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Making sense of depression: perceptions of melancholia in lay narratives

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ABSTRACT In the field of lay health knowledge research, little attention has been paid to mental health problems. Drawing on in-depth interviews with depressed people, this article analyses lay theories of depression, focusing on narrative accounts of depression. These narratives were guided and shaped by a core explanation of the individual etiology of depression. Three narrative types were distinguishable: one storyline was based on shortcomings of childhood and adolescence development. A second storyline focused on excessive demands and role-conflicts, presented as causes of work-related burn-out, which developed into or already contained traits of depression. A third storyline was formed along symptom-provoking factors, outlining a story of hardships and severe life events during adulthood, which were reacted to with depression. Apart from the core explanation, the accounts reflected upon other explanations of depression. In revealing individual and social circumstances that create discomfort, depression accounts act as powerful describers of society.

KEYWORDS *depression; illness narratives; illness perceptions; lay health knowledge*

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In his eloquent and compelling monograph, *The Wounded Storyteller* (1995), Arthur Frank describes illness narrative as an attempt at gaining a voice: telling the story is a part of healing where the ill person claims her/his body back from medicine and makes sense of the illness in her/his life. It is a postmodern experience of illness, claims Frank, that contains a need for the individual story to be told. The importance of illness narratives lies in the fact that they are a vehicle for reflection and expression in a process where the individual searches for explanations and constructs understanding of the illness experience in relation to self and others. An illness narrative is thus both a tool and a result in the process of making sense of illness

where the meaning of illness is contextualized. Conceptually, the process of making sense of illness includes three aspects: *individual contextualization* contains an attempt to find and give meaning and explanations to the origin and etiology of illness in the individual's life. *Social contextualization* embraces consideration on the effect and meaning of illness to the individual's social position and relationships. The significance of illness to the position of the individual is both practical and moral. A third aspect of this sense-making process from the individual's point of view is *cultural contextualization,* which affects and interacts with the other aspects of contextualization. Cultural contextualization consists of the use and contemplation of shared cultural knowledge regarding the illness: public images, cultural expectations, attitudes and norms, disciplinary theories, etc. Lay and scientific explanations of illness overlap in the process (see also Davidson et al., 1991). Making sense of illness thus involves reflection both of individual experiences and of social consequences and cultural constructions of the issue (for a similar argument, see Radley and Billig, 1996).

Making sense of the illness experience is a task most sick people engage in after the initial period of falling sick – or even during it. The conceptual differences outlined above blend in the practice of the process and individual, social and cultural contextualization are interwoven in complex ways. The process of sense-making is therefore an active search for meaning in which an attempt is made to answer the question presented by illness 'why me?'. Researchers have called this process 'narrative reconstruction' (Williams, 1984), where the biographical interruption (Bury, 1982) posed by illness is woven into the cloth of the individual's life. Giving an account of illness and forming an illness narrative is part of coping with illness and its consequences (Radley and Billig, 1996: 237). It is an ongoing and continuous process where new meanings are found and old meanings replaced, making the illness narrative a storytelling with no end. Illness is reinterpreted as the process goes on, and is thus difficult to comprehend solely from a singular perspective (Good, 1995).

In addition to making sense of the illness experience, an illness narrative often also struggles for legitimation of the sufferer's position (Radley and Billig, 1996). For the ill, there is always a threat to be defined as less than competent or capable, and in the case of mental illness, the question of whether the illness itself is self-motivated remains (Radley and Billig, 1996: 228). Byron Good (1995: 134) reminds us that an illness narrative always involves the effort to tell the correct story, to patch up the moral rupture presented by illness. Morally justifying their action and non-action therefore becomes vital to the storytellers.

How do people talk about depression? What kind of explanations do they give for their depression? Drawing on in-depth interviews with people suffering from depression, this article aims at highlighting lay sense-making processes of depression, focusing on narrative accounts of this illness presented in interviews. Depression is a frequent mental disorder in most

western countries: every fifth individual in Britain or Finland, for example, will suffer from a mental disorder during his/her life. Moreover, WHO recently termed depression as a major factor in worldwide disability rates (1999).

