as attempting to elicit certain responses (Maso, 2003). While the researcher attempted to manage this, it is likely that some bias was present in the interview schedule. During the actual interview process, the researcher's responses to participants may also be seen as providing covert support or disapproval, as the researcher is in a position of power in this instance (Malacridia, 2007). While the researcher paid attention to these factors and attempted to mitigate them, it should be noted that it is likely for some influence to have been experienced by participants, and some of the evident instances of this have been noted in the presentation of findings.

The self-reflexive journal was also utilised to capture the researcher's own responses in relation to participants during the interview process. Particular attention was paid to somatic responses, as is discussed by Turp (1999), and provided some additional information regarding participants as described by O'Callaghan (2005). The physical responses of the researcher in relation to participants were recorded, and the likelihood of this relating to the researcher was noted, before inclusion of these experiences into the research data. The researcher's responses to the participants are explicitly recorded in the presentation of findings chapter of this report.

The analysis of data is never entirely neutral as the researcher's perspective will inevitably affect the interpretation of results (Alvesson & Skoldberg, 2005). The use of a psychodynamic theoretical framework and understanding may also have contributed to the analysis of the data. As the analysis was partly informed by theory, it is plausible that if the data had been analysed from a different theoretical perspective, that differences may have occurred in the understanding and interpretation of the data. Even within psychodynamic theory, the researcher's interest in particular understandings of depression can be seen as guiding the analysis of the data. Thus the researcher's theoretical preferences can be seen as impacting on the data analysis and final discussion to some extent. In addition to issues of self-reflexivity, ethical considerations were also necessary as part of the research, and will be discussed below.

ETHICAL CONSIDERATIONS

Ethics approval for this research was granted by the ethics committee of the Department of Psychology at the University of the Witwatersrand (see Appendix E). The following ethics clearance protocol number was issued: MACC08/011IH. Approval was provided with regard to the ethical considerations as detailed below.

Individuals who suffer from depression may be considered a vulnerable population to study due to the fact that they are psychologically at risk. As a result, ethical issues were of great importance in this study. In order to limit the impact on participants, only individuals who did not perceive themselves to be suffering from a major depressive episode at the time of the interview were included in this study in order to reduce the level of vulnerability of participants. In addition to this, only participants who were currently receiving psychotherapy or had received therapy in the past were included in the study, with the implication that participants would have a greater emotional and intellectual understanding of their illness, and were therefore less likely to be psychologically vulnerable as a result.

As the researcher was an intern psychologist at the time of the study, and was being trained in psychotherapeutic skills, this provided an additional means of managing risk to participants. In addition to this, the psychotherapeutic training and experience of the research supervisor assisted in ensuring that the process of the interview, and the management of participants, was carried out correctly. The researcher made preparations to provide contact details for free counselling if needed, through Lifeline (0861 322 322) and the South African Depression and Anxiety Group (011 262 6396). However, this was ultimately unnecessary as the majority of participants were in therapy, and no issues emerged that indicated the need for immediate additional help.

As the research interview involved divulging a certain degree of personal information that may have potentially evoked an emotional response in participants, it was noted that this could impact on the process of the participant's own personal psychotherapy. Participants were informed of this fact prior to the research, in the information letter (see Appendix B), and the researcher was mindful of the fact that the process of the interview should not be therapeutic in nature.

Due to the stigma of mental illnesses, confidentiality for participants was of high priority, and participants were informed that all audio recordings would only be accessed by the researcher, and transcripts only by the researcher and research

supervisor. Following qualification, all recordings of interviews will be destroyed and transcripts deleted or destroyed. To help to preserve confidentiality, no names or identifying information from participants have been utilised in the research report and the same will apply in any potential publications.

Participation in the study was voluntary and all participants were provided with an introductory letter (see Appendix B) to read, providing details of the study being conducted as well as information on the research process. All participants signed an informed consent form (see Appendix C), saying that they agreed with the conditions of the study. A separate permission form allowing the interviews to be audio recorded (see Appendix D) was also signed. These forms were placed in an envelope and sealed after they had been signed, in order to preserve confidentiality.

Participants were informed of their right to withdraw from the study at any time, as well as the right not to answer specific questions if they felt uncomfortable. Participants were not coerced into answering questions or divulging any information that they felt reluctant to reveal. Participants were told in advance that the interview process could not be regarded as a form of treatment or cure.

A presentation of the central research questions guiding this study introduced this chapter. The interpretive social science research approach, with its focus on understanding subjective experiences, was discussed, as was the qualitative research approach chosen to assist in understanding lived experiences of the body during depression. The research design, with phenomenological approach and a few elements of case study research, was explained. The sampling method and eventual sample of five individuals who met the required criteria were discussed, including the attributes of the sample chosen. Procedures for accessing and interviewing participants was described, as was the thematic content analysis of the data collected. Self-reflexivity was discussed, and factors such as personal preferences, power dynamics and biases possibly introduced by the researcher were discussed. Finally, potential ethical issues and methods taken to avoid these were explained. Data collected in the manner detailed above, will be presented in Chapter 4.

CHAPTER 4: PRESENTATION OF FINDINGS

In this chapter, the findings of the research, as obtained via interview data and information from the researcher's self-reflexive journal, are presented, interpreted and related to relevant existing literature. Initially, a brief case vignette of each participant is given in order to provide background contextual information to assist in understanding the participants' emotional experiences. Emotional experiences of depression are then presented, in order to provide background information and to provide a context within which physical experiences can be understood. With this background in place, experiences of the body are explored, with a focus on the central themes of disconnection from the body, and experiences of lack. Finally, participants' own understandings of the relationship between physical and emotional aspects of depression are discussed.

CASE VIGNETTES

In this section, case vignettes based on the brief history and information provided in the interview process are discussed. Brief information has been given on the depression trigger, self-perception, and developmental history for each of the participants. This information has been included in order to understand each participant's own story and to contextualise their emotional and somatic experiences.

Participant 1 suffered from depression during an unsuccessful move overseas, where he felt extremely helpless and hopeless due to the fact that he was only able to obtain a menial job, in spite of already successfully completing postgraduate education. At the time of the interview, he described himself as being a physically active person, and enjoying analysing systemic processes. Participant 1 was in an incubator due to being born premature, and was described by his family as vulnerable and needing care at that time. He started to walk late, but walked perfectly, straight away, possibly indicating an early tendency towards perfectionism. Participant 1 was described by his family as organised and structured, which he felt did not capture his full personality. He described himself as isolated and lonely as a child who had gained most of his enjoyment via physical activity.

Participant 2 became depressed following the birth of her first child, which she described as resulting in feelings of a loss of self, and a loss of control over her life. At the time of the interview, she described herself as a mindful and caring person. In

terms of her early life, Participant 2 was an unplanned child and her mother was upset by the pregnancy as she had recently had her first child. Participant 2 was described as an undemanding infant, and mentioned that she was bottle-fed and not breast-fed. As a toddler, Participant 2 was a fussy eater, which lasted into childhood and early adulthood. Participant 2 was uncharacteristically deceptive around hiding food, and was otherwise a well-behaved and high achieving child who enjoyed playing. She described that, although she felt there was a lot to be happy about in her life, there had been little room for emotional expression within her family.

Participant 3 experienced depression in her late teens when she started university, which heightened her awareness of a lack of meaning in life, and the shallowness of society. At the time of the interview, she described herself as enjoying art, socialising, and being out in nature. Participant 3 was born shortly after her parents' immigration to South Africa. Around the time of her birth, her mother was described as possibly suffering from depression. Participant 3 described feelings of intense abandonment at 18 months, when her mother went to hospital to give birth to another sibling. As a child, she described her self as often running away from her mother, whom she actually wished to be close to, as well as experiencing a lot of anxiety, fear, loneliness and sadness. She often utilised cultural activities as a means of coping and found these to be enjoyable.

Participant 4 became depressed following the birth of her babies, as their birth led her to become more aware of the abusive nature of the marriage she was in. At the time of interview, Participant 4 described herself as vivacious and outgoing, while at the same time wary of who she really allowed herself to get close to. Participant 4 described herself as very relaxed as an infant, and described her childhood as quite idealistic. However, there were strict rules in her family that she found difficult to comply with, and she was often criticised for being demanding as a child and rebellious as a teenager. In general, she seemed reluctant to speak about her early childhood during the interview process.

Participant 5 became depressed regarding his role at work, where he felt that his need for meaning was not met, and felt pulled from all sides by his colleagues. Participant 5 described himself as a realistic and consistent person. Participant 5's conception was surrounded by controversy, as his parents were not married at the time, although he still described himself as feeling wanted. At age six, Participant 5's

parents divorced, resulting in feelings of instability. Participant 5 felt very responsible for his mother and sister, and described himself as giving up his childhood to take on a more adult role. Participant 5 was bullied at school, and found solace and stability in his religion. At school, Participant 5 described himself as being conscientious and as doing well academically. However, he always felt that there was an absence of a male role model, given that his father was not present and his stepfather was distanced from him.

In general, themes of a lack of sufficient nurturance from parents and experiences of loss of self or others seemed to be evident in the participants' histories. Similar themes arose in emotional experiences of depression, which will be discussed in the subsequent section.

EMOTIONAL EXPERIENCES OF DEPRESSION

While the focus of this research was on physical experiences of depression, emotional experiences were explored and discussed as part of this process in order to provide additional background information to assist in understanding the meanings of the body during depression. Within this section on emotional experiences, central concepts of disconnection from self and others, and experiences of lack and deficiency, are discussed.

Disconnection

A sense of disconnection in relation to the self and others emerged from participants' narratives of their emotional experiences of depression. This disconnect was evident in a sense of a loss of an aspect of self, which arose in relation to a situation in which the individual had to adjust to changing roles and circumstances. In addition to an internal disconnection, participants also described disconnecting from the world around them.

Experiences of loss due to adjustment

Adjustment to a new situation or life phase is commonly associated with the onset of depression (Bifulco et al., 2000; Kessler, 1997). For participants interviewed in this study, adjustment to a new situation, role, or life phase, was evident in each participant’s narrative regarding the onset of their depression, which is in accordance with the effects of stressful life events and life changes as common triggers for

depression (Bifulco et al., 2000; Kessler, 1997). For the participants in this study, adjustment can be seen as having led to a loss of either a role in life, or an aspect of self. A combination of adjustment difficulties and concomitant loss appears to have played a central role in the onset and maintenance of depression for all participants.

Adjusting to a new country and being unable to find employment had a negative impact on Participant 1. He also described feeling out of touch with his true needs at that time:

> I had moved countries, and went on a dogmatic search for the ideal white-picket fence job, not paying too much attention to vast quantities of information around me telling me that I was being a goon, and dug a deeper hole. I was blinkered to doing things that were in line with who I really was. I was trying to get a full-time job, but I couldn't get one... (Participant 1)

Feeling unable to be true to himself, as well as a loss of identity as an employed, and therefore worthwhile, person were evident in further descriptions of these events. This is in agreement with existing literature on the effects of unemployment and its association with onset and continuing course of depression (Stakunas et al., 2006). Paired with a stressful life event such as moving country, this was even more likely to result in depression (Kessler, 1997). In addition to losing a sense of himself as competent, he also found that due to various circumstances, he was unable to be in touch with his true feelings and desires at that time. As a result of being unable to change his circumstances, and due to the fact that he was not truly interested in the employment he was seeking, he became increasingly depressed as the situation continued to spiral.

While work was also an issue for Participant 5, his depression emerged in relation to the being unable to find meaning or a place for him in his work environment when he changed to a new job:

> I think my … quite a bit of my depression has been around my work. And trying to find meaning in my work. Um, and it's still an ongoing struggle, that to find a fit that matches my personality. Recently, well I say recently, the last eight years has been around my work... and not finding myself feeling very much at home in that environment. (Participant 5)

Meaning was also relevant for Participant 3, whose struggle revolved around a loss of

a sense of meaning that she had previously found in religion, which emerged as she entered adulthood. This left her with a sense of loss in relation to spirituality:

> So I dropped my religion at 18 and I was left with nothing. I had nothing to make sense in my world… (Participant 3)

From this it can be seen that due to the adjustment of becoming an adult and leaving high school for university, Participant 3 lost her role as a child who is given meaning by religion, and who can rely on a higher power.

Participants 2 and 4 experienced depression shortly after having their first children. For Participant 2, this presented as depression in relation to the task of mothering, and in having to give up aspects of herself for her children. The experience of loss, following giving up an aspect of self in becoming a mother, is commonly experienced in postpartum depression (Nicolson, 1999). Due to the fact that she struggled to adapt to the role of mother, her sense of herself as an incompetent mother replaced a view herself as a competent adult, leading to decreasing low self-esteem:

> And then I felt like I was a bad mother and all my life I'd managed to live up to very high expectations, and here I felt was something that should have come so naturally to me, and it just wasn't. So I felt like quite a failure. (Participant 2)

Participant 4's depression emerged after the birth of her infants, but was perceived as being related more to an abusive marriage, as opposed to the birth of her children. For her, it seems as though the added responsibility of becoming a parent highlighted the abusive and unsupportive nature of her marriage. Living in an abusive environment was also an obvious contributing factor, which combined with the birth of her children, led to an increasing sense of helplessness to escape her situation. For Participant 4, prior to the conception of her children, infertility was experienced as an initial loss. Following the birth of her children, she then became more aware of the nature of her home situation, and experienced a loss of herself as an adequate and self-directed adult:

> The world was a bit unfair because I couldn't fall pregnant. My children are

> fertility babies. And um… that was I think the start of it. And I was also in this completely dysfunctional marriage and so I kind of going down and doubting myself a lot... I was in an abusive marriage, he was unsupportive with the children. (Participant 4)

In all five of the participants, a sense of a loss of an aspect of self seems to have been present in the onset and maintenance of their perceived depression. For participants in this study, experiences of adjustment and loss of aspects of self can be seen as contributing to the affective, cognitive and behavioural traits associated with depression. As this loss of an aspect of self can be conceptualised as a form of disconnection within the self, the experience of adjustment and concomitant loss has been captured under the theme of "disconnection". In literature on depression etiology, an experience of loss in a variety of levels is commonly seen as triggering a depressive episode (Cameron & Carmichael, 1963; Freud, 1917) and therefore these findings can be seen as being in line with existing literature. This is discussed in depth later in this report.

Withdrawal from others

Withdrawal from others and a sense of isolation from the world around them was a predominant theme in participants' narratives of their depression. As social withdrawal and a sense of isolation is common in depression (Johnson, 2000) these findings can be seen as being in line with existing literature. Participants described feeling alone or feeling unable to connect with others. Thus, a withdrawal from others can be seen as disconnect between self and others.

For Participant 1, moving to a large city overseas increased his feelings of isolation, adding to his experiences of depression. In this instance, disconnection between self and others was more of a passive experience. However, given Participant 1's history of being a "loner", it seems likely that his experience of isolation may have been partly influenced by his pre-existing dynamics.

While Participant 1's isolation was experienced as inactive, for Participants 2 and 4, withdrawing from others seems to have been an active attempt at controlling feelings of inadequacy, as was described by Participant 2:

> … I definitely withdrew in terms of the depression from my circle of friends. I became very isolated. In part, because having a baby it was difficult to get

> around, but more so because I just felt so inadequate that I couldn't actually, I didn't want to face other people. And so I withdrew a lot. (Participant 2)

For Participant 4, her isolation appears to have occurred to a more profound degree, leaving her feeling afraid of going out into the world:

> …I was quite frightened of the rest of the world. I was terrified. I didn't know how I was going to go forward and face the world. So… I hibernated, I … agoraphobic. I almost became agoraphobic. (Participant 4)

Due to her feelings of an inability to cope with the world, it appears as though Participant 4 became increasingly afraid of facing the world due to her perceived inadequacies. These perceived inadequacies seem to have created increasing feelings of fear, and an active attempt to manage these by keeping herself isolated from her environment.

Social isolation can be seen as a factor which continues to exacerbate the condition of depression, due to the fact that individuals become distanced from possible social support that may help to alleviate symptoms (Maher et al., 2006). An experience of loss of a sense of self as being capable can be seen as influencing participants 2 and 4, leading them to become more disconnected from those around them. For Participant 1, the loss of a familiar environment led to an increasing disconnection from others, which possibly interacted with his existing dynamics.

Disconnection can be seen as emerging from an experience of loss, leading to two aspects of the self no longer being joined. This disconnection was then experienced in relation to the self as well as in relation to the social world. This experience of loss can be linked to the psychodynamic etiological concept of object loss (Freud, 1917) and will be explored in greater depth later in this report.