Despite the wealth of sociological studies of depression (the notable landmark of that research being Brown and Harris, 1978), and with the exception of David Karp's work (1996), the experience of depression has remained a rather unresearched area of study among sociologists of health and illness, left to the psychologists and psychotherapists to explore and explain. The social research on lay theories, narratives and explanatory models of illness has tended to centre on illnesses of either a physical or a psychosomatic nature (e.g. Helman, 1985; Pill, 1987; Kelly, 1992; Garro, 1994; Monks, 1995). My aim here is to present findings from a Finnish sample of lay depression accounts in order to highlight the different aspects of illness experience of depression sufferers.

What is depression?

Under the name of 'melancholia', depression is one of the oldest known mental disorders, mentioned in the *Old Testament* as well as by Hippocrates (see Jackson, 1986, for a detailed historical analysis). Depression can be understood either as a feeling (mood) or a syndrome (disease), either as an emotional or bodily state (e.g. Pang, 1998). The contemporary western medical conception of depression maintains that it consists of somatic, behavioural, cognitive and affective symptoms (Marsella et al., 1985). With such broad symptomatology, the origins of depression are contested: depending on the perspective, depression is presented as having either a social, a biological or a psychological etiology. Within psychiatry, explanations concerning the causes of depression are increasingly physiological; neuroendocrinological explanations, for instance, have been growing in popularity (Good et al., 1985). Psychological explanations of depression offer causes such as personality traits, losses and other provoking agents, and vulnerability factors such as a result of problems in early psychological development leading to low self-esteem (Carr and Vitaliano, 1985). The dual position of depression within psychiatry and psychology as, on the one hand, a neurophysiological disorder caused by chemical imbalance of the brain, and on the other hand, a psychological disorder caused by mental vulnerability factors and provoking agents, is operationalized in dual treatment strategies: both medication and psychotherapy are offered to ease the suffering of depressed individuals. The social explanations of depression do not offer a straightforward treatment option, since they focus more on structural issues at the societal level. Still, even from Brown and Harris's life-event study (1978) it can be established that a disadvantaged or deprived position can have a serious effect on an individual's mental health.

Medical anthropologists, focusing on the cross-cultural study of depression, conclude that depression, like so many illnesses, is a cultural construction: dysphoria has different meanings and expressions in different cultures (Kleinman and Good, 1985). The cultural variation of symptomatology, demonstrated also in some sociological studies (Fenton and Sadiq-Sangster, 1996), indicates that certain emotions or conditions are labelled as depression through a cultural interpretation of symptoms. But even though the claims of a universality of this disorder are questionable, western societies recognize depression as a serious mental health problem requiring attention.

In what is currently usually termed 'lay health knowledge research', little attention has been paid to mental health problems (see, however, Fenton and Sadiq-Sangster, 1996; Pang, 1998 for examples of studies of different ethnic groups). Furnham and Kuyken (1991) have explored lay theories of depression from a psychological perspective. In these works lay perceptions of the causes of depression are categorized into either some form of personal or interpersonal problems, but also mention social deprivation as a cause of depression. Karp (1996) has described the process of a depression career and notes briefly that among his American subjects a gradual acceptance of biochemical explanations for their problems is common. His subjects, however, were all suffering from clinical depression and thus represent only a part of depression sufferers. Karp also speculates that the medicalization and illness ideology of the American culture might play a role here (1996: 168–77).

Subjects and methods

As part of a larger study on lay illness perceptions in Finland, 11 individuals suffering from depression were interviewed. The interviews lasted between one hour and four hours. Three of the subjects were male and eight were female. Their ages varied from 36 to 56 years (the mean age being 46.6 years), and they represented a wealth of occupations and educations from secretary to ex-farmer and journalist. These people were found through two Finnish mental health patient organizations, one of which focused solely on depression. Subjects were recruited on the basis of self-reported depression. Clinical measures were not taken, although the majority of the subjects had at some point during their illness careers received a diagnosis. The duration of the subjects' depression varied from a suspected onset in childhood to three years of distress caused by depression. The severity of depression of the interviewees varied. Five of the subjects had experienced episodes of institutionalization during their depression careers. Not all subjects had agreed to take medication for their depression, but some had tried several types. Eight had at some point taken medication and three had tried alternative or complementary treatments such as aromatherapy or homeopathy. All except one had also tried some form of psychotherapy, and three interviewees were still seeing a therapist at the time of the interview.