Overall, for participants in this study, it appears as though loss of a familiar environment or a sense of the self as competent and worthy led to an increased disconnection from self and others. Just as could be seen in the physical aspects of depression, disconnection and loss also led to experiences of deficiency and lack at an emotional level.

Lack

A sense of deficiency in relation to self, others and the world was described by all of the participants. The self was often viewed as lacking in competence or purpose, and for some participants, social relations were viewed as insufficient to provide what was needed. In both instances, an experience of participants being unable to access enough or to be enough, was prominent. Captured within this theme are the ways in which participants managed a sense of lack. Feeling anxiety, being comforted by others and comforting others, as well as a focus on survival, were identified as ways in which participants managed their experiences of not having enough.

Experiences of deficiency

Participants in this study described concepts related to deficiency with regard to the self and others. The self was experienced as helpless, and the situations they were in were hopeless due to a lack of sense of agency. An inability to access their own or external resources was also conveyed.

Helplessness and hopelessness

The low self-esteem that is commonly associated with depression (APA, 2000) emerged in participants' accounts of feeling helpless, hopeless and insufficient. Feelings of helplessness and hopelessness are also commonly associated with depression (Mays & Croake, 1997) and are frequently referred to in literature on depression. Participants felt inadequate to solve problems and control aspects of their lives. For Participant 1, experiences of helplessness were experienced in relation to being unable to find a job, leading to increased feelings of low self-esteem and ultimately contributing to his depression, and he also described feeling a "lack of agency." Participant 5 also described feelings of hopelessness in relation to changing issues in his vocational setting, feeling incapable of managing conflict between colleagues and not feeling able to do anything to change the situation. Disempowerment was therefore evident, with a sense that external events could not be influenced and the self was viewed as lacking the power and agency to change situations.

For Participant 2, being a mother and being unable to alter her circumstances led to feelings of disempowerment and helplessness:

> I felt that my life was so out of control and I could do nothing to stop it. I couldn't resign from being a mother. (Participant 2)

Participant 4 described feeling insufficient in terms of escaping from her abusive marriage and taking care of the children. However, she also felt that she could not stay in the marriage. She thus felt trapped between two impossible options:

> I felt there were no options for me, because now I had these two children that needed looking after, and I found it hard to look after them. And the thought of doing it on my own was… insurmountable, but doing it with this absolutely impossible person was also insurmountable and I just… and that's when I just slowly started spiralling. (Participant 4)

Feeling insufficient in relation to others was particularly prevalent for Participant 2, and gives an indication that she just did not feel good enough, and was therefore lacking in her ability to mother:

> My mom, I just I felt very judged by her. I felt like the whole time my mothering, which at the time was my identity, was being judged from a very critical kind of stance. (Participant 2)

These feelings of insufficiency to cope, resulting in helplessness and hopelessness as described by the participants, can be seen as resulting from adjustment issues and a loss of aspects of the self. Without access to normal resources to cope (such as a view of the self as competent) the participants seem to have increasingly felt helpless, which added to the ongoing cycle of depression.

Unable to access nurturance from others

In addition to descriptions of the self as insufficient, participants also discussed their feelings of the world as insufficient. While this theme was at times countered by descriptions of accessing support from others (as will be discussed later in this chapter), a sense of the world as not being able to provide enough was present for some participants. Depression is commonly associated with a negative view of the world (Maher et al., 2006), indicating that participants' experiences of the world as deficient are in agreement with this. With regard to social support and depression, literature frequently refers to the fact that social support is a protective factor for

depression. However, Maher et al. (2006) discuss the fact that depression affects perceptions of social support, with the result that depressed people are less likely to recognise, utilise, and benefit from social support. Participants' experiences of deficiency in social support can therefore seen to be related to literature implying that the depressed person's negative view of the world also impacts their view of, and ability to utilise, social support (Maher et al., 2006).

A sense of the world as lacking emerged in Participant 3's account:

> It was actually very empty, and I was trying to cling on to something, but the world couldn't provide me with that… And it was never stable enough to really hold onto anyway. (Participant 3)

Her words convey that the world was not only deficient but also could not be relied on to be sufficiently stable to meet her needs. For Participant 4, life was described as helping others and yet not receiving any support for herself. A lack of nurturance and support from her environment can be seen in her explanation of the events that led up to her nervous collapse:

> I was helping him build this house and I had other work I needed to do for my father, and it was just all the demands on me. (Participant 4)

In her narrative, it was suggested that this experience of excessive demands, without receiving anything back, contributed to a sense of helplessness and her eventual collapse. In addition to this collapse, the portrayal of her marriage as abusive and her husband as "unsupportive with the children" (which occurred a year or so after her collapse) indicates that a lack of caring, support and nurturance were everyday occurrences for her within this marriage. Participant 1 described how, although people were supportive of him, it did not feel as if it provided him with what he felt he needed to get out of his depression:

> I think that everybody was very nice to me, and unfortunately that didn't help. But it wasn't their fault. So I mean… [My wife] was being understanding. But somehow that didn't help. [My sister in-law and her boyfriend] were being helpful but nothing anyone did seemed to go anywhere. (Participant 1)

For Participant 2, although help was available in the world, she felt herself unable to access it and gain nurturance from it.

> But I never sought help, you know, I just felt I couldn't… So even though we had the [resources]… I just felt that I had to grin and bear it. (Participant 2)

In this excerpt, it is evident that Participant 2's own feelings of insufficiency led to an experience of being unable to access help from others, even though it may have been available. This is congruent with Maher et al.'s (2006) discussion of people with depression being unable to utilise social support. For Participant 2, it appears that these particular dynamics led to a continuation of feelings of deficiency in relation to gaining help from others.

Overall, it is evident that for many of the participants, the world seemed unable to provide them with the caring and support they needed. This was perceived as either due an impoverished world, or was experienced more in relation to the self as unable to access the nurtrance required.

Managing and reacting to deprivation

While feelings of insufficiency and lack were explicitly described in relation to the self and the external world, this experience also emerged in covert ways throughout the participants' narratives. Feelings of anxiety and fear in relation to insufficiency were experienced, as were ways of accessing comfort, which was utilised in order to counter a sense of deficiency. A focus on survival also seemed to be related to managing without sufficient internal and external resources.

Anxiety and fear

Anxiety emerged in participants' descriptions of their experiences during depression, indicating that these findings are in accordance with existing literature on this topic relating to the comorbidity of depression and anxiety as discussed earlier. Anxiety is conceptualised as acting as a warning of overwhelming emotions or as in indicator of internal conflict (Zerbe, 1990). Participants 1, 3, 4 and 5 described either anxiety or fear in relation to various situations. This seemed to be in response to feelings of deprivation following loss.

Participants 4 and 5 described anxiety as predominant in their experiences during depression. For both of these participants, anxiety was a part of everyday life for them. This concept was conveyed by Participant 4, who struggled to differentiate whether anxiety or depression was more central to her experiences:

> It was more of an anxiety thing, I'd actually just become like "I don't know what to do. "… But the depression was mostly after the children. Then I just did the whole morbid kind of going into myself thing. Um, crying a lot and stuff. Whilst with the anxiety side of things, there's not a lot of crying – just I become frenetic and no one can calm me into anything that resembles a normal human being. (Participant 4)

While Participant 4 succeeded in differentiating between depression and anxiety in her experiences in the excerpt above, these two concepts were woven together throughout her interview data, giving the researcher the impression that they frequently overlapped and were part of the same experience.

The phenomenon of anxiety and depression co-occurring can also be seen in Participant 5's account of his experiences of the body in which he explains:

> That's why I've put the depression and the anxiety together. (Participant 5)

Upon reflection, the responses of Participants 5 and 4 indicate a need for them to differentiate between anxiety and depression, although these experiences clearly coincided as is described in literature on the comorbidity of depression and anxiety (Gotlib & Hammen, 2002). As the study was stated as being related to depression, this may have led to participants feeling the need to separate out their experiences of anxiety from their experiences of depression. Participant 3 described more integrated experiences of depression and anxiety, describing herself as being "always stressed."

Participant 1 spoke more of fear than of anxiety. However, both of these concepts can be seen as experiences of distress due to a concern about danger, pain or misfortune. For this reason, fear is being conceptualised as a more intense feeling of distress that is related to anxiety and therefore included under this theme. For Participant 1, fear was frequently described in relation to concerns about the future, and his ability to survive and overcome his difficult circumstances.

While likely reasons for anxiety could not be obtained for all participants,

Participant 3 described anxiety in relation to her mother's irritability and in relation to driving. Issues of a lack of nurturance may be seen as an influencing factor in this anxiety. Irritability in Participant 3's mother may have been related to her being unable to obtain sufficient nurturance from her mother, leaving her feeling dependent on an unreliable source:

> My mom was also going through a depression at that time… She tends to almost tantrum at home, and you feel like you're walking on eggshells – it makes you very anxious and it makes you feel very unsafe. (Participant 3)

She describes herself here as "you". This suggests that these feelings towards her mother may be sufficiently overwhelming that they had to be conveyed in a distanced way. In relation to a need for dependency, driving can also be seen as symbolic of independence, leaving Participant 3 possibly wishing to stay in a more dependent and nurtured position due to these needs not yet being adequately met.

Participant 4 spoke of anxiety around feeling unable to cope, as well as having to continuously having to care for others, and in having no external emotional support. These can be seen then as experiences of deficiency in nurturance leading to her feeling anxious in response to either the threat of overwhelming feelings or the conflict aroused by a wish for something that she can not have. For Participant 1, fear seems to have been largely linked to a personal sense of deficiency in relating to finding a job and surviving overseas. While Participants' 1, 3 and 4's experiences appear to have beem linked to an experience of deficiency, for Participant 5, no particular predisposing factors were evident in the interview data in relation to his anxiety. However, it should be noted that additional factors may have contributed to feelings of anxiety. While anxiety was utilised as a means of coping with experiences of deprivation, seeking out comfort was also used to make up for a sense of internal lack.

Seeking comfort and nurturance

Seeking comfort from others also emerged as a means of managing a sense of deficiency. If participants felt helpless, as indicated above, seeking help and comfort from others can be seen as a means of managing feelings of insufficiency. Active attempts to seek comfort can be seen as a means of externally acquiring the sense of

sufficiency which participants felt lacking in. The concept of seeking comfort and nurturance is evident in psychodynamic literature in depression (e.g. Fenichel, 1946; McWilliams, 1994) and the findings are therefore congruent with these conceptualisations.

Participant 4 conveyed the need for others to provide her with support that she could not access internally, as can be seen in the excerpt below:

> Those people close to me – my family and my close friends and the lady who helps with my children, my domestic, like they actually rally around me when I have fallen apart. They've come in very close and like really attempted to hold it all together for me. (Participant 4)

The phrase of "hold it all together for me" further substantiates this hypothesis that she is gaining nurturance and support from others that she is unable to access herself. Further support from others was obtained during her nervous collapse. At the time of the interview, she linked this to an attempt to have others provide care for her, as she was unable to access this in any other way. She viewed her nervous and physical collapse as a "hysterical" means of acquiring the support she needed, yet was lacking at that time.

For Participant 3, her relationship with her boyfriend provided the sense of safety that was described as missing from her early background:

> The relationship was loving and stable... he did provide a safe place for me. He was very confirming and very umm… he was very safe. And I could always go there… (Participant 3)

This sense of stability and safety described here can be linked to a deprivation of this early in her life, and in relation to her mother during her depression. As she was unable to internalise this safety and stability during development, it appears as though she sought this out in adult romantic relationships during her depression to make up for a lack of this both internally and in relation to her care givers.

In a similar way, Participant 5 described his wife as supportive and non-judgmental, providing him with the caring he needed during his depression and helping to bolster his self-esteem, which he described as lacking during his depression.

Accessing nurturance from others in order to make up for developmental and depression-related experiences of deficiency were common in participants' narratives. As mentioned in Fenichel (1946), this may have been utilised to access caring that should have been internalised at an earlier stage in life.

Another means of managing feelings of deficiency was to nurture others. This phenomenon is commonly associated with depressive personalities (McWilliams, 1994) and therefore this phenomenon is corroborated by existing literature. In this situation it can be seen that rather than actively seeking comfort, participants gained comfort by providing nurturance to others. This led to them vicariously experiencing something they were lacking in themselves. This response can be seen in Participant 4 and Participant 5's narratives of their depression. Both described taking care of children and gaining a sense of comfort or relief from this. Participant 4 described caring for her children as the one positive thing in her life:

> I absolutely loved connecting to my children. (Participant 4)

And later went on to say:

> It was a no thanks job, but I adored it. (Participant 4)

Participant 4 also relayed how she had spent a great deal of her time and energy focusing on having enough stamina to provide for her children. This caring for her children can be seen as a means of vicariously having her needs met through providing her children with the nurturance she herself was clearly lacking at the time, within the context of her abusive marriage.

For Participant 5, his sons' neediness evoked a caring response in him that allowed him to provide for their needs. It is possible to assume that he gained vicarious comfort from this:

> The boys, they were young, um, being quite needy and dependent, they wouldn't judge me in terms of … But they'd get me up and going. I would just want to be a couch potato and my boys would say "Daddy, come and throw a ball with me." And then I would get up and get out of my mind and go and play with them. (Participant 5)

From an emotional perspective it can be seen that participants sought out comfort both explicitly and implicitly in order to manage their feelings of lack. A focus on survival was utilised as another means to manage deprivation.

A focus on survival

The theme of surviving in spite of emotional and physical deprivation was evident in some participants' accounts of their depression. For Participant 1, survival focused on an attempt to keep going despite difficult circumstances, and led him to take on the job of an unskilled labourer when unable to find work in line with his tertiary education.

> I was trying to get a full-time job, but I couldn't get one and ended up doing manual labour type work.

While the concept of manual labour seems to relate to the body, this was not covered in relation to the body, as Participant 1 went in to no further detail on this.

The theme of survival was particularly evident for Participant 4. For her, life was simply about surviving in the face of lack, in the face of overwhelming circumstances.

> I went into survival mode. It was like "bare minimum, look after children… The rest doesn't matter." It was a survival thing, ja. (Participant 4)

From this, it is apparent that she was forced to focus on survival as a means of reducing energy expenditure and remaining able to function. Operating in survival mode can be seen as a way of continuing to exist against difficult odds. For Participant 4, this appears to have been about cutting down on non-essential functions so that she could get the basics done in order to ensure the emotional and physical survival of herself and her children in the face of an abusive marriage in which hope and support were lacking. Even though Participant 4 was in a difficult situation, she still made the effort to provide basic care for her children, possibly related to the social norms of mothering. For other participants, this dynamic of having to respond to social norms, was more evident in relation to physical aspects of the self, as will be discussed in the following section.

These experiences of lack can be seen as relating to a disconnection from the self, as discussed earlier. Following a situation in which the individual has to adjust to different circumstances, a loss of an aspect of self is experienced. Deficiency then emerges in relation to this loss, as the pre-existing connection is no longer present, and access to the same resources are no longer available. These experiences can be seen as mirroring etiological concepts of object loss, regression to an oral phase, and unmet oral dependency needs (Cameron & Carmichael, 1963). A further explanation of this will be discussed in Chapter 5.

Throughout this section, experiences of lack were evident in relation to views of the self as helpless, and the inability to access resources. Concepts such as anxiety, seeking nurturance, and adopting a survival mode, can be conceptualised as a means of coping with experiences of deficiency related to a disconnection.

Overall, concepts of disconnection, lack, and ways of managing these, have emerged in participants' narratives of emotional experiences during depression. These concepts did not appear in isolation from other aspects of self. Similar themes emerged in relation to experiences of the body during depression, and will be presented and interpreted in the following section.

EXPERIENCES OF THE BODY DURING DEPRESSION

In this section, experiences of the body during depression are discussed, and interpreted, in relation to the themes that emerged during data analysis. The central themes of experiences disconnection from the body and lack in relation to the body are explored, and relationships between these themes and their sub-themes are discussed.

Disconnection

The concept of a disconnection from the body emerged as a central theme in participants' narratives of depression. This was experienced as a sense of separation and distance from the body, an experience of loss of the body, and a sense of the body as an autonomous "other", or enemy. The disconnect was not just experienced as internal, but was also experienced in relation to the environment, with the body acting out a withdrawal from the world around it.

The body as disconnected and distanced from the self

Disconnection and distance from the body was a primary experience for participants, and was described as occurring in some form by all participants. This sense of disconnection was associated with experiences of detachment, a feeling of physical distance from the body, and an experience of living in a mind that was separated from the body. These experiences varied, both in intensity and over time, yet nonetheless were described as forming a significant part of participants' experiences.

While mind-body dualism is frequently discussed in reference to topics such as the nature of the mind (e.g. Damsio, 1994), or in relation to psychosomatic problems (e.g. Meissner, 2006), little information could be found exploring such concepts in relation to depression. Within the literature on the mind-body relationship, almost no information is provided on the lived experiences of feeling detached from the body, which was core to the participants' experiences of the body.

During the interview process, the researcher became aware of the fact that the majority of participants initially struggled to engage in discussion about their bodies. Some participants seemed awkward, and uncertain of how they should respond. However, this attitude became more relaxed as the interview process progressed. The researcher also struggled to maintain a connection to either her own, or the participants' physical experiences during the interview process. The responses of both

the researcher and participants can partly be seen as indications of a disconnection from the body, in line with the dualistic norms in society, as discussed by Capra (1984) and Bordo (1997).

For the researcher, an awareness of a gap in her psychotherapeutic training also became evident. While her training emphasised thoughts, feelings and fantasies, no focus on the body was ever covered in training. Thus, it was an unusual and difficult experience to engage with both participants and herself in this way during the interview process. This can be seen as in-line with comments by therapists such as Balamuth (1998) and Wrye (1998), who discuss how a focus on the physical is often ignored in psychotherapeutic settings, and a large amount of relevant information is subsequently overlooked. However, the researcher's own personal struggle to maintain connection to her own body may also have contributed to the difficulties experienced in relation to the interview process.

The body as detached from the self

For all participants, a sense of detachment and separation from the body was experienced. These experiences led to feelings of a lack of groundedness and a separation from an aspect of the self, resulting in a more fragmented experience of being.

This feeling of not being fully connected to the body was also clearly apparent in the interview transcripts, at both an implicit and explicit level. Participant 1 explicitly described a sense of detachment from the body while discussing his relationship to his body during depression:

> I mean, I guess to a degree I certainly was a bit detached. Detached… just not fully connected. (Participant 1)

This sense of disconnection from the body was also conveyed by other participants, although it could not be seen as clearly. Participants 2 and 3 described a “self” that was experienced as separate from the “body”, implying a sense of disconnection between the individual and their bodies. Participant 3 described how her body was experienced as an almost separate entity:

> I felt like my body wasn’t me… I didn’t own my body. It wasn’t a part of me.

> It was more like just a physical thing… (Participant 3)

Her experience of a lack of ownership of the body indicates that it was as experienced as something separate that was not truly part of the self, and not controlled by her. The description of a physical "thing" implies a level of dehumanisation of the body, which is therefore not experienced as being connected to her human self. A sense of the body as dehumanised was discussed by Turp (1999) whose case study referred to experiences of the body as a machine, and Wilson (2007), whose participants described themselves as feeling like a robot or zombie. While neither explicitly engaged with the alienation and disconnection implied by these images, they can still be seen as referring to a similar concept. This sense of separation from an almost non-human body emerged again later in the interview for Participant 3:

> [It was like I was]… looking out of a… sort of shell, really… Like one of those hermit crabs that crawls into a strange shell that doesn't quite fit. (Participant 3)

The illustration of the body as a shell provides a sense of the body again as something external and detached from the self. Just as a shell encapsulates the creature inside but is made of a different substance, so Participant 3's body contains her and yet does not feel incorporated into her as a whole. A shell can also be seen as a form of protection, and this metaphor can be seen as related to Bick's (1988) conceptualisation of the body forming a protective shell to contain the self, following a lack of adequate containment in early development. The description of a hermit crab taking over a strange shell also indicates that her body not only feels external to her sense of self, but was also experienced as feeling unfamiliar and alien to her.

The body as feeling unreal was described by Participant 2:

> My body was almost not something – like for example I'd look at myself in the mirror and not really see myself.

In this instance, Participant 2 also seems to experience her body as unreal to some extent, which indicates a lack of connection. Her experience of being unable to really see herself implies that even though her body was in front of her, she was not able to

connect with it sufficiently to actually be able to genuinely "see" it or to experience it as part of her.

Participant 2 described her body as something that lacked shape and definition, something without clear structure, also indicating a lack of awareness of her physical self.

> My body was something that was just there. It was not well defined, so I would probably say amorphous. (Participant 2)

This experience of the body seems to convey an inability to connect with the body, and to be able to feel its shape and definition in the world. Rather than adopting the shape of the person, it is something that exists without connection to her, rather than as being experienced as part of her.

A further illustration of a feeling of disconnection from the body was discussed by Participant 1. He discussed unintended weight loss resulting from a lack of awareness of hunger and his body's need for food. While a loss of appetite is commonly associated with depression (Middeldorp et al., 2006), as is weight loss (Sadock & Sadock, 2007), this is not linked to the concept of a disconnection from the body in the literature reviewed. However, in this instance, Participant 1's lack of awareness seems to imply a disconnection from his body. This disconnect, in turn, results in a lack of ability of the self to ascertain some of the body's basic needs, ultimately leading to weight loss:

> I wasn't immediately aware that I'd lost weight in a somatic way. I was aware of it in an evidential…I didn't feel hungry…I didn't suddenly feel that I had been starving myself – but clearly I had. [When I got back] I looked in the mirror and I was like "Oh my gosh, what the fuck's going on here?" (Participant 1)

It appears that Participant 1 was unaware that weight loss was occurring, and only once he was out of his difficult situation and intensely depressed mood, was he able to reconnect to some extent and suddenly see his body. This lack of awareness implies that his body did not feel fully connected to his "self", meaning that its needs and signals were not able to be discerned and acted on.

For Participant 5, a lack of awareness of his body was seen in the description of

not being able to receive and interpret his body's signals of distress.

> [I] wasn't aware… not taking heed of the messages. Ja. So almost short-circuiting the messages that the body was sending me. (Participant 5)

Participant 5 linked this to physical problems, such as a spastic colon, that formed part of his depressed experiences, and he related this disorder to a stress warning signal sent by the body. His lack of awareness of his body and the information it was providing about physical and emotional needs during depression, indicates a disconnect between mind and body. Participant 5 also described his body as an almost separate entity which sent messages to the "self", again indicating a body that is disconnect from the self.

Disconnection from the body was described by Participant 3 as a fragmentation of the self:

> I think I was very fragmented. I think that if I look back… I have never really been in my body. (Participant 3)

From this excerpt it seems that her description of never having been in her body implies a notable separation from the body that extends back to childhood. This indicates a lifelong experience that may have existed due to the childhood anxiety and possible depression, as described in her history. Her description of never having been "in" her body starts to convey a sense of distance from the body. This concept was conveyed by other participants to a greater extent, with a sense of actual distance and a feeling of literally being outside of the body, being conveyed by some of the other participants.

Distanced from the body

An experience of the self as being distanced from or outside of the body emerged in some participants' accounts. Participant 2 conveyed this experience when she described an overall relationship to her body during depression, during which she felt sufficiently disconnected from her physical self to the point of experiencing herself as separated and away from her body:

> I can say I felt like I was in such a daze, that probably from outside my body. It felt like my body was going through the motions, but I wasn't there. (Participant 2)

From this excerpt it can be seen that Participant 2 felt as though she was not fully present in her body. Her use of the word "outside" to describe her relationship with the body, implies an increased sense of disconnection to the point of feeling a more intense sense of separation. This separation also appears to have fulfilled the purpose of helping the participant to feel distanced from the more difficult aspects of her life, so that while her body could be seen as living her life, she was somehow separated from her day-to-day reality

Participant 4's experiences of being outside of her body were described far more strongly than the experiences of other participants:

> Sometimes it didn't feel like I was in my body at all. Sometimes it was kind of a bit surreal… I often felt like I was sitting in the corner watching the whole thing. (Participant 4)

From this excerpt, it seems as though Participant 4's experiences were quite dissociative, which may be linked to the domestic abuse that was taking place in her life at that time. Such experiences of dissociation are commonly linked to traumatic events (Sadock & Sadock, 2007). From this example it is also evident that this was not a constant state of feeling outside of herself, but more something that was experienced at times of increased stress. This may be linked to being unable to cope with the physical and emotional reality of an abusive situation. However, it should be noted that dissociative experiences are often experienced to some extent in individuals suffering from depression (Tapio, Saarijarvie & Laurema, 2004), and therefore this may not necessarily be linked purely to a traumatic event. It is interesting to note that Participant 4 later stated that she had never felt outside of her body at all. This contradiction may be due to the fact that she found it difficult to process and understand these experiences, or that she was defending against these unpleasant experiences.

While Participant 5 also felt like he was out of his body during depression, he related this to the physical side effects of the anti-depressant medication that he was taking:

> At times, you know, when I was having the medication, those initial two weeks of… as it took hold, there was … there were side-effects. And um, a bit of tremor … I felt like I was out of my body at that point. (Participant 5)

Again, the source of the experience of literally being outside of the body appears to be a complex one. For Participant 5, biological effects of medication may have led to him feeling as if his body was not under his control, leading to increased feelings of being outside of his body.

The experience of actual distance from the body can be seen to indicate an increased disconnection from the body. Not only is there a vague sense of detachment, but also the body is literally observed from the outside and experienced as an almost separate entity. In relation to existing literature, this concept can be seen as linked to dissociative experiences. Dissociation refers to an unconscious defence mechanism whereby a group of mental or behavioural processes are separated from the rest of an individual's psychic activity (Sadock & Sadock, 2007). Based on this understanding, separation of the body from the rest of the "self" and feeling distanced from a separate sense of body can be seen as related to a dissociative experience. In most contemporary literature, dissociation is not generally seen as being related to depression. However, Tapio et al. (2004) refer to an overlap in experiences of depression and dissociation, indicating that these concepts may be commonly co-experienced, which may indicate that the experience of being disconnected from the body by participants, may be related to these findings.

Being in the mind vs. being in the body

The theme of disconnection from the body can also be seen in participants' accounts of being located in the "head" or mind during their depression. While this sense of being located in the head is a common experience in Western discourses (Winnicott, 1987), these two participants conveyed that during their depression, an experience of being more intensely located in the head as opposed to the body was experienced. Participants 3 and 5 discussed this phenomenon as a negative aspect of their depression, and considered this to be out of balance, when thinking back during the interview. Participant 3 described occupying herself with abstract thoughts:

> I could zone out for ages thinking about stuff. I could live in a world of

> abstractions and philosophy… I was consumed in my head. (Participant 3)

This excerpt gives a sense of Participant 3 being far more located in her head and filling a great deal of her time with thinking and intellectual pursuits. Her description of using thought to "zone out" indicates that this may have been used as a defence mechanism in order to escape her current reality, or her emotional experiences. It would also seem that her psychic energy is being withdrawn from the body and into the mind, possibly as a defence against somatic experiences of emotion. Participant 3 described this process in more depth, as will be shown in the section on participants' understandings of their body during depression. Following on from this excerpt, Participant 3 went on to describe how the emotional and cognitive experiences felt more real to her, during the time of her depression, than actually being in her body did. Thus it can be seen that the head or mind was far more central to her experiences of herself at this time, with her body being experienced as less important in her day-to-day life.

When asked where in his body he felt located during his depression, Participant 5 described himself as being very much located in his head. For him, this seems to have been the dominant aspect of his experience of himself:

> … I think I would place it in the head. Because of those thought processes that I would see as a downward spiral… In the head, and what I'm thinking, and how dark it is. (Participant 5)

From this account it appears that Participant 5 saw himself as tending to ruminate and get caught up in his thoughts. He later went on to describe himself as being "disembodied" at the time, which indicates that he experienced himself as being without a body, and rather as being in his mind for much of the time during this depression.

The feeling of being located in the head as a predominant feeling during depression again indicates a disconnect from the body, with the mind being experienced as more "real" and central to daily life. While feeling located in the mind or head as opposed to the body is often associated with psychosomatic disorders (Winnicott, 1987), this concept is seldom related to more general disorders, such as depression and the category of mood disorders.

While feeling located in the head can be seen as an experience of distance from the body, feelings that the body was actually lost in some ways emerged for three participants and can be seen as a further example of disconnection from the body.

Loss of the body

Two of the participants conveyed predominant feelings of loss in relation to changes their bodies had undergone during depression, that were still present to some extent at the time of the interview. This sense of loss has been conceptualised as a disconnection due to the fact the body is experienced as lost to the self. One other participant experienced a sense of loss in relation to her physical self, but without the same intensity of experience or lasting impact.

While only two participants explicitly mentioned this, this sense of loss was central to their experiences. While literature regarding general loss and depression is prolific (e.g. Freud, 1917; Kendler et al., 2003; Stankunus et al., 2006), no specific information could be found relating to experiences of a lost body during depression. While Thomas and Siller (1999) discussed how depression and a sense of loss resulted following an injury or accident leading to physical disability, this is not directly related to the sense of a lost body during depression that can be seen as resulting from the depression rather than causing it.

A sense of mourning in relation to the loss of the body was evident in the tone of sadness that emerged during the interview in relation to the experience of bodily changes, and was very apparent in two of the participants. While such a tone of sadness cannot easily be captured in quote form, this sense of loss can be seen in Participant 2's descriptive words of how she no longer has the posture she had prior to the depression:

> You know, whereas my weight, I kind of got it back…but my posture is something that I feel I've lost. And that I've never fully regained… And the sad thing is that it is something I haven't been able to rectify. (Participant 2)

It becomes apparent from this example that the participant feels as though she has lost something important to her that is experienced as being irrevocable. While she later mentioned an intention of getting assistance in working on regaining her posture, in this excerpt it can be seen that the loss of this connection to herself seemed

unchangeable at times, in spite of efforts to rectify it.

As this loss in relation to the body was partly due to the experience of having children for Participant 2, concepts around postpartum depression can be seen as relevant. According to Nicolson (1999) losses are often experienced after birth, including losses of autonomy, time, femininity, sexuality and occupational identity. These factors have all been identified as contributing to depression. While a loss of a physical sense of self is not as explicitly mentioned, Participant 2's descriptions of her abdominal muscles being affected by carrying a pregnancy, and the contribution of this to her postural problems, indicates that some of the loss in relation to her body was influenced by pregnancy.

For Participant 1, a loss of a sense of being healthy, strong and injury-free emerged. While these concepts themselves will be dealt with in later sections, it was the overwhelming sense of loss evident during the interview that characterised his experience of his body.

> I didn't realise how much of my capability I'd lost… I'm no longer as capable... I'd like to get rid of long-term injuries. That would be nice, if they vanished. (Participant 1)

For Participant 1, an almost wistful tone is was present regarding his lost body. Again, as for Participant 2, it seems to be incredibly difficult to regain his previous experiences of his body. It should be noted that the tone of sadness, relayed as part of the voice intonations and body language expressed by this participant, is not adequately captured in his words.

For both of these participants it can be seen that they initially had a good relationship to, and experience of their body, which was altered by the depression. No other participants mentioned this sense of loss so explicitly. However, this was central to these two participants' account of themselves in their interview. The particular prominence of a sense of loss in these two participants may well be related to specific etiological factors or predisposing personality attributes, although insufficient information has been obtained to provide this link.

A slightly different dimension to the experience of loss in relation to the body was described by Participant 4. This was related to a loss of herself as physically lively, striking, and noticeable. It should be noted that these were evident in her

presentation at the time of the interview, however, during her depression, this was no longer a part of her self image or presentation to the world.

> I remember once, I was walking through the shop and it struck me that not a single person looked up at me. I was, I was the invisible person. And I had never been the invisible person my whole life. And suddenly my hair was back in a pony, tied up, no make-up. I was wearing elasticated clothing. Not a soul turned their head as I walked along. (Participant 4)

The sense of loss in relation to this participant seems to have been a loss of response by others to her physical appearance, and a loss of her sense of herself as physically vivacious and striking. While this loss is not on the level of intensity or importance experienced by Participants 1 and 2, this theme of experiencing loss in relation to the physical self can be seen as common to all three of these participants.

Loss of the body has been incorporated into the theme of disconnection, as the self is disconnected from the lost aspect of the body. This sense of disconnection also arose in experiences of the body as in conflict with the self.

In conflict with the body

The concept of the body as a separate entity, which constrained or thwarted the self, came to light during the interview process. The body was described as being experienced as an almost separate entity that was either a burden, and was seen as constraining the self, or was seen as actively hindering, and viewed as thwarting the self.

Constrained by the body

Being constrained by the body meant that participants felt as though they were being limited by their physical self. The body was experienced by some participants as being burdensome and heavy, and something almost separate from the self that had to be borne by the participant.