At the beginning of the interview, the subjects were asked to tell the story of their depression with minimum interference by the interviewer. After this initial question, and based on the information disclosed in the accounts, more detailed questions concerning the experience and meaning of depression were asked with the help of a semi-structured interview guide. Subjects were also asked about the effects and consequences of their disorder. The first phase of the interview produced narratives, which for the majority of the subjects formed the core of the interview that was referred to in the second phase of the interview, adding details or nuances, clarifying points or opinions. The accounts of depression given in the interviews are analysed using both narrative and content analysis techniques. The accounts were grouped according to the storyline they presented, and several categories of the contents of the accounts were formed.

Narratives of depression

Prompted by the question of telling the story of their depression, most of the subjects began their story by painting the scene for the onset of their depression. This frequently meant describing their lives in detail. Thus, stories of depression were always lifestories. Even to a larger extent than a physical or chronic illness or condition, depression is deeply interwoven in everyday life, in an existential understanding of the self and in a person's sense of social and individual identity. A narrative of depression is essentially a contextual narrative, focusing on the changing relationship between the self and the world. Like other illness narratives, narratives of depression describe the complex relationship of the person and culture, social relations and illness (Good, 1995: 157).

The accounts of depression were usually organized and shaped by a core explanation of the individual etiology of depression, forming a storyline. A storyline guides the narration and is often derived from symbols, metaphors, dramatic scenes or themes, constituting a recognizable plot (Schaefer, 1992: 29–31). Three narrative types following a distinctive storyline were detectable: first, a storyline based on the shortcomings or deprivations of early development, concentrating on childhood and adolescence experiences. A second storyline, focused on excessive demands and role-conflicts, presented as causes of work-related burn-out, that developed into or already contained traits of depression. A third storyline was formed along precipitating and symptom-provoking factors in adulthood, outlining a story of hardships, losses and severe life events, which were reacted upon with depression. All these three storylines express the contextual nature of depression: the illness is described as having causes in the particular circumstances and incidents of a person's life.

Sometimes the account of depression contained several narrative episodes based on more than one storyline. This reflects the fact that an illness is often an indeterminate process that cannot be represented from

a single perspective (Good, 1995: 158). The three storylines themselves did not exclusively concentrate on one explanation, either. But the storyline influenced the way the story was profiled and designed: a storyline included elements essential and exemplary to highlighting the explanation. The narrative also started from different points of life, depending on the storyline. What all these three types of narratives share, however, is an account of what went awry in the subjects' lives and subsequently caused depression.

When the narrative held difficulties or imperfections in early development responsible for depression and used them as the explanation for the onset of depression, the story started from *childhood experiences*, and with the emotions and the psychological effects of the early life events that dominated the scene. The story of depression presented the life of the subject from childhood onwards. A problematic relationship with parents was often described, as were feelings of loneliness, inferiority or despair. Specific episodes of childhood and adolescence, experienced as traumatic, were often included. These featured among other things bullying, rows or fights between parents and religious strictness. After describing traumatic childhood incidences, the subjects recounted the difficult and often negative feelings these events had aroused. A childhood story often took advantage of psychological or psychodynamic terminology and theories. For example, in the narrative of a 38-year-old man, all these features are illustrated. This narrator began his narrative by stating that he was a son of a single mother:

> My mother raised me all by herself. As long as I can remember, she was always ill. During the weekends she had a terrible migraine. She vomited and held a cold compress on her head and I learned that I should help and alleviate her symptoms. And I felt guilty for being such an extra burden for her.

After describing his relationship to other relatives and mentioning that he did not know his father, he accounts for his experiences of going to school:

> School didn't go too well in the beginning, because my teacher had something against me. And there was nothing wrong with me. I was just an ordinary lively boy, but he didn't get along with me. My memories of the first grades are of him constantly pulling my hair because I couldn't eat the food. . . . And he suggested this was a problem of my mother being a single parent, and this certainly didn't help at home.

Although this episode was solved successfully after the boy was put through some psychological tests and deemed normal yet shortsighted, then moved to the front row in the classroom, his marks rising accordingly, the events had a profound and continuing impact on his self-concept and self-esteem. For example, he states:

> I hoped that things would change and get better. That maybe in secondary school or if I get to the university, I'll meet nice people who would like me, so I figured

> I have to study hard to get out of here. But before A-levels I realized that regardless of good grades, I'll be lonely. I lost my motivation.

In the end he did not go to university but spent several years doing menial and occasional jobs, and consequently suffered from depression. In his thirties, after his mother died, he said that:

> I have only slowly started my own life, emotionally. To feel the disappointment, the frustration and the bitterness of this restricted life and the fact that I have missed out on so many things that are considered natural and self-evident in childhood.

After reviewing his current life he remarked:

> Depression has a hold of me in that I still feel lonely. . . . I still have to struggle hard to get myself to meet people. I mean that meeting people on a business basis is easy, but to meet people just because it's nice to meet them is difficult, since I can't convince myself that somebody would like to get to know me. I know that I like some people but that somebody would like me – that's very difficult to imagine.

In this narrative the childhood experiences are told as seriously damaging the individual's ability to lead a normal life. Feelings of depression and hopelessness, as well as the consequent dissatisfaction and despair are described as resulting from these childhood experiences. In a childhood story, the storyline of a disadvantaged past is also used to illustrate the impact of later events to the individual. The sufferer presents him/herself weakened by the disappointing childhood experiences and thus easily vulnerable to depression when other life events occur.

When the account of depression was characterized by the affliction of severe life events and losses during *adulthood*, the story was filled with episodes describing these circumstances. A narrative was formed with a storyline linking precipitating and provoking factors, making the story one of misfortunes and adversities. An example of this type of narrative was accounted by a 56-year-old woman, whose story's main feature was a description of a difficult and violent marriage, which ended in divorce yet continued to be an emotional burden because of split custody of the children. At the end of her account this woman concluded:

> Let's put it this way: in my opinion I've had too harsh a life. I've had too little of the so-called normal life and happy moments. And throughout my life I have lacked having a real partner. I've had to manage on my own, without a proper education, to advance my career in order to raise the kids without any support from their father, even to acquire a home.

Even though this type of narrative sometimes also described episodes of childhood, it concentrated on and usually also started with life events during adulthood. Death, divorce and different tragedies figured frequently in these narratives and the protagonist was pictured as having a miserable fate in life. The storyline of the impact of severe life events was used to demonstrate

the difficulty of coping with such a life and the ensuing exhaustion and distress.

These two types of depression narratives shared the characteristic of having an external view of the etiology of depression: the subject was not responsible for falling ill with depression, nor was he/she capable of resisting it. Rather, the sufferer had involuntarily and unwantingly been exposed to circumstances and conditions which would cause anyone to be depressed. The moral position of the subject was that of a victim, and self-infliction was thus ruled out as an alternative.

An account of depression dealing with experiences of excessive demands and role conflicts was narrated as a story of work-related *burn-out*. Finland was hit by a severe economic depression during the early 1990s when many workers were made redundant. Unemployment rates rose steeply and those who remained employed had to face the challenges and difficulties posed by the growing demands and extra workloads. The storyline in burn-out accounts was thus the inability to cope with too much work. In these narratives, the story concentrated on performance at work and the individual blamed her/himself for not noticing the overload early enough to prevent depression. Curiously enough, this type of depression narrative used the same line of argument as the two other narratives: when the illness struck, the subject was a helpless victim of depression even if the signs were there to be detected. The narrator maintained that anyone taking on such a work overload would fall ill. This type of legitimizing is especially characteristic in cases of mental illness (Radley and Billig, 1996), where moral judgements of the cause and quality of the illness are feared to question the acceptance of the subject's suffering by others. Narratives of depression were thus attempts to 'normalize' depression rather than define it as a mental illness.