> Umm… being inside [my body] felt heavy. That's the best word I can … I just felt, "how am I going to pick myself up and take myself forward and move and go and do?" (Participant 4)

Here Participant 4's account of physical heaviness seems to be constraining her from

being active in her life and from just getting by on a day-to-day basis. Her body was described as something that she was "inside" rather than a part of her, indicating a disconnect from it.

For Participant 3, her body was described as being burdensome and with a will of its own:

> I felt like my body was… heavy and uncooperative, because it wasn't in the form that I felt it should be. (Participant 3)

In this extract, Participant 3's experience of her body as not doing what she wanted it to be, again indicates a feeling of separation from the body as an "other", with a contradictory will of its own. Other participants also spoke about a body that was uncooperative and out of control. Participant 2 experienced frustration in relation to her body being unable to perform the activities it had previously. She experienced a sense of a lack of control over her body, with her mind no longer able to exert the control she desired.

> I felt as much as my mind was pushing my body to go, I couldn't make it go anymore. And so that was frustrating. (Participant 2)

In this instance, Participant 2's experience seems to relate to an unruly body refusing to submit to an ordered mind. The body is therefore separate and unruly from the mind, and not connected to its functioning. This concept of the body as unruly and needing to be controlled has been discussed in relation to the mind-body question in historical writings (Bordo, 1997).

Biological needs were also seen at times as increasing the body's uncooperative nature. Participant 2 related her depression to the physiological impact of child birth and caring for an infant. This biological focus can be interpreted as an experience of a separate and unruly body that ends up constraining the self. Again, this is similar to the concept of mind-body dualism discussed by Bordo, in which the body is conceptualised as something primitive and hormone-driven that needs to be tamed (1997).

However, it is undeniable that pregnancy, birth and looking after young children have a definite physiological impact. It is evident from this viewpoint that

determining cause and effect in physical aspects of depression is not a clear-cut issue. Physiological experiences related to motherhood were seen here as inducing aspects of depression, a theme which commonly re-occurred in the two participants who experienced depression shortly after childbirth. Although existing studies on postpartum hormones have not provided any direct link to depression, the physiological aspects of this process are still not fully understood (Gjerdingen & Yawn, 2007).

Medication was also described by two of the participants as making the body feel out of control. Participant 5 experienced a sense of shakiness when his anti-depressant dose was incorrect. A sense of anxiety and other similar side effects that may relate to shakiness are indeed associated with SSRI usage (Sadock & Sadock, 2007). Both participants 4 and 5 experienced a loss of libido they associated with their medication, which is another common side effect of such medication (Sadock & Sadock, 2007). In this instance, although the experience of physical side effects from medication cannot be refuted, it seems to have compounded their experiences of the body as out of their own control, possibly increasing the separation between mind and body. Overall, the sense of a body that constrains the self could be seen in participants' descriptions of burdensome, biologically-driven bodies.

Thwarted by the body

Further to feeling constrained by a body that is cumbersome and out of their control, some participants experienced their body as attempting to prevent them from doing what they wanted to. Once again, the body as separate emerges, and anger in response to the body as trying to thwart the individual, was evident.

The concept of feeling trapped or imprisoned emerged, with two participants feeling as if they were being held captive in a body where they did not want to be. Participant 3 described her body shape as trapping her and holding her back from being who she felt she was.

> I sometimes felt trapped by my body, if that makes sense.

This feeling was more evident in Participant 5's clear physical experiences of being imprisoned by the anxiety, discomfort and dis-ease experienced in his body:

> Well, as we've been talking, I've had the image of a prison. That it felt like a prison. Ja… And just trying to get out of it. Out of the body. (Participant 5)

Participant 5's wish to escape from his body again highlights his sense of disconnection between mind and body, as if he were desperate to increase this sense of disconnection to the point where he was no longer constrained by the body, which was experienced as imprisoning and separate. The image of the body as a prison powerfully conveys his sense of being unable to escape from his physical self.

While Participant 5's experiences were of being imprisoned, Participant 1 described feeling as if he was being actively thwarted by his body. Here, the body seems to be experienced as something external to the self that is sabotaging his attempts to move forward with his life.

> I mean it's in some way definitely was and still is I guess... related to a sense of agency that is related to being thwarted at every turn. So every time I wanted to try do something, wanted to move on, expand, get on with my life, then suddenly I'd have yet another injury. And that would undermine my efforts. (Participant 1)

The body in this instance is described as both separate and as punitive towards Participant 1 for trying to move forward in his life. Both the image of the imprisoning and the thwarting body appear to contain a sense of anger at their core. The anger of being held captive and of being sabotaged would create anger in the "self" and also possibly imply a punitive anger on the part of the "body".

In literature, a constraining, limiting, body has been associated with Westernised mind-body dualism, and related to disorders such as anorexia and bulimia (Bordo, 1997). Bordo (1997) discusses how the body has been historically experienced as a confinement and limitation from which the mind struggles to escape, and indicates that this concept is still present in dualistic Western society. These concepts are evident, although to a lesser degree, in the participants in this study and their experiences of being constrained and thwarted by the body. However, no relevant literature could be found relating this concept to depression.

This phenomenon can be seen as associated with the sense of disconnection from the body. As the self feels disconnected from the body, the body then becomes viewed as being an "other" with a separate will of its own. Participants described the

negative impact of this "other" as part of their experiences during depression.

While the experience of the body as a thwarting or constraining "other" indicates disconnection, this sense of disconnection could also be seen when participants described physically withdrawing from the world.

The body as withdrawn from the world

The concept of withdrawal from the world became apparent in participants' narratives in which it can be seen that the body is actively disconnecting from the world. The disconnect between mind and body is less apparent here, but the self as withdrawing from the world becomes enacted by the body withdrawing into sleep, the safety of a room, and under the bed clothes.

The body as withdrawing from the world was described by two participants who gave explicit descriptions of their body as actively withdrawing from the world, seemingly as a means of hiding from the reality of their lives at that time. Participant 1 described burying his head under a pillow to escape from his difficult circumstances:

> I was convinced it was perfectly normal. I could see no issue with hiding my head under a pillow. (Participant 1)

In this instance, it can be seen that for Participant 4, hiding away from the world was experienced as normal and necessary during depression. The implicit meanings related to the use of a pillow will be discussed later in this chapter.

Participant 4 described excessive sleeping in order to withdraw from the world. Her hypersomnia appears to have served as a means to provide herself with a safe place amidst her experiences of difficulty and abuse.

> And I almost… it's almost like I sleep more, I can just cocoon and I can just sleep and I almost go to the extreme of too much sleep… So I distance myself from the world by going to sleep.

Although Participant 4 was being asked about her experiences of depression, her use of the present tense indicates that she still utilises sleep as a means of physically withdrawing from the world. Hypersomnia is commonly associated with depression

(Sadock & Sadock, 2007; Szuba, 2001), but was only explicitly mentioned by one participant in this small sample. This withdrawal from the world into sleep can be seen as a means of hibernation, which she explicitly described later in the interview. Participant 4 recounted how she kept herself and her babies separated from the rest of the world by staying in a single room during winter, partly due to her infants' ill health.

> I hibernated… I was in my den, and literally it was winter, and literally I put the heater on in… in the room with their two cots and a bed… people weren't allowed to come and visit us. (Participant 4)

For both participants, this physical withdrawal seems to have provided them with a sense of comfort, which will be explored in later sections of the data analysis.

A disconnect can be understood as breaking the connection between two things. Here, this broken connection can be seen between the body and the self. This broken connection can be conceptualised as resulting from an experience of loss, which can be associated with etiological concepts of object loss (McWilliams, 1994). This relationship will be further explored in the discussion chapter of this report.

Disconnection from the self and the world has been examined as occurring in a number of different somatic ways during depression. A disconnect can be seen as leading to a sense of deficiency, the physical manifestations of which will be explored in the following section.

Lack

Experiences of physical lack, and responses to lack, were evident in participants' narratives of depression. This sense of deficiency emerged both overtly and at a more subtle level in participants' accounts of their experiences of the body. Both a sense of the body as deficient, and use of the body to manage a sense of not having, or not being enough, were evident in the interview data. The concept of lack is discussed in this section in relation to experiences of physical weakness, a lack of health, a lack of energy, and decreased libido. Cognitive experiences of the body as deficient are also discussed in relation to body image. Experiences of the body in relation to managing lack are also discussed, including feelings of anxiety, seeking out comfort, and comforting others.

Experiences of bodily deficiency

Feelings of the body as deficient were present in participants' accounts of their bodies during depression. The body was described as weak, fragile, lacking in energy, and lacking in a general sense of well-being and health. A decrease in sexual desire was also prevalent.

Weakness and fragility

A sense of physical weakness and/or fragility emerged in the participants' narratives around their bodies during depression. Participants' experiences including feeling weak, having insufficient muscle tone, a lack of physical resilience and feeling physically tenuous. These feelings seem indicative of a lack of the physical sense of being sufficient to withstand day-to-day demands made on the body, leaving the participants with a sense of overall insufficiency.

Weakness can be described as a lack of strength and vigour. This understanding can be seen in participants' experiences of weakness:

> I was weaker, and I felt weaker. I couldn't do the same things I did before. (Participant 1).

Participant 1's description here indicates a feeling of a decrease in strength, and a lack of sufficient strength to carry out needed physical activity. Physical weakness was also described by Participant 3, who conveyed an overall sense of her body as not being sufficient:

> When I look back, I felt quite weak. Physically. Like my body felt weak. I didn't feel strong or ... fit. And also my muscles were not really well developed so I didn't hold myself, my body, well. (Participant 3)

Here again the body can be seen as experienced as insufficient and lacking in strength. Upon reflection, this description is also quite critical and derogatory in nature. This derogatory view of the body is indicative of anger towards the self, and will be discussed further in Chapter 5. Participant 2 also described a lack of resiliency in her body that was no longer at its previous level.

For Participants 2 and 1, a difference in strength is described in comparison to a

previous level, whereas for Participant 3, this sense of insufficient strength seems to have been carried with her since childhood. This may be related to her early experiences of depression and anxiety as described in her history.

In addition to a lack of resilience, Participant 1 also conveyed a sense of fragility in relation to his body. In this instance, fragility was experienced as continuous injuries incurred as he tried to do normal physical activity. From this it appears that his body no longer felt as if it had the strength and resiliency to perform physical activities that were once part of Participant 1's active lifestyle. Instead, his body was experienced as much more fragile and unstable:

> Once I got back, I started to injure myself a lot. Like straining tendons... I was trying to … re-use my body in more ways, and my body was no longer in a position to support that. (Participant 1)

Rather than being able to trust his body to perform adequately, continuous injuries seem to have led to an experience of a body that could not be trusted to perform daily duties. In addition to this, Participant 1 also described experiencing his body as lacking in sturdiness:

> Physically I did feel, thinking back, a sense of lightness of frame, tenuous, less substantial. (Participant 1)

This description of the body as not being able to be grounded and sturdy during depression, gives the sense of a lack of the strength and stability that would be physically required in order for Participant 1 to experience his body as more substantial. The description of the body as "tenuous" also carries the connotation of something that may easily be destroyed, and that does not have the strength to withstand external events. This tenuousness seems to be linked to the fragility related to injuries. As Participant 1's body did not feel sufficiently physically sturdy and able to withstand demands placed on it, it follows on from this that he would be more likely to injure himself, and to experience his body as fragile.

The deficiency in strength described indicates that the participants experienced a lack of sufficient internal resources to provide them with a sense of strength in the world. This can be seen as related to disconnection, in that the individual no longer

has a sense of connection to the aspect of the self that would provide strength. Disconnection can also be seen as creating anger that is later directed against the self, leading to feelings of being insufficient. These concepts will be further discussed in Chapter 5.

It should be noted that the experiences of weakness described in this section do not relate to the actual physical strength of participants, as this cannot be ascertained. It is purely the perception of this experience that is relevant at this point in providing an indication of underlying emotional processes. However, Jacobsen et al. (2006) in their study on the physical responses of depressed participants found that poor overall physical ability was associated with depression, which can be seen as linked to the concept of strength, perhaps indicating that what participants experienced was real at both an emotional and physical level. Vaccarino et al. (2008) included the concept of weakness in their category of "feeling fatigued, weak, or tired all over" in their study, with over half of participants indicating that they felt this way, implying that aspects of these results fit with this literature. However, combining these sections did not fit with the data from this research, as weakness and fatigue were not necessarily conceptualised as co-occurring by participants. Vaccarino et al. (2008) also discussed a lack of a sense of wellness in relation to depression, which will be covered in the next section.

Lack of health and well-being

In addition to feelings of weakness and fragility, some participants associated a lack of good health and general wellness with their somatic experiences of depression. These varied from chronic ailments, to pain and stiffness. These experiences of a lack of good health are consistent with literature that associates depression with a higher level of physical illness (Balon, 2006) and a decreased sense of well-being (Vaccarino et al., 2008).

A lack of a physical sense of well-being was experienced by Participant 5 in relation to digestive disorders.

> [I was] more aware of my body being dis-eased at those times. So, you know like, with the spastic colon, that kind of thing... I was quite out of rhythm. (Participant 5)

According to Henningsen et al. (2003) and Visser et al. (2008) digestive problems that affect the bowels, such as those experienced by this participant, are commonly associated with both depression and anxiety, and thus these symptoms are in accordance with existing literature. A lack of wellness, balance and ease is apparent in this description, leading to experiences of deficiency of healthiness. This is mentioned by Vaccarino et al. (2008) who discusses the fact that general feelings of not being in "good health" and "not feeling well", are common experiences for people suffering from depression.

Participant 5 also described his body as having felt "sore and tense and stiff" if he did not exercise due to low energy, leading to an ongoing cycle of a lack of well-being. These experiences of the body as described above are in line with Jacobsen et al.'s (2006) physiotherapy study, which found muscular tension and a lack of flexibility to be associated with depression. The effect of exercise in assisting in managing depression as discussed by Foley et al. (2008) can also be seen in his description. Physical pain was also recorded by Jacobsen et al. (2006) and Vaccarino et al. (2008), and thus these findings are also congruent with current literature.

Injury and the implicit resulting lack of health was part of Participant 4's experiences of depression:

> And I had such bad back problems. I mean it started during my pregnancy because all my joints just went. And then carrying these two [babies]… I mean I was at physio twice a week, basically through their whole first year. (Participant 4)

While there is clearly an inter-relationship between pregnancy and caring for infants that impacted on her physical health, this still formed a dominant experience for her during depression. Back pain is considered a predictor of depression (Nakao & Yano, 2006) and therefore Participant 4's experiences can be seen as related to existing literature on this topic. Participant 1's experiences of injuries also indicate a lack of a sense of wellness. He also described generally lacking a feeling of health and vitality during and just after his central depressive episode. A general incidence of pain is discussed by Jacobsen et al. (2006), Tylee and Gandhi (2005) and Vaccarino et al. (2008), and can therefore be seen to be an accepted physical symptom associated with depression.

Feeling as if the body is not healthy or balanced enough appears to be linked to a similar process to that of experiences of weakness and fragility. Again, the body has insufficient resources to provide a sufficient sense of well-being, and feelings of anger with regard to insufficiency are directed against the body. This experience of insufficient internal resources can also be seen in participants' descriptions of lacking energy.

Lack of energy

Feeling exhausted and lacking in energy characterised four out of five participants' day-to-day experiences of living and doing basic everyday tasks. For the remaining participant, a lack of motivation and a sense of hopelessness was experienced as the reason for being unable to complete day-to-day tasks. Participants' experiences of low energy as discussed in this section can be seen as related to the diagnostic criteria of a lack of energy and fatigue, as specified in the DSM-IV-TR (APA, 2000). This lack of energy can be seen as another experience of internal deficiency experienced by participants.

In the accounts of some participants, a lack of energy was acknowledged as generally affecting everything they did, and no specific cause was attributed to it. Participants 3 and 5 described a general sense of fatigue:

> I would get depleted very easily, to the point of actually physically shaking from lack of energy… everything was exhausting. I was tired all the time. (Participant 3)

> At that point I just didn't have much energy. (Participant 5)

A widespread sense of depleted energy was evident in these two excerpts, leading to an experience of an overall sense of deficiency that was described as impacting on day-to-day functioning and resulting in participants struggling with everyday tasks.

However, for the two new mothers, understandably the experience of tiredness and physical exhaustion was largely attributed to the demands of being a new mother. Participant 2 described extreme fatigue due to her infant's sleep pattern, which impacted on her to a great extent, leaving her struggling to function:

> Well, I remember the once I was sitting and having a conversation with my mother, and I literally fell asleep mid-sentence. Ummm… I was sitting upright in a chair, and I just zoned out and fell asleep. (Participant 2)

For Participant 4, weariness was largely centred around the body's demands to physically provide food for her twin infants, which she described as decreasing her energy levels.