The burn-out narrative was often an account of facts and, unlike the other two types of narratives, which were told with emotions often surfacing in the subject's voice, the tone of voice in the interview lacked any emotions. The narrative started by asserting that the subject's depression was work-related and concentrated on this aspect of his/her life. Thus a 49-year-old man, working on a farm yet also self-employed and holding a job, started his story by stating that his depression was induced by too much labour.

> I worked so hard that I didn't remember to take any vacation time or to go out with anybody or have any fun. It was too big a workload for one man, since the farm had no mistress or farmhands to help any more. I had all the responsibility and chores and everything. You become, when you work day and night, you don't remember to sleep and dining becomes snacking, just coffee and sandwiches. You wouldn't sleep even if you had the time, since working interferes with your sleeping pattern. You just lay awake and think all night, and you feel as if you can't do anything.

After realizing something was wrong and visiting a doctor at a local health centre, he became even more dissatisfied with his condition:

> The medication [both for sleeping and mood] made me numb so that I was really depressed. I couldn't go on working or anything any longer, I was so tired, and then I really got depressed. I felt as though it was too much for me, and I had to quit, and I mourned for the loss of work as well. I couldn't do anything but to think what to do, now that I was unable to continue working at all. My stamina left me and I was totally unable to do any physical work. I went without sleep for a long period of time, just worrying about my future and my life, as there weren't many options left for me. It was like a dead end, there was no way out.

In one burn-out story, a woman also remarked on the dual expectations she had to confront being a working mother. Family or multiple responsibilities have been found to cause distress to the women in other studies as well (Walters, 1993). In this study, women mentioned excessive demands stemming mainly from work or the dual careers rather than solely from family. One 42-year-old woman, after confessing that 'when I fell ill, my husband started to do the shopping. And he started to cook and everything', meaning that she no longer had any extended family responsibilities, thus picturing the equality of gender roles in the family, commented:

> I think that it was the combining of work and family that wore me out. . . . Because I felt that I had to divide myself into two. I had to be a good mother at home and cook and tend to the garden and, on the other hand, be good at work, helpful and multilingual and cognisant of all software and everything.

The burn-out story is characteristic of Finnish culture and the Protestant ethic, where work-related ethos of hard-working, high-performing individuals prevails despite high unemployment rates and a reconstitution of work force and employment.

Apart from the dominant storyline, each account reflected upon other explanations for the causes of depression. Sometimes this reflection was performed in the form of consecutive narrative episodes, but it could also be accomplished by means of philosophical reasoning. Subjects tried out several possible explanations to account for their depression, distancing themselves from some and accepting others. This process of movement between different explanations is similar to the search for 'experiential coherence' (Blaxter, 1993), which has been found in lay people's attempts to link their health experiences and other life events. People look for satisfactory explanations to fit their experiences in order to cover most of their illness experiences. One 36-year-old woman commented after her narrative, which contained episodes of both childhood and current emotional suffering:

> There are others who fall ill with depression only when they are adults, all of a sudden. And then they get ECT and then it's over. And they continue their lives. But my depression is not like that. It's always been there.

In two cases, the accounts had no clearly dominating storyline, but consisted of consecutive narrative episodes pointing to different directions and using all three storylines equally. Thus a 52-year-old woman began

her storytelling by reflecting on her childhood experiences. She described her parents' fights and rows and her own position as the eldest of the children. She explained that she needed to tell the story of her life if she wanted to explain her depression.

> Sometimes we [the kids] hid in the closet, but in the end our parents usually opened the door since they wanted the four of us to witness their fights. It was rather hard for a 12-year-old to carry the younger ones in her lap and calm them down and put them to sleep after our parents had stopped their fight. It wasn't every night, but at least once a week that they had these rows, two or three times a week. And my mother for instance, she said that she was having a heart attack and my father said that she was faking it. And my mother acted as though she would die. And I said, 'call the ambulance'. When the ambulance arrived my mother went out to the yard and screamed that my father tries to make her look like a mental case, that he calls for the ambulance so he could get the custody of children in divorce. . . . When my breasts started to grow, my mother didn't let me buy a bra. But my gym teacher pressured me. Then I had to cheat that I needed a schoolbook so I could buy them and I washed them in secret at night. One morning my mother woke up earlier than usual and she found them and got really mad. And for a year she smelled me and said that she could smell sewage, since I was washing my bra. She was jealous of all women. And when I started to look like a woman she was jealous of me as well.