In both of these instances, it is clear that exhaustion was related largely to the physical and emotional demands of motherhood, and as such cannot clearly be linked to depression. As low energy is a common symptom of depression (APA, 2000), it is plausible that this may have contributed to or exacerbated the new mothers' experiences of a lack of energy. Due to the fact that Participant 2 felt that her depression was in part caused by the physical tiredness, it seems plausible to assume that these factors interacted and influenced one another in her case.

During the interview process, the sense of low energy was apparent during participants' descriptions of their body during depression. The researcher gained a general sense of participants having to drag their way through daily activities. This resulted in a sense of low energy in the researcher, although the extent of the effect of participants is difficult to isolate, as the researcher's own experiences of low energy may have also been a factor.

This low energy and exhaustion was also evident in participants' struggles to get out of bed in the morning. While waking up was experienced as occurring naturally, an inability to access sufficient energy and motivation to get up and face the day was reported by some of the participants:

> I just remember like feeling I just can't actually get my body out of bed. That it was just completely a case of my willpower to actually get my body out of bed. (Participant 2)

> It was a sheer act of will to get up. (Participant 5)

A continuing experience of disconnect can be seen in these responses. Here the body seems to have no energy, whereas the active mind is attempting to force it into action. Additional mental energy seems to have been needed in order to get the physical body to perform the task of getting out of bed in the morning.

Fatigue or a loss of energy is beginning to be recognised as one of the central features of depression and, therefore, these findings are consistent with Arnold's (2008) discussion and viewpoint.

Low energy levels as experienced by participants may be linked to both cognitive, emotional and physical responses in depression. It should be noted that it is difficult to determine the impact and influence of each of these aspects of self on the experiences of the body. A similar difficulty in discerning effects of the body from effects of the mind can be seen in relation to decreased libido in depression.

Decreased libido

A decrease in sexual activity and sexual desire are commonly experienced by individuals suffering from depression (Dobkin et al., 2006). According to literature, this is a particularly prominent experience for women (Dobkin et al., 2006), and this phenomenon was visible in the small sample used for this study, with all three women describing these experiences.

> Ja my libido was right down… that was like one of the biggest problems. We were young … and I had zero interest in sex. (Participant 2)

An almost total absence of sexual drive seems to have been experienced by Participant 2, and clearly created problems concerning sexual expectation in her relationship. Experiencing distress in relation to decreased libido is also discussed by Dobkin et al. (2006). Participant 2 later went on to explain that she felt that emotional problems, such as having her needs met and struggling to claim space for herself, were part of this phenomenon. No other participants referred to emotional reasons for their experiences, although Participant 3 referred to a decreased libido as occurring when she was having a bad day.

Participant 4's decrease in sexual desire was linked to the physical demands and hormonal changes related to caring for and breastfeeding young infants.

> You don’t know to what degree lactating, hormones or what it’s got to do with, but I can’t say that I really felt like sex until a year ago. (Participant 4)

However, her description of taking around three years to regain sexual interest implies

that other factors were possibly contributing to her experience. She mentioned that her anti-depressant medication may also have impacted on her sex drive, an opinion that was also shared and experienced by Participant 5:

> I think with the medication I have noticed that… that's always a side-effect of … And I've come to have to accept that. Um, ja… I think that's definitely affected our relationship. Just the drive. (Participant 5)

For Participant 5 it seems as if this change in libido has negatively impacted on his sense of self, and the effects of this were still experienced at the time of the interview. However, it may be difficult to directly link a loss of libido to medication, as opposed to a physiological and emotional change as part of depression. Kennedy et al. (1999) explore this topic and indicate that it is not possible to determine whether the depression or the medication is more strongly linked to a decreased libido.

An experience of deficiency in relation to sexual energy can be seen in these narratives. Although this topic was difficult for some participants to engage with, possibly due to common taboos surrounding sexuality, a decrease in sexual energy and a sense of deficiency in relation to sexuality emerged for the majority of participants. While participants 3 and 4 did not mention this affecting their sense of self to a great extent, the effect on the relationship and experience of participants 2 and 5 was more evident. Dobkin et al. (2006) indicate that sexual dysfunction can have a major impact on quality of life and often ends up leading to the maintenance of depression. Therefore, it is congruent with this literature that participants felt that a lack of sexual drive had an effect on their sense of self and relationships.

Within the evidence from the data collected in this study, a disconnect from the body leading to a sense of deficiency may have impacted on libido. As sexual desire is often related to energy, an overall lack of energy may also have impacted on libido. As there is a disconnect between aspects of the self, energy and strength are no longer easily accessed, leading to an experience of deficiency. This sense of deficiency could also be seen in relation to participants' cognitive appraisal of their bodies.

Poor body image

Body image concerns are frequently associated with depression (Bilby, 1998; Noles et al., 1985; Pimenta et al., 2009) and also emerged in participants' discussion of their

bodies. Within the framework of this study, body image is not viewed as an explicit experience of the body, as it is more about cognitive appraisal of the body, as opposed to the lived experience of how participants felt in their body at the time of their depression. However, the experiences of the body and the cognitive appraisals of it can be seen as mutually influencing and mutually exacerbating.

Participants 2 and 3 referred to weight concerns at the time of their depression. A concern with weight and body size is commonly associated with depression (Pimenta et al., 2009) and thus these findings are in accordance with existing literature. Participant 2 described herself as "not feeling happy" with her weight during depression, and later on discussed feeling relieved once she had lost the weight following her pregnancies and depression. For Participant 3, weight concerns were more prevalent:

> I was quite weight conscious so I would be careful what I ate when I was depressed. Like I didn't over-eat. But I was actually more on the thin side. I'd actually stop eating or like try not to eat. (Participant 3)

For Participant 3, weight and body size seems to have become quite an extreme concern for her, leading to some restricted eating. However, Participant 3 did not make any further mention of this to give the indication of the definite presence of an eating disorder. However she did discuss further body image concerns related to a feeling sexually unattractive, and perceptions of herself as generally unappealing:

> I had a low body image… I remember, having more serious issues with my breasts. And I was determined to get implants. Determined. Because I felt that way I could be beautiful, sexy, or whatever I was trying to achieve… I've got a skin condition and at that time I was fixated on it. All consumed with the fact that I had this skin condition and it was ugly and people would think it was ugly. (Participant 3)

The more cognitive, as opposed to experiential, nature of Participant 3's description of her body can be seen here. The focus is more on her thoughts than about how her actual body felt.

Participant 5 also described body image concerns, and mentioned that during his depression he often compared himself to other men:

> When I'm feeling depressed or anxious, there is a bit of the self-doubt, … um perhaps comparing myself to others. To other men. With the vitality, the energy. (Participant 5)

Here Participant 5 described himself as currently struggling, and as having struggled during his depression, with feelings of insufficiency regarding his masculinity, energy and vitality. In the description above, Participant 5's experiences of a lack of energy and vitality in his body seem to contribute to poor body image, leading him to compare himself to others and think of himself as inadequate.

Body image is defined as perceptions, thoughts and feelings towards the body (Bergstrom & Neighbors, 2006) and while it would seem that this concept is similar to bodily experiences during depression, these concepts seem to interact but do not seem to refer to the same idea. For both Participant 3 and 5, explicit body image disturbance seems to impact on body experience. A lack of feeling sexually attractive may have contributed to decreased libido in Participant 3, whereas comparing himself to other men may have led to experiences of being less energetic and vital. Similarly, somatic experiences would have influenced body image in both of these cases.

An understanding of experiences of lack can be seen in relation to the thematic concept of disconnection. A disconnect implies that two aspects of the self (in this case, the body and the self) are no longer connected or joined. As a result, these two aspects are not as related as they were or could be, leading to a sense of deficiency and deprivation in response to this disconnect, as whatever was obtained previously, or should have been obtained, can no longer be accessed. This sense of deficiency can be seen as related to descriptions of unmet oral dependency needs that are present in etiological understandings of depression (Fenichel, 1946), and will be explored further in Chapter 5.

As discussed in this section, an experience of deficiency could be seen in experiences of the body as lacking in energy, sexual vitality and strength, as well as in poor body image. This experience of lack can be seen as related to the disconnect between mind and body, which leaves the self with a sense of deprivation. Feelings of anger in relation to deprivation that are directed towards the body can also be seen as accounting for these feelings. These feelings of physical deficiency, as well as the emotional feelings of deficiency described earlier in this chapter, appear to have been countered or managed by participants in various ways, as will be discussed in the

following section.

Managing and reacting to deprivation

Within participants' narratives of the body during depression, ways of reacting to and countering feelings of emotional and physical deprivation could be seen. Participants' experiences of physical anxiety, reducing to functionality to survive, as well as seeking comfort and nurturance, can all be seen as responses to an internal sense of deprivation.

Anxiety and fear

Physical experiences of anxiety were referred to by a number of participants. While anxiety occurs on both an emotional and somatic level, somatic experiences are focused on in this section. From a psychodynamic perspective, feelings of anxiety are conceptualised either as providing a warning that emotions may be overwhelming, or as an indication of internal conflict (Zerbe, 1990). It should be noted that while it was not possible to accurately link experiences of anxiety directly to experiences of lack, some conjecture was possible with regard to this phenomenon, given the context and specifics of the anxiety related by participants. In relation to a sense of lack, it appears that participants' anxiety may have been linked to experiences of deficiency that either threatened to overwhelm, or arose out of internal conflict relating to nurturance.

Participants 4 and 5 described feeling shaky at times in relation to their anxiety.

> It was more of an anxiety thing, I'd actually just become like "I don't know what to do. I'm going to shake…" (Participant 4)

> When I have felt anxious, I have certainly felt … kind of like shaking inside. (Participant 5)

Here the concept of shaking for Participant 4, appears to be in response to being overwhelmed, which she described as relating to a lack of emotional support. For Participant 5, anxiety was described as more general and not described as related to any specific circumstances. For Participant 3, physical anxiety responses were often experienced in relation to driving:

> My anxiety was so bad that I would drive from home to varsity, and by the time I got there, I was physically shaking because of the emotional exhaustion of the drive, because the drive was so anxiety-provoking. (Participant 3)

Here Participant 3's concerns around independence and a lack of internalised self-soothing and nurturance, contributed to physical experiences of anxiety in relation to driving. She also referred to experiences of insomnia, which were closely related to anxiety. Insomnia is commonly associated with depression in existing literature and is considered a predominant somatic symptom (Ford & Cooper-Patrick, 2001), although was only referred to by one participant in this small sample. Participant 3's insomnia was experienced as being related to her anxiety, and was therefore captured within this theme:

> I had to actually go for sleeping pills, prescribed sleeping pills. Um… because I couldn't sleep. I was … I had bad dreams, and would wake up, especially early morning, like three or four, and then I wouldn't be able to go back to sleep... It was also part of the anxiety and that kind of thing. I think I would fall asleep quite easily but I would then wake up early in the morning, feeling very down, generally. (Participant 3)

Whereas anxiety largely refers to a state of worry and angst, fear is related to feelings of alarm and apprehension. Fear can therefore be seen as a more severe and immediately active experience of anxiety. Participant 1 described how he carried himself during depression, indicating an experience of fear:

> The kind of body you would expect of a creature that is scared… Like an alert, ready to try and… not cowering, but at the same time, afraid. (Participant 1)

Here it can be seen that he felt as if he carried himself like something that is frightened and waiting for the next assault. This can be linked to his experiences of a lack of stability and trust in his environment or his ability to respond to it during the time when he lived overseas.

Anxiety in general is discussed as co-occurring with depression as either a separate disorder (Gotlib & Hammen, 2002) or as one of the features of depression (APA, 2000). Findings in this study are therefore in agreement with existing literature.

However, while anxiety includes a number of somatic experiences, these are not typically discussed in literature related to depression and, therefore, the particularly somatic nature of experiences is not specifically referred to in existing literature. Another means of managing with experiences of lack was to seek out comfort and nurturance from others.

Seeking comfort and nurturance

Attempting to access comfort or nurturance from the self, others or inanimate objects, was evident in participants' experiences of the body. Physical acts of nurturance were seen in response to what appeared to be both emotional and physical experiences of deficiency. Another means to gain comfort can also be seen in the fact that participants described caring for others in order to increase their own feelings of well-being.

Seeking physical comfort was evident in Participant 1 and Participant 2's accounts of their physical responses and actions during their depression. The desire for comfort or nurturance is associated with a psychodynamic and psychoanalytic understanding of depression, and is mentioned in literature on these topics (Fenichel, 1946; McWilliams, 1994). However, specific information on physical experiences is not mentioned. For both of these participants, pillows were used as a means of providing physical comfort and a sense of physical safety for participants. Participant 1 reported escaping from his problems by gaining comfort from pillows:

> What stands out for me is pillows. Heads under pillows… It was very comfortable and comforting. (Participant 1)

In the case of Participant 4, it can be seen that pillows provided her with a sense of comfort, containment and support.

> I just wanted… to be cuddling something, … And also because of my back, I would put pillows all over to try and support the, to try and get the back better, but I was always cuddling something. (Participant 4)

The use of pillows can be seen as a means of comforting one's self in response to anxiety or deprivation. Here Participant 4 can be seen as utilising pillows in a

pragmatic attempt to counteract the lack of physical health evident in her back injury, and possibly also to provide emotional comfort. The softness of pillows can be seen as linked to the symbolic nurturance obtained from the breast, and appears to have been needed by both participants to soothe themselves. For Participant 4, the act of cuddling something is clearly of importance and provided her with a sense of being physically comforted. During this portion of the interview, she wrapped her arms around herself, which made the intensity of these feelings more evident. Participant 4 also described cuddling her children for comfort:

> And then when my kids actually moved into my bed, it was so easy, because there they were, right there – just to be cuddled. (Participant 4)

Nurturance and care was clearly a core need for Participant 4, and emerged again when she described her experience of a collapse at around the time of the depression, which she related to hysteria and a need to be supported by others. Participant 4 felt that a lot of demands were being placed on her, with no time for herself, and responded to this by physically collapsing:

> And eventually one night I came home and to the house and I said "I need to go to [my friend's] and just spend some time there" and he said "Why are you choosing [her] over me?" And he wouldn't let me go. And I literally, I walked into the house and I just collapsed on the steps. And I didn't walk or talk for about 3 days at all. I wouldn't do anything. (Participant 4)

Participant 4 described a sense of relief at her physical collapse and how it led to support being provided from friends and relatives, that was clearly lacking in her home environment. Not walking or talking can be seen as a regression to an infantile state, in which others needed to help her to perform basic tasks, and therefore seems to have served her by eliciting a parental caring response from others, possibly to make up for an experience of deficiency.

For Participant 2, food was used as a means to make up for an experience of physical insufficiency related to her lack of energy.

> I remember you know, craving sweet things, just to try and somehow boost my body, just to try and acquire energy from the outside. (Participant 2)

From this description it seems as if she was making up for a sense of having not enough resources internally, by engaging in the nurturing activity of eating. However, it is also likely that due to the demands of a new child, she really did require additional energy.

Descriptions of nurturing others were mentioned by Participants 4 and 5. For Participant 4 this was particularly prominent, and she described comforting and loving her infants as providing her with something she needed.

> As I ate and drank, I felt it was becoming food for my children. (Participant 4)

It is evident that for Participant 4, nourishing herself was merely a means of nourishing her children. She later described that she would not have continued to function without them, indicating that they provided a very necessary means of meeting internal needs.

Participant 5 described finding helping his children with day-to-day physical tasks like getting ready for school as assisting him in being able to function during his depression:

> I think that was a big factor. You've got their bags ready, their breakfast, and get them off to school. And then you're up. (Participant 5)

In this description it appears that Participant 5 found that helping his children physically get ready for the day assisted himself as well. Perhaps this nurturing of others was able to partly to meet his own need for being cared for, and served as a means of providing self-care vicariously through others, and thus allowed him to continue functioning, in a similar way to the more explicit example of Participant 4.

While nurturing others is associated with depression (McWilliams, 1994) no literature could be found relating to physical experiences of this in depression. Overall it can be seen that emotional and physical feelings of lack were dealt with via an experience of anxiety and via accessing nurturance. Another means utilised by participants to manage experiences of deprivation was a focus on survival.

A focus on survival

Reducing energy and superfluous tasks in order to survive was apparent in participants' physical experiences and seemed to have been used as a means of coping with feelings of deprivation and a lack of energy. A focus on bare survival was seen particularly in relation to everyday grooming. Participant 1, when asked how he dressed responded:

> Uh, probably quite badly… plain. Functional. (Participant 1)

Here it can be seen that Participant 1 felt clothing was more for survival and practically as opposed to enjoyment. A mode of survival seems to have been adopted, whereby basic minimum criteria were met, but nothing was extended beyond this. However, the "badly" can be seen as a self-deprecating. This same functional approach was evident in Participant 2's interview data:

> Again it came down to a very functional, well... this was what was on sale – whether it was my size or not, I just bought it. (Participant 2)

Participant 4 also described wearing tracksuits all day and making no effort to dress herself up for others.

> So all I had were tracksuits. Schlopped around in tracksuits, morning, noon and night. (Participant 4)

The desire to not spend excessive energy on meeting anyone else's needs was evident in her narratives. Rather than looking attractive for others, her focus had turned to survival purely for herself. Participant 4 spoke about survival as central to her general experience of depression, and related much of her behaviour to it. She also explained her need to pare down unnecessary things in her life and just focus on the survival of herself and her children. This can be seen in her choice to wear basic clothes and to focus purely on comfort and practicality.

A focus on survival left some participants with little energy to engage in self-care. The term self-care refers here to nurturing the body beyond the functional level. For many participants, just getting by was more important than focusing on

appearance or being able to enjoy the body:

> Previously I'd always had long hair, and [cutting] it was part of trying to keep my body as functional as possible, rather than something I enjoyed. (Participant 2)

This statement seems to indicate both a denial of enjoyment and a focus on getting by, as opposed to pleasure. Participant 3 described a similar process when it came to choosing clothing:

> I generally kind of just wore average clothes. Whatever just fitted. Not even clothes that I particularly necessarily liked or expressed who I was… Um, whereas back then, I didn't care. It really didn't matter… (Participant 3)

Managing by survival as opposed to giving in to disintegration emerged again in participants' responses about grooming. The majority of participants mentioned that they had not completely disintegrated during their depression, and had managed to survive with basic needs intact:

> I was a lot less concerned with it. I didn't lose hygiene or self-care or anything like that, but I generally wasn't as concerned with fashion. (Participant 3)

> I mean not, certainly not, badly being grubby, but not being spruced up. (Participant 1)

> I didn't ever degenerate into… but I certainly didn't feel any urge to preen myself. (Participant 4)

From these narratives it appears that participants felt the need to explain to the researcher that they had not completely disintegrated and been unable to maintain basic hygiene functions. However, their need to mention this during the interview can be seen as an almost unconscious wish to disintegrate at that time. Participants seem to have needed to counteract this desire by simply holding themselves and their state of hygiene together at a purely functional level. This phenomenon was not referred to in literature, although the presence of a sloppy presentation is commonly referred to

(Sue et al., 2002), no adoption of a survival mode was mentioned in this context.

Managing to maintain a basic level of hygiene, and the need to convey this fact to the researcher, may indicate that participants were responding to social norms at the time of the depression and during the interview. This may have meant that they needed to appear presentable (albeit at a basic level) at the time of the depression in order not to contravene social norms. In relation to the interview, participants may have felt a pressure to ensure that the researcher did not think that they had degenerated drastically during their depression.

For Participant 5, this same pattern emerged in his description of getting up and going to work, rather than in relation to appearance.

> ... Even though I might feel lacking in energy, I would still. I still get to work. And I think that's for me the big measuring rod. It's never got to the point where I wasn't able to get out of bed or anything like that. (Participant 5)

In Participant 5's account, it seems as if there was some aspect of him that would have wanted to disintegrate to the point of not getting up and going to work. This wish to degenerate to the point of being cared for by others can be conceptualised as resulting from an ongoing deprivation. This ongoing deprivation can be seen as leading to a deep wish to be cared for by others in order to counteract that deprivation, resulting in a wish to disintegrate and be cared for. However, participants were seemingly able to counter this unconscious wish by a focus on functional survival.

The concept of survival in depression can be understood as a means of getting by without sufficient resources, and therefore can be seen as a way of managing experiences of lack that may result from disconnection. Rather than having the emotional energy to invest in looking attractive, participants described reducing everything to its most functional level, and some explained that this was done in order to survive. The concept of adopting a survival mode, or defending against disintegration was not found in the literature on depression.

Experiences of anxiety, seeking comfort and adopting a survival mode can be seen as emerging due to a need to manage and/or counter difficult experiences of lack. As lack appears to emerge from a sense of disconnection, this same disconnection can be seen as ultimately contributing to the somatic experiences as described above.

Physical experiences of lack, such as weakness, a decrease in energy and a lack of health and well-being, as well as means to manage experiences of deficiency, were covered in this section. These somatic experiences were seen to decrease following depression, as is discussed in the following section on recovery from depression.

Increased strength, sufficiency and self-care in recovery

In juxtaposition to a sense of physical disconnection and insufficiency during depression, participants described an increasing sense of reconnection to the body, as well as feeling stronger and more capable, as they recovered from depression. Reconnection involved an increase in awareness of the body's needs, and an experience of being more present in one's body. An increase in a sense of the body as sufficient was evident in the sense of a stronger and healthier body. In addition to this, being able to access adequate resources to move beyond a survival mode, and an ability to nurture the physical self, were evident.

It should be noted that while some participants still experienced some aspects of depression at the time of the interview, a shift in both emotional and physical functioning was evident in all participants. This was associated with physical experiences of connection, sufficiency and increased well-being.

Literature on recovery from depression tends to focus on recovery being defined as a remission of symptoms at emotional, cognitive, behavioural and physical levels (Fava et al., 2007). The change in participants' experiences of the body can be seen to be a reduction in somatic symptoms, and can therefore be conceptualised as being related to the concept of recovery as defined in these studies. In literature, total recovery from depression and remission of all symptoms is considered rare (Gotlib & Hammen, 2002) and therefore the continuation of some physical symptoms of depression follows depression trends. The concept of recovery from depression should also focus on an increase in a sense of psychological well-being (Fava et al., 2007). This concept of well-being could also be seen in participants' experiences of the body as discussed at the time of the research interviews.

An increased awareness of the body, its needs, and its signals, was related by Participants 1 and 5, and can be seen to be in contrast to a lack of awareness of the body during depression. Participant 1 explained how he had to actively learn to increase his awareness of his body:

> I had to be a lot more aware of my body's distress signs… I had to with great difficulty, learn to be hyper aware of the sensitivities and stresses that my body might undergo when trying to do stuff. And as a result of that, I'm still more aware than I was before. (Participant 1)

While Participant 3 described herself as feeling fragmented and very separate from her body during depression, a sense of her functioning in a more holistic manner emerged in her narratives of recovery:

> I'm a lot more integrated… I'm a lot more expressive in my body than I used to be... I generally feel more like I am who I am. I can express myself generally as a whole being. (Participant 3)

The physical self-expression portrayed here can also be seen as a means of connection. Rather than withdrawing from her body, as explained during her depression, she described utilising her body to facilitate a connection with the outside world following her depression.

Participant 5 also experienced feeling more present in his body and greater acceptance of his body and of his self:

> Now I'm feeling more that I'm in my body and appreciate what it is to be in my body… I can see the contrast now, to how I felt then in my body to how I feel now in my body. More accepting of it. Ja, almost embodied, rather than disembodied. Now that I'm in a place where I feel more together… that's a better word, it's definitely heart. (Participant 5)

Participant 5's awareness of the change from disembodied, to embodied, and from being in the mind, towards being in the heart, indicates an increased awareness of and connection to his physical self and to his emotional self (as indicated by the term "heart").

This shift towards feeling more connected to the body following depression provides further evidence for the disconnect between mind and body that can be seen during active phases of depression. This slow move towards increased connection appears to be on a continuum rather, than comprising of discrete stages, with increasing connection to the physical self occurring over time.

Some of the participants described their bodies as being experienced as stronger

and healthier in recovery than during depression. For Participant 3, it seems as if her essential feeling of weakness had been actively counteracted by an active effort to change:

> I have created a body that is what I feel is stronger and more toned and healthier, and fitter. (Participant 3)

In this description by Participant 3, it becomes evident that she had taken an active role to make her physical body stronger and healthier. This makes it unclear as to whether a healthier psyche leads to a healthier body, or whether the creation of a healthier body leads to an improved sense of emotional well-being and psychological strength. The effects of exercise on depression are well-documented in recent literature (Foley et al., 2008) indicating that exercise may have helped Participant 3's emotional well-being. Ongoing exercise is seen as alleviating depression by improving a sense of self-efficacy and the ability to cope (Foley et al., 2008). In her description of having "created" a stronger body, an increase in self-efficacy can be seen that is congruent with this literature.

Participants also described an increased interest in sexual activity. Participant 2 described how feeling better at an emotional level lead to an increase in enjoyment of sexual relations:

> It probably took about 5 years to get to a point where I felt happy and OK with myself and that coincided with an almost like second wind in our sexual relationship, if I can call it that. I've actually really got to a place where I really enjoy it. Whereas for a very long time, it wasn't that. (Participant 2)

An experience of having more energy to invest in self-care activities was also conveyed. For Participant 4, a process of starting to care more for herself, which included engaging in exercise, was described:

> I think what I've done is I've chosen to care externally. I cared for my children, cared for my children. And I haven't cared for me at all... And I have started exercising – and that's about me, it's not about them any longer. (Participant 4)

Rather than just focusing on survival and caring for others, it can be seen that during

her recovery from depression, Participant 4 managed to invest energy in herself and to meet her own needs. This is congruent with Lafrance's (2009) discussion of how self-care is an integral aspect of recovery from depression for women. Lafrance (2009) links this to caring for the self as opposed to others, a process that is particularly relevant to Participant 4 due to her tendency to care largely for her children.

During the interview process, the way participants physically carried themselves indicated a difference in their bodies. When describing themselves in the past, participants' posture would become more hunched and closed, in contrast to when they described their current state, during which a physical sense of increased flexibility, openness and groundedness could be observed by the researcher.

The concept of physical connection strongly overlapped with sufficiency in many instances, with a sense of connection possibly enabling and contributing to self care (due to an increased awareness of needs) and sexuality (due to an increased connection with the sexual aspect of the self). This link between a sense of deficiency and a sense of disconnection frequently co-occurred in participants' narratives, indicating a link at a more conceptual level. While many changes can be seen in participants' experiences of their bodies, it should be noted that these experiences still remained to some extent at the physical level.

In relation to literature, information regarding lived experiences of the body in depression was lacking to a large extent. Quantitative studies on physical experiences were dominant, but little information was related to the data from qualitative studies. While literature could be found on overt measurable symptoms such as insomnia and decreased libido, it was harder to find anything to match more subtle experiences. This may be due to the fact that studies that focus on more physical aspects of depression tend to be based more on a medical model, which excludes more subtle emotional and physical experiences of depression. This can be related to Cornford et al.'s (2007) discussion on how medical conceptualisations of mental disorders often fail to capture real lived experiences. More research could also be found in relation to emotional, as opposed to physical, experiences. As a result, it can be seen that the lived experiences of the body are generally overlooked in psychological and psychiatric literature.

Experiences of the body centred around themes of disconnection of the body from the self, and of the body from the world. This sense of disconnection appears to

have contributed to experiences of lack that were also relevant, and were related to physical experiences of insufficiency, such as exhaustion and feelings of weakness. Ways to counter both emotional and physical experiences of deficiency relating to a sense of disconnection were also visible in experiences of the body, and included somatic anxiety responses, physically seeking nurturance or nurturing others. An adoption of a survival mode was also used to cope with these feelings. These experiences of the body in depression were corroborated by differing information on the body during recovery from depression. Participants' own understandings of their bodies were both related to, and different from, the interpretations made in relation to the findings. These understandings will be explored in the following section.

Participants' understandings of their bodies

Participants described various understandings of the relationship between their bodies and emotions during their depression. Somatic experiences were linked to biological understandings, a form of self-protection, and a reflection of emotional processes. These perspectives can be seen as related to common social explanations of depression, as well as some of participants' own emotional viewpoints.

Participants 2 and 4 adopted a predominantly biological viewpoint, describing how their body's difficulty in dealing with the process of birth and caring for young infants influenced their emotions, and ultimately led to depression. Ridge and Ziebland (2006) discuss how this is commonly understood by people suffering from depression to be a cause.

In addition to this, participants understood some of their physical experiences as being related to more emotional aspects of the self. For Participant 3, her disconnect from her body was experienced as being related to a form of defence from the reality of her situation:

> Your body is a very concrete thing, your body is the place where you experience reality. But when you're depressed you don't want to experience reality and you just go into a higher and higher world of abstraction and you start to lose connection, not only with your body but with other people. (Participant 3)

This conceptualisation can be seen as portraying a process of defending the self via withdrawing from a potential harmful environment or interactions. It also contains

some links to the concept of the withdrawal of psychic energy, or libido, as seen from a Freudian perspective, which will be discussed later in this research.

Another strong pattern that emerged for participants was the concept that their bodies were in some way mirroring their emotional processes. Being a physically active person, Participant 1's somatic experiences were quite central for him during, and just after, his central depressive episode. He described how he felt his body was expressing some of his major conflicts, after they had peaked emotionally:

> During the height of the depression, I was sort of banging my head against a vocational problem, a value-based problem. A non-physical vocational issue. And feeling … definitely a sense of a lack of agency and as a result of that, purpose, and in some ways I left there, came back here, and suddenly I'm playing that out – I was definitely playing that out – in a physical … in terms of I want to go and do stuff now and I'm going to injure myself. (Participant 1)

Participant 1 later explicitly described his body as reflecting his emotional processes:

> It was mirroring the process, where I felt that the injuries were undermining my sense of agencyto move on with my life and to do things. (Participant 1)

Here he discusses how just as he felt insufficiently able to have power in his life due to difficult circumstances, he experienced a physical inability to carry out tasks, as well as a sense of being thwarted by his own body.

When asked about her opinions on the relationship between her body and emotions, Participant 2 responded as follows:

> I suppose that within myself I was just feeling so lost on the inside, just so lost and incompetent, that my body didn't really, was almost an expression of that… That sense of loss of self, I think that came out of my body that it was almost immaterial to me. (Participant 2)

While this question was asked more explicitly than may have been ideal, Participant 2's responses describe the way in which her disconnect from her body seemed to be an expression of her disconnect from her emotional self. Further from this it can be seen that there is a strong sense of loss in relation to both of these aspects of self.

The symbolic nature of her physical injuries was briefly mentioned by

Participant 4:

> You know, if you do the whole Louise Hay readings, and your back is your support structure. (Participant 4)

Here Participant 4 is referring to a popular psychology/new age psychology concept in which parts of the body are seen as being symbolic of specific problems. Therefore she indicates that her back problem felt to her as if it might be linked to experiences of a lack of support. This conceptualisation can be seen as similar to the one reached in the process of analysing this data. However, it should be noted that Participant 4 was very cautious in mentioning this, and became uncomfortable when the researcher tried to understand more of what she was conveying. This may have been due to the fact that it clashed with her otherwise biological understanding of her somatic symptoms. For both Participants 2 and 4, differing opinions as to the cause of their physical symptoms were given. This existance of two possibly conflicting concepts is common in narratives of cause in depression, according to Ridge and Ziebland (2006).

The possibility of the body as representing emotional processes as was presented by Participants 1, 2 and 4, is congruent with literature by Balamuth (1998), Meissner (2006) and Turp (1999) in which the body is discussed as physically expressing emotional needs. This can be seen as similar to literature on physical expression via specific symptoms, such as those discussed by Taylor (2008a), Sklar (2008) and Beutel et al. (2008). While participants' experiences and narratives were focused on more general experiences, the concepts related to specific symptoms still seem relevant here.

Participants' understandings of their physical experiences during depression were diverse. Some were related to biological causes, with a focus on childbirth. Additional understandings focused on withdrawing energy from the body as a means of self-protection, and an understanding of the body as mirroring emotional processes, with the body seen as symbolising or conveying their emotional experiences at that time.

Overall, considering both the emotional and physical aspects of the self, it can be seen that similar processes were inherent in each of these. As stated by a few of the participants, it appears as though some of the experiences of the body can be seen as

reflecting the emotional processes at the time surrounding, and during, their central depressive episode. The existence and importance of the interrelationship between emotional and physical aspects of the self, and the possible deeper meanings behind the body will be discussed in the following chapter.