After telling these and other episodes from her childhood, this woman started telling about her career. This episode in her narrative turned out to be about her programming work-related burn-out.

> I worked overtime because there was always a request from the CEO to give information to the media about the statistics of the process. And since I was in charge of the system, I was the one to do all that he wanted. I could have delegated the programming to somebody else, but I thought that since I would have been accountable for his doings anyway, I might as well do it myself. In the end I got real bad cardiac arrhythmia. I was on sick leave for three weeks.

Apart from the loss of work she suffered as the consequence of burn-out, she described several severe life events which in her experience had caused her to become permanently depressed. She described herself as the matriarch of the family, taking care of everything and everybody. Among the things she had witnessed was the death of her husband, and the drug-use by one of the members of her family. When her children were still small, she – typically of young mothers, she said – had little sleep. But when her mother-in-law was found to have cancer, she tried to care for her and her household as well. In the middle of these extended family responsibilities, she was contacted by the police who were interested in her brother's whereabouts. This made her worried, since her brother was an alcoholic and she had always felt responsible for his well-being because of their childhood experiences. 'It was the first time I realized that I could kill myself. I had had too much. I didn't want to live. I didn't want one single setback in my life anymore. Because when you started to count them, there were too many

of them.' Following Good's (1995) reasoning, this woman could be argued to facilitate a subjunctive mode in using multiple perspectives and disparate points of view. This tripartite account represents different aspects of the subject's illness experience, all relevant to the sense-making process.

Describing depression

The majority of subjects described depression as a threat. A frequently used metaphor of depression was an enemy, but depression was also depicted as paralysing, suffocating and even destroying the person. A 50-year-old woman outlined her experience: 'I cannot feel at home anywhere, because I sort of dys-exist, I only subsist in a dark tube with no ends . . .'. A second common feature of depression in the accounts was its comprehensiveness. Depression was portrayed as lack of concentration or as feebleness. As a 53-year-old woman said:

> It is so total. . . . There is no reason to wake up in the morning. I just let the blinds stay down. . . . Sometimes I wonder what life will be like, where can I find a fixed point, a hold to my life.

The most important feature of depression in the accounts is, however, its ability to isolate. Depression is incomprehensible for others not suffering from it. The accounts reveal the fact that people suffering from depression also suffer from loneliness, and that depression could be equalled with feelings of loneliness and isolation (see also Karp, 1996).

Cultural resources in understanding depression

The individual contextualization of the illness experience, finding the individual causes of depression and explanations answering the question 'why me?', is part of the process of making sense of depression. The narrative is one way to answer the existential question illness presents (Hydén, 1997). Telling the illness story and making sense of the illness are important in order to be understood – both by oneself and by others (Frank, 1996: 63). Whereas the narrative around individual causes and explanations is an attempt or result of the illness being contextualized by the subject and then explained to others, another aspect of the sense-making process, cultural contextualization, is placing this knowledge and understanding in a broader context of cultural knowledge about depression. Sufferers do not only have individual understanding of their condition, they also use and construe shared cultural knowledge and conceptions of the illness (Good, 1995: 52–5; Radley and Billig, 1996: 223). As the individual narrative is being constructed it can be compared to other narratives, popular accounts and expert views, and a second question is raised: 'why do people suffer from depression?' This question is often approached in general terms, in an attempt by the individual to determine what he/she

shares with fellow sufferers and their circumstances. Working through the individual and social contextualization can also provide the sufferer with an insight of depression, similar to what Frank (1995: 122) calls a 'manifesto'. Manifestoes are explicit theories about the illness which stem from experience, knowledge and conviction. To find out about the theories of depression the subjects held after they had accounted the story of their depression, they were asked an explicit question regarding their theories, perceptions and explanations of depression. In the interviews, four explanations that could be described as lay theories or perceptions of depression were expressed. These explanations differed somewhat from the explanations given in the individual narratives, although the explanation of the individual causes of depression often coincided with the theory expressed.