CHAPTER 5: DISCUSSION

This discussion chapter focuses on enhancing understanding of the somatic experiences communicated by participants, in order to gain a more in-depth perspective on these experiences. Initially, parallels between emotional and physical experiences are investigated in order to ascertain whether there is a relationship between these elements of the self. Etiological theories of depression, which are usually utilised to understand emotional experiences, are then applied to physical experiences. Theories of object loss and unmet oral dependency needs, as well as Winnicott's theory of psyche-soma indwelling, are then utilised to provide additional understanding of the body during depression. Finally, the possibility of understanding the body as a symbolic representation of these etiological processes is discussed.

THE RELATIONSHIP BETWEEN PHYSICAL AND EMOTIONAL EXPERIENCES

In both the emotional and physical experiences of depression, the overarching themes of disconnect and of lack, emerged from the data. This indicates a parallel between the physical and the emotional aspects of the self, which will now be examined in greater depth.

The theme of disconnection emerged in both the emotional and physical experiences of the body. In terms of emotional experiences, disconnection predominantly emerged in relation to a loss of, and disconnect from, an aspect of self. In relation to the body, the body was experienced as detached from the self, and as lost to the self. Here it can be seen that similar processes of loss and of disconnection appear to be present at both a physical and an emotional level. It seems as if the loss of self, felt at an emotional level, is mirrored by a detachment from the body, as well as an experience of the body as lost.

A disconnection and withdrawal from the surrounding world can also be seen at both the physical and the emotional level. Participants described emotional experiences of withdrawal from friendships and a retreat into the safety of the self and the home. At a physical level, the body was described by some participants as actively withdrawing from the world, by hiding under the bed covers and by retreating to a “hibernation” space. Here, a disconnection from the external world can be seen as being enacted in both emotional and physical spaces.

A disconnect from the body that manifested in viewing the body as the "other" with which the self is in conflict, emerged in the physical domain. No direct parallel could be observed in the emotional context, although overall processes of disconnection are similar, as described above.

Experiences of lack and deficiency could also be seen in relation to both emotional and to physical aspects of the self. The body was experienced as lacking in relation to feelings of weakness and fragility, a lack of a sense of health and well-being, a lack of energy, and decreased libido. At an emotional level, helplessness and hopelessness predominated. In both of these instances, it can be seen that the self is described as lacking and insufficient. Emotionally, the external world was also experienced as lacking. Once again, the existence of a relationship between physical and emotional aspects of the self is evident.

Ways of dealing with a sense of deficiency emerged in similar ways in relation to both the body and emotional and psychological experiences. On the emotional level, participants described feelings of anxiety, a need to seek comfort and comfort others, as well as the adoption of a survival mode. These same processes emerged at a physical level, with somatic experiences of anxiety being experienced. Physical means of comforting the self and of comforting others were also described. The adoption of a survival mode could also be seen at both a physical and emotional level. Emotionally, participants described focusing on bare survival in order to get through difficult situations. A physical adoption of a survival mode largely focused on functional dress and grooming.

From the information presented above, it can be seen that there are clear parallels in emotional and physical experiences during depression. Based on the evidence as described above, it appears as if the participants' experiences of the body in depression were analogous to their emotional experiences of depression. According to Henningsen et al. (2003), psychological and somatic symptoms may be different forms of expression of the same underlying psychological problem. The findings of analogous experiences here indicates that, in accordance with Henningsen et al.'s (2003) explanation, both emotional and physical processes appear to be following similar underlying processes. These underlying processes can be further understood when viewed in relation to etiological theories of depression, as discussed in the section below.

AN ETIOLOGICAL UNDERSTANDING OF EMOTIONAL AND PHYSICAL EXPERIENCES

This section attempts to gain an understanding of experiences of the body during depression, by applying etiological theories of depression to the central themes obtained from the research data. A brief justification for the application of etiological theory to physical experiences is given. Following this, each main category of somatic experience is linked to theory in order to provide an etiological understanding. Theoretical concepts relating to object loss, unmet oral dependency needs, and Winnicott's psyche-soma indwelling, is then utilised to facilitate this process.

In the previous section, parallels between emotional and physical experiences of the self were highlighted. From this, it can be seen that there is a relationship between emotional and physical experiences of depression. While etiological theories are often utilised to understand emotional experiences of depression (e.g. McWilliams, 1994) this study posits that, due to the existence of a parallel relationship between the emotional and the physical, etiological theories can also be utilised to understand physical experiences during depression. Further justification for this approach can be seen in the fact that an understanding of unconscious conflicts is frequently used to understand the physical symptoms in some somatoform disorders (Meissner, 2006). Therefore, this same approach can be seen as potentially useful in relation to experiences of the body in depression. The discussion below will apply etiological theories of depression in order to gain an understanding of in-depth meaning in relation to physical aspects of the self, with a brief mention of related emotional concepts

Experiences of disconnection from the body during depression were central to participants' accounts. This disconnect from the body will be discussed utilising Freud's theory of object loss and Winnicott's concept of psyche-soma indwelling. Loss, at either a concrete or an abstract level, is central to an understanding of depression (Freud, 1917), and Freud's theory of object loss is frequently related to emotional experiences of depression but also appears to be relevant to understanding physical experiences of depression, and can be seen in the lived experience of being detached and distanced from the body. In these instances it appears as though an experience of emotional loss is replayed via the body, with the distanced body reflecting a distanced aspect of the self and/or reflecting a sense of detachment from

the lost object.

Experiences of detachment from the body can be further conceptualised in relation to the energy that is turned inward during depression. According to Freud (1917), following loss of the relationship between the individual and the object, energy is withdrawn from the object. A regression of libidinal energy takes place, with energy being withdrawn from the lost object. Therefore, energy moves from a position of object-choice to one of narcissism, meaning that energy is now turned inward instead of outwards (Freud, 1917). At an emotional level, this withdrawal of energy can be seen in participants' withdrawal from the social world, which was also conveyed physically by some participants. Similarly, at a physical level, this withdrawal of energy can also be linked to experiences of physical disconnection. In this instance, energy can be seen as withdrawn from the body, in addition to being withdrawn from the outside world. Participant 3 related this in her own words, describing how she withdrew energy from the world around her, and from her body, as a means of self-protection. This withdrawal of energy from others and from the body, may be seen as related to an experience of detachment from the body, as well as a detachment from the social world.

The experience of detachment from the body was also seen in relation to a sense of the body as a separate "other" that was thwarting the self. This conceptualisation of the body can be partly understood as arising via the process of identification, and the internalisation of anger in relation to object loss. In addition to a withdrawal of energy following loss, an identification with the lost object is made by the individual, as an attempt to keep the object. As a result of this, many of the feelings and experiences that should be directed towards the object, are now directed towards the self (Freud, 1917). As loss invokes experiences of anger, this anger is now largely directed against the self (Freud, 1917). Conflicts that should be experienced between the self and the abandoning object are now experienced internally, between the ego and aspects of the ego that result from identification with the lost object (Freud, 1917). Some of these conflicts can be seen in the relationship between the self and the disconnected body. The body was described as both constraining and thwarting by participants, indicating that the anger that should have been expressed against the object is now being experienced internally against the body and the self.

This anger turned inwards can also be seen in relation to experiences of being

detached or distanced from the body. Denial of the body as part of the self can also be seen as evidence of turning anger inwards. The body is therefore disowned in a similar pattern to which a lost object might be denied as important and therefore ignored.

The experience of disconnection from the body can be further understood from Winnicott's perspective of psyche-soma indwelling, although this is not specific to the etiology of depression. Winnicott (1949) refers to the split between psyche and soma leading to experiences of not feeling alive in the body in later life. This sense of not feeling alive in the body can be related to participants' experiences of disconnection, detachment and distance from the body.

Winnicott's view of psyche-soma indwelling postulates that good enough parenting means that the infant's physical and emotional needs are met, and therefore no split is necessary between mind and body, and the psyche and soma remain connected (Winnicott, 2007). If, however, the infant's needs are not adequately met, the infant attempts to meet its own needs in the realm of the psyche. This leads to a detachment from somatic aspects of the self, and an increasing split between psyche and soma (Winnicott, 2007). Balamuth (1998) extends on this concept by saying that a split between psyche and soma is related to an unacknowledged loss or violation, and that this leads to inability to have a grounded and authentic connection to the body. In participants, particularly those who described a history of being disconnected from the body, it seems plausible that a psyche-soma split may have occurred, resulting in experiences of not being grounded or alive in the body. The description of these experiences can be seen as similar to participants' experiences of disconnection and detachment.

Winnicott's concepts can be seen as related to both oral dependency and object loss, and provide an additional understanding of the nature of disconnection from the body. Oral dependency can be seen in relation to the concept of “good enough” mothering that, in turn, allows the infant to remain connected to their body. From Balamuth's (1998) extension on Winnicott's theory, he describes how a loss can exacerbate disconnection from the body. Therefore, unmet early needs due to insufficient caregiving and experiences of loss, can be seen as related to Winnicott's view of not good enough care, resulting in a split between mind and body.

Experiences of the body as deficient can be understood in relation to both unmet

oral dependency needs and object loss. These concepts can be seen as interrelating (Abraham, 1927; Fenichel, 1946; Freud, 1917). Unmet oral dependency needs result in a predisposition to depression (Fenichel, 1946) and those who are orally dependent are also seen as being more vulnerable to object loss (Fenichel, 1946). With respect to experiences of the body as lacking during depression, both of these processes appear to be relevant and will be discussed below.

Physical experiences of deficiency, including weakness, a lack of health, energy and sexuality can be seen as partly related to unmet oral dependency needs. As being physically and emotionally cared for is a natural part of the development process during the oral stage, a deficiency of this means that the infant is unable to take in and integrate sufficient narcissistic supplies. This leaves the individual with a deficiency of narcissistic supplies, leading to a need to seek these out in adult life, frequently via the complaining behaviour associated with depression (Fenichel, 1946). A lack of self-esteem also results from this deficiency (Fenichel, 1946) and experiences of helplessness (indicating that the self is not sufficiently strong) may also indicate a lack of sufficient narcissistic supplies. Weakness and fragility of the body indicate a sense that insufficient strength has been internalised, and insufficient resources are available for physical daily life or to keep the self functioning. These experiences can therefore be understood as physical expressions of having insufficient narcissistic supplies, as is associated with a lack of needs related to oral dependency (Fenichel, 1946).

Experiences of the body as deficient can also be seen as related to the concept of psychic energy, or libido (Freud, 1977). As energy is withdrawn from the lost object, and possibly also from the body (as discussed earlier), the body is left with insufficient resources, resulting in feelings of low energy, fatigue and a decreased interest in sexual activity.

Experiencing the body and the self as deficient can also be seen as related to internalised anger. As anger cannot be expressed towards the object, it is instead turned against the self (Freud, 1917). Within this framework, experiences of the body and the self as deficient can be seen as related to an evaluation of the self as lacking. This sense of the self as lacking might be more appropriately related to the lost object (Freud, 1917) which was experienced as being deficient (Fenichel, 1949). Therefore, anger and a sense of insufficiency are experienced in relation to the self, instead of in

relation to the object. This in turn leads to a sense of deficiency at a physical, emotional and cognitive level, resulting in poor body image, feelings of physical insufficiency, and low self-esteem.

Physical experiences of anxiety may also be related to deficiency. Anxiety may be conceptualised as a warning signal, indicating that overwhelming emotions may take over, or may serve as evidence of an underlying internal conflict (Zerbe, 1990). Within the context of this research, it is postulated that these feelings of anxiety may have emerged in relation to experiences of deficiency and loss, although insufficient information was obtained to gain a clear understanding of this phenomenon. However, emotional and physical experiences of anxiety can be made sense of to some degree within this framework.

Participants' physical attempts to comfort themselves can be seen as related to unmet oral dependency needs. Gaining comfort or nurturance from caregivers is a normal aspect of an individual's development, and is associated with the oral stage (Abraham, 1927). Individuals who do not receive sufficient nurturance may continue to attempt to obtain this via other means at a later stage in their life, and this is particularly common amongst individuals with a tendency towards depression (Fenichel, 1946). For participants in this study, attempts at nurturing and comforting the self physically, were evident in the use of pillows by two of the participants. In these instances, pillows were utilised by participants in order to provide themselves with a sense of nurturance and support, which they may not have received during their development. Thus, participants' actions, such as seeking comfort from pillows in order to nurture the self, can be seen as attempts to make up for a lack of nurturance.

Providing comfort for others, as could be seen in relation to caring for children in participants' narratives, is potentially related to a projection of oral dependency needs. In the defence mechanism of projection, an aspect of the self that is too overwhelming to engage with, is seen as belonging to another individual (Freud, 1957). This defence mechanism is strongly associated with oral stage (Abraham, 1927). In relation to participants, it is postulated that a need for being taken care of was projected by some of the participants onto their children, who were then nurtured and provided with care both at a physical and an emotional level. This resulted in parents' needs being vicariously met through nurturing their children. However, it is important to note that caring for children is also a normal part of parenting.

An adoption of a survival mode, which manifested both physically and emotionally, can be seen as related to the individual having not been able to internalise sufficient nurturing resources at an early age. As described earlier, if insufficient caring is provided for the infant, they are unable to internalise this process, leading to insufficient internal resources to care for the self (Cameron & Carmichael, 1963). As a result of this sense of insufficiency, a survival strategy to cope with fewer resources may have been adopted and resulted in functional self-care and preservation of resources evident in participants' narratives.

A lack of energy, as discussed earlier, may also contribute to survival mode, as only enough energy for basic functions is available. A harsh superego, due to anger turned inward (Freud, 1917), may also contribute to the focus on survival, as the individual is provided with little space to meet their own needs in the face of harsh criticism, and this may contribute to the adoption of a functional strategy.

In relation to a focus on survival as opposed to disintegration (as was described in relation to grooming), a wish to regress to a state of oral dependency can be seen. A wish to disintegrate and have to be cared for by others indicates a desire to return to an early stage of development, possibly as this was not adequately resolved at the time.

This focus on survival, rather than disintegrating, may also be related to the harsh superego associated with depression (Freud, 1917). The social norms internalised in the superego as described by Freud (1950), as well as anger turned inwards (Freud, 1917) may have contributed to participants feeling that they could not disintegrate completely, as this would be contravening social norms. Therefore, participants continued to maintain basic hygiene and day-to-day activities, in spite of a wish to disintegrate. This internalisation of social norms may have also led to participants wishing to reassure the researcher that they had not degenerated to a point of losing hygiene.

Overall it can be seen that etiological theories of both object loss and oral dependency needs, as well as Winnicott's understanding of psyche-soma indwelling, can be used to make sense of experiences related to depression. While emotional processes in depression are frequently acknowledged as related to etiological theories of object loss and unmet oral dependency needs, similar processes could also be observed in relation to the physical experiences of depression. The utilisation of this

psychodynamic etiological framework has provided additional understandings of experiences of the body during depression, which can be seen as reflecting emotional processes related to loss and disconnect, as well as to unmet needs and feelings of lack. Winnicott's conceptualisation of psyche-soma indwelling has also provided more of an understanding in relation to a physical sense of disconnection. Further to this, the concept of the body as symbolically representing etiological processes will be discussed in the following section.

THE BODY AS SYMBOLIC IN DEPRESSION

In this discussion so far, it can be seen that emotional and physical processes are analogous in depression, with central themes of disconnection and lack being seen in both of these areas. These thematic concepts were then related back to etiological theories of depression surrounding object loss and oral dependency needs. From this it could be ascertained that experiences of the body could be made sense of utilising etiological theories to understand participants' physical experiences. Therefore, it can be implied that the body can be seen to be representative of underlying etiological processes in depression. Utilising existing psychodynamic literature, the existence of this phenomenon will now be explored further.

As discussed by Freud (1923), the psychological self can initially be seen as arising from the physical self. This implies that emotional and psychological processes mirror the physical processes of development, as is discussed in Freud's understandings of psychosexual development (Freud, 1977). Winnicott's view of physical development also incorporates the idea that the sense of self arises from early physical experiences, specifically related to how the infant is handled by the mother (Winnicott, 2007). Viewing both Freud and Winnicott's concepts, it becomes apparent that the physical self is important in relation to later emotional functioning. Anna Freud (as cited in Meissner, 2006) commented that not only is it that the body affects the psyche, but that the psyche also impacts on the body. These early dynamics indicate that there is a cross-over and flow of energy (or processes)u between mind and body in early development. Therefore, for participants in this study, it can be viewed that mind and body can be seen as interrelated, particularly with regard to the expression of early developmental experiences.

This concept of an interrelation between mind and body is not just present within the understanding of psychological development. With regard to

predominantly somatic psychological disorders, the body can be seen as providing information about unconscious emotional processes (Meissner, 2006). Freud's (2004) work on hysteria is also congruent with this perspective, and serves as a symbolic expression of an unconscious wish or conflict.

Literature on certain somatoform disorders, such as conversion disorders and pain disorders, are understood as being related to underlying unconscious emotional experiences that are expressed physically (Beutel et al., 2008; Sklar, 2008; Taylor, 2008a). As discussed by these authors, such phenomena can emerge in a wide variety of symptoms, from pain and paralysis to physical tics. However, emotional processes can also be seen in everyday posture and body movement, rather than just in explicit somatic disorders (Cameron & Carmichael, 1963). Bick (1988) and Turp (1999) focus on the fact that developmental experiences appear to become inscribed in the body, and later emerge in physical attributes such as posture and physical style.

This embodiment of unconscious processes in every day posture and physical experiences seems to be evident in depression. As discussed above, etiological theories provide a level of insight into physical experiences during depression. This indicates that an interrelation exists between the two. Therefore, physical experiences ranging from feelings of detachment from the body, to back pain and joint injuries, to feeling a lack of energy, to being imprisoned, and to feeling as if the body is lost, all appear to be symbolic representations of the etiological theories of object loss, insufficient early care-giving, and unmet oral dependency needs. Just as in some somatoform disorders, where the body is conceptualised as being symbolic of unconscious processes (Beutal et al., 2008; Taylor, 2008a), and developmental experiences are seen as being inscribed in day-to-day physical movement (Bick, 1988; Turp, 1999) so the experiences of the body can be seen as symbolic representations of underlying etiological processes in depression.

In this section, parallels between the emotional and physical experiences of the self were drawn, indicating a relationship between the two. These experiences were then engaged with at a deeper level, by applying etiological theories of depression to explain physical experiences of the body during depression. From this it was ascertained that the experiences of the body can be seen as representing emotional and etiological processes in depression. Therefore, it appears that there is an interrelation between mind and body. The symbolic nature of the body in some somatoform

disorders and similar physical manifestations, from a psychodynamic viewpoint, was discussed. It was then concluded that a similar process may also be occurring in depression. Just as the body symbolises an unconscious process in somatoform disorders, so the experiences of the body can be seen as symbolising the emotional and etiological processes in depression. Having drawn this conclusion of the body as potentially symbolising etiological processes in the sample of participants researched, the following chapter will conclude this research report.

CHAPTER 6: CONCLUSION

This chapter provides a synopsis of this study as well as final concluding comments. In addition to this, some of the limitations of this study are discussed, and areas for potential future research are identified.

This research investigated experiences of the body during depression, utilising a qualitative approach. Interviews were conducted with individuals who perceived themselves as no longer suffering from depression. Central themes emerged relating to a feeling of disconnection from the body, experiences of lack and deficiency in relation to the body, and responses to these deficits. These physical experiences presented similar patterns to those of the emotional processes, indicating a possible link between the two. Participants viewed these somatic experiences as relating to biological factors, a need to withdraw from the body for self-protection, and as being representative of emotional processes. Evidence of constructs related to the etiological concepts of object loss and unmet oral dependency needs were identified within the themes, and the existence of these was further explored in a discussion of how physical symptoms could be explained in relation to the etiological theories of object choice and unmet oral dependency needs. Finally, it was postulated that physical experiences may possibly be seen as symbolic representations of the etiological emotional processes in depression.

This study highlighted the importance of the acknowledgement and exploration of physical experiences of depression, given that they provide additional understanding of lived experiences of depression, and appear to possibly be linked to underlying emotional processes. Incorporation of both physical and emotional aspects of depression can also be seen as providing a more holistic understanding of depression that does not simply focus on only physical or only emotional aspects, but examines the interrelation of the two. This understanding may assist in providing an enhanced ability to work with physical symptoms of depression and to understand their possible emotional origins.

LIMITATIONS

While this research attempted to take the view that the mind and body should be viewed as a whole, a divide between the mind and body was still inherent in the design of this study, as well as in the data analysis and presentation of the findings.

The existence of such a split in the conceptualisation of the research further indicates the pervasive nature of the mind-body split in current society, as described by Capra (1983).

Several methodological limitations are evident in this research. As this study utilised a small sample of participants in order to gain a more in-depth understanding of their experiences, these results cannot be generalised beyond the sample studied. However the in-depth nature of the data obtained is in line with a qualitative approach. In addition to this, the sample cannot be seen as representative of all individuals who are no longer depressed. As the majority of participants were from Westernised backgrounds, experiences may well differ in other cultural groups. In addition to this, the age of participants ranged from 25 to 37, providing a certain homogeneity with regard to their experiences. Individuals from different age groups may have reported on different experiences, based on differences in socialisation and experience. The education level of participants was also at a tertiary level, providing further homogeneity in their way of processing their experiences. Although depression is more likely to be reported in women, an attempt was made to include both males and females to provide a more gender-neutral perspective. However, this may not have allowed subtle differences in experiences of the body between men and women, to emerge. As participants were accessed via non-random convenience and snowball sampling techniques, the participants interviewed tended to be of similar age and backgrounds, which is a limitation in terms of representativeness and generalisability (McLeod, 2001). As two of the participants were related to the field of psychology, and all participants had been in psychotherapy, a greater understanding of their own experiences may have been present and impacted on the data collected. In addition to this, a greater level of familiarity with psychological discourses around depression may have potentially affected their understandings and responses.

In terms of the use of interviews, participants provided information that was self-reported in nature, which means that the data collected is highly subjective in nature. While this is in accordance with qualitative research methods, it limits objectivity in the study. The retrospective data obtained in relation to depression can also be seen as being influenced by memory, making it potentially less reliable (Babbie & Mouton, 2004). A wish to appear socially desirable may also have impacted on participants, leading to them respond in ways that they felt was desirable

or would please the researcher (Babbie & Mouton, 2004). Being audio recorded may have added to the participants' concerns of social desirability.

Although all of the interviews were conducted by the researcher, as the interviews were semi-structured as opposed to fully structured, interviews were conducted slightly differently with all participants. These slight differences may also have affected the results. According to Barriball and White (1994), bias may be introduced if questions are asked in different ways. This occurred to some extent in this study, as the researcher attempted to respond to the differing needs of the participants. Interpretation of non-verbal signals as interpreted by the researcher may also have introduced bias into the study, as this is extremely subjective.

As this study was exploratory in nature, once the data was analysed, certain gaps in the information collected were observed. For example, only physical descriptions of recovery were provided, with no information on emotional experiences of recovery. A more in-depth history would also have provided further useful information.

Subjective analysis of the data also leads to potential problems, as important information may be overlooked. As the researcher was working from a psychodynamic perspective, it is possible that concepts that were not in line with this may have been neglected. The influence of the researcher, as discussed in the method chapter, can also be seen as having influenced the data and led to a bias in the nature of the study, research questions, data collection, data analysis and interpretation, as discussed by Maso (2003).

DIRECTIONS FOR FUTURE RESEARCH

This study explored an area of research that seems to be frequently overlooked, but can be considered as having potential value. From the data and theoretical understandings of this study, it would appear that the experiences of the body provide useful information on the phenomenology of depression and potentially enhance understanding of the meanings of the body during depression. In addition to further research on depression, the same concepts might then be applied to other disorders that are not explicitly physical, such as anxiety disorders. This could lead to a greater understanding of the somatic nature of these disorders.

While some basic background and history of participants was collected in this study, the acquisition of a more detailed clinical history additional useful material.

This material could then be utilised to formulate early experiences in greater depth, thus assisting in providing a deeper and more accurate understanding of the psychological meanings behind physical experiences.

The use of a case study approach could also provide a more complex understanding of an individual's physical experiences from a psychodynamic perspective. As described by Ivey (2008) complexities and contextual factors, as well as therapeutic interactions, are provided by case-study research. The inclusion of such information could provide an in-depth understanding of an individual client's experiences and meanings of the body during depression from the basis of a theoretical case formulation.

While the above examples would provide a more in-depth perspective on the relationship between mind and body, gaining an understanding of the breadth of this phenomenon would also be useful. The use of quantitative research methods, if based on qualitative exploratory research, could provide more objective information on the overall extent of specific experiences of the body in depression.

Future research could also be linked to the potential usefulness of utilising experiences and meanings of the body in a psychotherapy context, as described by Miller (2000) and Turp (1999). In relation to psychodynamic therapy with depression, research on ways to incorporate experiences of the body and integrate this with existing therapeutic approaches could be valuable. Possible future research questions could relate to how best an understanding of the body could be integrated into therapy, and research relating to the effectiveness of this could be undertaken.

More directive therapies could also engage with how thoughts of the body and experiences of the body interact to contribute to depression. Negative thoughts that influence how the body is perceived and experienced, could be discussed and countered in a psychotherapeutic context. In addition to this, normal experiences of the body during depression may be catastrophised or excessively dwelt on by clients. This could be addressed in psychotherapy, so that these thoughts do not lead to an increasingly negative view of the self and concomitant depressed mood.

In a therapeutic context, focus on the experiences and meanings of the body during depression could assist clients in becoming increasingly aware of their somatic experiences and the meanings behind these. This in turn could ultimately lead to improved intellectual insight and emotional awareness, and therefore possibly

contribute to the effectiveness of psychotherapy.

The potential usefulness of taking a holistic approach within the context of psychotherapy could also be an area for future research. Combining a focus on emotional and physical aspects of self may positively influence the outcome of psychotherapy, as more aspects of the self are incorporated in therapy, in line with Eastern and African worldviews and healing practices (Bojuwoye, 2005; Chan, How & Chow, 2002). This may also be of particular relevance for individuals who have cultural beliefs that incorporate the strong association between mind and body.

CONCLUDING COMMENT

This study examined the lived experiences of the body during depression utilising a qualitative research approach. While the study can be seen as having various methodological weaknesses related to sample size and subjectivity, overall, it was ascertained the experiences of the body during depression seem to be of higher importance than is often accorded in literature. The existence of a relationship between emotional and physical experiences of depression was ascertained, indicating that physical experiences may express similar processes to those evident at an emotional level. A psychodynamic interpretation further indicated that an in-depth understanding of these physical experiences could be achieved by relating them to etiological theories of depression. Finally, it was postulated that, in a similar way to psychodynamic understandings of conversion disorders and some other somatoform disorders, the body in depression may be seen as symbolically representing emotional and etiological processes in depression. While further research into the depth and breadth of this area, as well as an examination of its applicability to psychotherapy is indicated, it can be seen that the symbolic nature of the body in depression may be a useful means of conceptualising and understanding some of the lived physical experiences evident during depression.

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APPENDICES

APPENDIX A: INTERVIEW SCHEDULE

Interview schedule

Background questions

1. Could you tell me a bit about yourself? *(Elicit age, occupation etc.)*
2. How would you describe yourself? *(Elicit personality and self-concept)*
3. I'd also like to find out a bit about your early life. As a baby, do you know what you were like? Did you cry or not? Did you eat and sleep normally?
4. Did you walk, talk and sit up at the appropriate time?
5. Are there any stories told about you as a baby?
6. How do you feel when you hear these stories?
7. Were there any significant events affecting your family when you were born?
8. And moving on a bit, how would you describe your childhood?
9. Were there any major events that affected you?
10. What were you like as a child?
11. How did people describe you?
12. How were things between you and your parents?
13. Did you have siblings? How did you get on with them?
14. What was school like for you?

Mind-body questions

Moving on from your early life, I'd like to find out a bit more about what things were like for you when you were depressed.

1. Could you describe some of your experiences during the time you were depressed?
2. What were your relationships with other people like?
3. Did you have any problems with your energy level, appetite or sleep? What sort of problems?
4. How did you feel about your body?
5. What was it like to actually live and be in your body at that time?
6. Did you feel that you liked or disliked your body?
7. What did you like or dislike about your body?
8. If you can think of a metaphor to describe how your body felt at the time, what

would it be?

9. How did you find it to exercise or do other day-to-day physical activities, and how is that different today?
10. How did you tend to dress and groom yourself, and is it different to how you tend to dress yourself now?
11. How did you carry yourself (move through the world) at the time?
12. What position/s would you tend to sleep and sit in?
13. What was it like to wake (your body) up in the morning?
14. What were your sexual relations like at the time? How is this different from the way they are now?
15. Where did you primarily experience yourself from i.e. your head, in your body partly or fully, not really present etc.?
16. How do you think people unknown to you perceived you at the time?
17. At that time, was there anything you would have liked to change about the way your body felt? Is there anything you would want to change about the way your body feels now?
18. Did you feel that your body was limiting you in any way? If so, how?
19. How do you feel about your body now? Does this feel different from how you felt when you were depressed? In what ways?
20. Looking back on it now, how do you make sense of what was happening in your body?
21. Is there anything else that you feel you would like to say about depression or about your body?

Thank you

APPENDIX B: PARTICIPANT INFORMATION SHEET

SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT
UNIVERSITY OF THE WITWATERSRAND
Private Bag 3, WITS, 2050
Tel: (011) 717 4500 Fax: (011) 717 4559

Hello,

My name is Althea Sherry and I am currently completing my Masters degree in Community-based Counselling Psychology at the University of the Witwatersrand. I am conducting research into people's experiences of their body during depression. I am interested in how you felt about your body during depression, and how you feel about it at the moment. I would like to invite you to participate in this study if you have previously suffered from depression, but feel that you no longer do, and have attended psychotherapy.

The research will involve participation in an interview by myself at a time and place that is convenient. In the interview, you will be asked to give some demographic information (e.g. age and occupation) and I will need to ask you some questions about your background, how you felt about your body during your depression, as well as how you feel about it at the moment. Interviews will take approximately two hours and will be audio recorded for accuracy. As this research will be about your own experiences, you are welcome to contribute any comments you may have and your active participation will be valued.

As a participant in this research project, your participation is voluntary and you would have the right to withdraw your participation from this study at any time. You have the right to refuse to answer any questions or to withhold any information you do not feel comfortable revealing. It is possible that you may feel uncomfortable during the interview, in which case you are welcome to stop if would like to. Please note that as you are talking about quite personal information in an interview setting, the research process may impact on your own personal psychotherapy.

As a participant in this study, all information will be kept confidential and your identity will be kept private. All information you supply will only be processed by the researcher and supervisor and any identifying details will not be revealed. All audio tapes and transcripts will be kept in a secure location at the Department of Psychology with restricted access. The results of the study (including selected quotes) will appear in a research report and may be published as part of an article in a psychological journal. With your permission, direct quotes may be used in the research, but these will not include any identifying details and it will not be possible to identify the individual participants from this information. Results will be made available to participants in the form of a 1 page summary that will be available on request.

Participating in the study will have no direct benefits for participants. However, it is hoped that this research will contribute to an increase in understanding how people feel about and understand their bodies during depression. This understanding will possibly lead to improved treatment being provided for other people who have been in this situation.

Please be aware that this research is not intended as a replacement for counselling and is not intended to provide a cure. It is not anticipated that participation in the study has any direct

risks for participants. However, if you experience any distress as a result of the interview, the contact details of free counseling services will be provided.

In order to participate in this study, you will need to read and sign the two attached consent forms.

Please feel free to phone me on 084 728 5444 or email me at althea.sherry@wits.ac.za if you have any further questions. My supervisor, Ms. Tanya Swart, may be contacted telephonically on (011) 717-4586 or via email at Tanya.Swart@wits.ac.za.

Kind regards,

Althea Sherry

Free counseling services:
South African Depression and Anxiety Group: 011 262 6396
LifeLine: 0861-322-322

APPENDIX C: INTERVIEW CONSENT FORM

I_____ have read the information letter provided about Althea Sherry's research on experiences of the body in depression. I understand the processes involved and personal implications of the study. I consent to participate in the study as described, with the understanding that:

- I may withdraw from the study at any time
- I can refuse to answer any questions that I prefer not to
- My identity will be protected and will remain confidential
- There are no direct risks or benefits to participating in this study

Please tick one of the boxes below:

☐ I agree

☐ I disagree

Signature: _____

Date: _____

APPENDIX D: AUDIO RECORDING CONSENT FORM

I_____ consent to my interview being recorded onto audiotape. I am aware that:

- My identity will be protected and kept confidential
- Audio tapes will only be processed by the researcher and transcriptions will only be accessed by the researcher and her supervisor
- Audiotapes will be kept in a secure location with restricted access
- Audiotapes will be destroyed once the research report has been accepted for qualification
- Direct quotations may be used that do not reveal my identity

I am aware that details from my interview will be used for a research project and potentially for other future academic publications.

Please tick one of the boxes below:

☐ I agree

☐ I disagree

Signature: _____

Date: _____

APPENDIX E: ETHICS CLEARANCE

See attached sheet