Various forms of *psychodynamic theory* of depression were the most popular among the subjects. In the accounts, most references were made to psychological discourses of depression, as is well documented in the first two examples of the narratives cited in this article. Terminology was borrowed from psychological discourse and problems in the emotional development and background were frequently referred to and used as explanations of depression: 'I had a very difficult home, a very strict and violent home', explained one of the subjects. Incidents in the individual's past were interpreted as significant causes of current depression. The relationship with parents, an experience of neglect or lack of love, were typical examples of the psychodynamic discourse used in this context. The cause of depression was seen as originating in the unsuccessful social relationships of the individual's past. Depression could also be understood as a consequence of reaching the limits of emotional resources, of meeting the boundaries of individual psychological strength. If an individual suffers too many hardships in his/her personal and professional life, he/she will fall ill with depression. Almost contradictory to this view, the etiology of depression could also be explained to be caused by psychological susceptibility, under which certain conditions then bring the predisposition into action. Even a minor misfortune can thus cause depression in a sensitive person. Psychodynamic theory was mentioned in relation to accounts containing all three types of narratives, and it dominated in the accounts containing childhood or severe adulthood life-event narratives.

A *social theory* of depression was also presented in the subjects' accounts. Community and communication problems were mentioned as causes of depression. Social causes of depression included isolation and deprivation because of unemployment, divorce or other life events. Depression in itself was said to cause loneliness and isolation. This theory positioned the depressed individual in a wider social context and claimed that structural patterns of society cause depression in people. Loneliness as a result of the sense of not belonging was therefore seen as a change in late modernity affecting the individual in a negative way. One 46-year-old man concluded:

> I've been thinking about the meaning of the end of the old agrarian society to people. All right, it has meant a lot of freedom because the rules were strict and fettering. But still, especially on the rural areas, people knew each other and their families and they shared a lot of work. So it was a sort of a safety network in a way. And I've wondered how we could develop this society into fostering close-knit communities again, so that people would know each other and help each other and it would contain these positive elements without too much normativity or fettering. Because I think that people who suffer from depression – and I'm among them – have been left outside these real communities.

The social theory of depression was used in connection with all three types of narratives.

A *biomedical theory* of depression constructed depression in biological terms, referring to psychiatric discourse and to information from doctors. Various conceptions were presented where biological factors were believed to cause depression, the most popular being a description of neurotransmission disruption. 'It has been said that it is an endocrinological disturbance of the brain. And I've been told that my neurotransmitters don't function the way they should', stated a 42-year-old woman. A second conception of biological cause was expressed in the belief of genetic or hereditary predisposition. 'I think that it is almost like a primitive instinct. It's in the genes, this sort of way to react, for some reason, to certain kind of issues', commented a 53-year-old woman. Biological factors were, as the latter example indicates, seen to make individuals susceptible to depression but in order for the illness to surface other factors had to be involved. Maybe surprisingly, the biomedical theory was most often referred to in the accounts containing a burn-out narrative.

As with the explanations in the narratives, one theory was often not enough but several of these theories were reflected upon in some of the depression accounts. Thus a *holistic theory* of depression was presented, combining many explanations of depression. The 38-year-old man quoted in the childhood narrative example explained:

> I think depression is to do with the person in his entirety, it is an experiential total issue. Its causes can be traced to biological factors, for instance, my mother's family has factors that predispose me to depression. They are introverts and shy like me and my mother. And they feel guilty about everything. And then there is a change in the brains. It is difficult for instance to become light-hearted if one is depressed, or has experienced long periods of depression, so that even if something nice turns up it's difficult to rise to the occasion. So I feel it is only natural that all this has a biological background. And then at the same time there are social relationships, your conception of life and living and the meaning you attach to yourself, they all affect your interaction. Does my life have a purpose? So that for instance unemployed people can experience terrible spells of depression because the meaning and script for life have been taken away from them.

The disciplinary conceptions of depression: the neurophysiological, psychological and social explanations were all used in lay theories of

depression, in a contextualized manner. The disciplinary conceptions were often slightly changed and expressed as interpretations filtered through experience.

Conclusion

Whereas the etiology and causes of depression are contested and complex within the field of disciplines, the lay explanations, perceptions and theories likewise express this multiplicity and reflection. Lay theories of the etiology of depression take advantage of the psychiatric and psychological explanations of depression but are not identical with them. The social explanation of depression seems to be more popular among lay accounts than it is in the media that mostly reflects the psychiatric and psychological discourses. Perhaps more importantly, depression is also depicted as a multidimensional and holistic illness in these accounts. As such, a single explanation does not necessarily suffice in the sense-making process, even if a core explanation is found and a narrative formed accordingly. It seems that a single explanation does not structure the entirety of depression experience.

Making sense of depression entails that people leaf through the many explanations of depression that shared cultural knowledge has to offer, and compare their experience to them. They then proceed to adapt the ones with most power of explanation in their individual and social lives. Lay perceptions of depression are made of bits and pieces taken from many sources, reflecting the fact that individual, social and cultural contextualization of depression takes place in an era of increasing reflexive practices (Giddens, 1991) and of diminishing faith in scientific and thus also in medical truths and medical authority (Kelleher et al., l994), exposing people to a wealth of complementary and competing information from multiple sources. Lay theories, perceptions and explanations of depression are constructed and negotiated in an increasingly plural and complex environment of knowledge. These findings differ from previous research by Karp (1992, 1996) and Karp and Watts-Roy (1999), who found that biological explanations dominated sufferers' and caregivers' perceptions of mental illness, even though some subjects were willing to speculate on situational factors contributing to the illness. Although Karp seems to stress the prevailing biochemical causation theories, some of his subjects recite 'biographies littered with failures' (1992), thus revealing the inadequacy of sole biochemical explanations.

Gaining a voice of their own is indeed a postmodern experience of illness, as Frank (1995: 7) claims. But what makes it postmodern if one accepts the term – and what makes a voice and a narrative so important to the sufferer – is at least partly the increase in the amount of both complex and contested knowledge around health and illness. Making sense of illness by contextualizing the experience on individual, social and cultural levels and thus

gaining a voice, is an arduous task. As was mentioned earlier, the majority of the subjects had experience of various forms of psychotherapy. The importance of experience of different forms of psychotherapy lies perhaps in the fact that in psychotherapy the sufferer has a chance to rehearse formulating narratives of the illness experience.

As Susan Sontag (1978) has noted, illness is the night-side of life that we all share at some point in our lives. Melancholia is a part of the human condition and everyday life; everybody feels low sometimes. Accounts of depression describe depression as an experience intertwined with everyday life. Depression in these accounts is not presented as a disease, but as a social and personal problem, a feeling or condition that disables the sufferer and restrains his/her ability to act in his/her ordinary social relations. Wolf Lepenies, in his inventive *Melancholy and society* (1992), argues that social circumstances and historical conditions turn people involuntarily to melancholy when their group has lost its previous significance. In this sense, stories of depression are stories of marginalization: they tell what went wrong in the individual's life and thus they are also powerful descriptions of what an individual's life is supposed or expected to be like. In revealing the night-side of life, these stories also depict the ideal lifestories of individuals, the ideal social and personal relationships and positions. By telling what they were deprived of, or what they unwillingly had to endure, the subjects also describe what life should be like: a person should have loving parents who provide a sheltered and happy childhood followed by a balanced adolescence, filled with satisfactory relationships and acceptance, followed by a relatively stressless adulthood without extensive losses or difficulties, a relevant position in society, an equilibrium of work, family and leisure activities, a network of friends, family members and acquaintances to turn to. At the same time these stories are also descriptions of what is wrong in society from the individual's perspective; what kind of structural and social factors create unbeneficial or unwanted circumstances and environments. Accounts of depression thus reflect not only the psychological conditions that shape an individual's life, but also the cultural, social and structural circumstances that position individuals in a specific society and time.

Accounts of depression seek acceptance not as stories of madness, but as stories of suffering. They express the social and individual pressures encountered by today's individuals and convey depression as a legitimate form of suffering. People suffering from depression are depicted as heroes and martyrs, validating and recognizing depression as a normal and natural illness rather than madness.

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