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Virginia Leigh Hamilton Crowe, RN, MS, Ed.D. and
Jeanne Ellen Bitterman, MA, MA, Ed.D.

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Unprivatizing: A bridge to learning

Virginia Leigh Hamilton Crowe, RN, MS, Ed.D.
Jeanne Ellen Bitterman , MA, MA, Ed.D.

Abstract

Depression is a complicated condition situated in a cultural environment that often impedes learning. The purpose of this grounded theory study was to better understand depression from the perspective of those who are living with depression. Data were collected from many sources including document review and autobiographical literature; however, the primary data were collected through in-depth interviews. Fifteen individuals, thirteen women and two men, who felt they had learned both about and from their depression volunteered to participate in the primary interview process. Analysis of the data generated categories, properties and the core concept of unprivatizing. Through theoretical coding a process of learning about one's depression emerged which suggests that learning about one's depression can be experienced as a transitional and meaning-making process that occurs over an extended period of time and facilitates development.

Background

> The disease of depression remains a great mystery. It has yielded its secrets to science far more reluctantly than many of the other major ills besetting us. (Styron, 1990, p. 11)

Depression, or depressive illness, is often referred to as a constellation of disorders that depict a condition or disease which disrupts a person's mood, behavior, physical well-being, and thought (National Institute of Mental Health Depression Brochure, 2000; O'Connor, 1997; Thompson, 1996). Depressive illness is most often attributed to a complex interaction between physiological, psychological, and sociocultural factors (Mazure, Keita, & Blehar, 2002; Murthy, 2001; Surgeon General's Report on Mental Health, 1999). Depression is not a rare phenomenon nor is it without significant cost.

According to the National Institute of Mental Health (NIMH) (2000), in any given 1-year period, 9.5% of the population will suffer from a depressive illness. The World Health Organization

(WHO) notes that major depression presents the greatest burden of disease for women and is a leading cause of disability globally for both males and females (Lopez et al., 2006; Murthy, 2001). In the United States, Major Depressive Disorder (MDD) is a leading cause of disability and produces one of the highest medical costs of all behavioral conditions (Goldman, Nielson, & Champion, 1999; Hasin, Goodwin, Stinson, & Grant, 2005). It is most difficult to calculate the significant personal and family costs associated with depressive illness, specifically given that one of the most indefinable and devastating of these costs is suicide (Dumais et al., 2005; Goldman, Nielson, & Champion, 1999).

The Surgeon General's Report on Mental Health (1999) states that more than 80% of people with depression can be treated successfully with medication, mental health therapy or a combination of both (Goldman, Nielson, & Champion, 1999; Mazure, Keita, & Blehar, 2002; Murthy, 2001; O'Connor, 1997). The difficulties dealing with depression include the under-diagnosis and cultural stigma associated with mental illness; the complex interaction between physiological, psychological, and sociocultural factors; and the numerous yet often elusive and compounding contributors and triggers to depressive episodes. Thus, to become aware of, acknowledge, and continue learning about depression and how it interacts with one's life are daunting tasks (Beck, Tush, Shaw, & Emery, 1979; Burns, 1999; O'Connor, 1997). And while much is known about what the experts believe is important to teach the depressed individual (Beck, Tush, Shaw, & Emery 1979; Burns, 1999; O'Connor, 1997), little is known or understood about the essential process of learning about depression from the perspective of those living with and learning about their own depression. The purpose of this study was to explore the experiences of those who are living with and learning about their own depression and better understand their process of learning about depression as it unfolds over a continuum of time.

Methodology

This study was situated in the constructivist interpretivist paradigm aligned with the "goal of understanding the complex world of lived experience from the point of view of those who live with it" (Denzin & Lincoln, 1998, p. 221). The rigorous and emergent analytic characteristics of grounded theory were especially applicable to the process of learning about depression,

which is embedded in social situations and influenced by individuals as well as organizational structures. A basic tenet of grounded theory is that "all is data" (Glaser, 1998, p. 8). In alignment with this tenet, data for this study were collected from several sources, with the foremost source being interviews with individuals who have experienced depression. Other data sources included document review (depression information available to individuals online or in physician's offices), autobiographical literature, from which the original themes developed, and two data collection instruments used with interview participants - a Demographic Data Sheet and Learning Audit Tool, both developed by the authors for the study. The primary participants were 15 individuals who, by design of inclusion criteria, had experienced more than one episode of depression, who were not in an acute stage of depression, who had access to help if needed, and who felt they had learned from and about their depression. The participants were obtained through self-identification, referrals, and snowball sampling.

The Theory of Unprivatizing

Individuals with depression often veil their symptoms and keep their experience private. Recognizing and learning about one's depression is difficult and inhibited by privatizing influences. These privatizing influences, such as the near normal characteristics of depression, familial beliefs, and societal minimizing, are many, varied, and often synergistic. Furthermore, these privatizing influences are embedded in and supported by a cultural and societal stigma against mental illness. As the individual's symptom veil begins to weaken, the medicalization of depression provides a language and access to support the unprivatizing process; leading to learning and development.

The core variable of the theory, unprivatizing, is identified by specific changes in the individual's actions and attitude. Behaviors such as obtaining an outside view, seeking consistent discourse, and developing the ability to critically reflect are noted. In addition, an attitudinal awareness and acknowledgement of the limitations and weaknesses of the culture emerges. These changes appear to happen initially in a sequence (stages) which occurs over time and becomes iterative. This process greatly facilitates the individual's awareness and understanding of their own relationship with depression. In addition, growth and

development in frames of reference often occur, making these frames more useful for living and decision making. The individual often outstrips the care professional in their ability to understand their depression.

The transition to integrating is identifiable by specific changes in the individual's actions and attitudes. Behaviors such as an unbending intention to persevere, reflect, learn, and unlearn habits of mind and patterns of behavior that no longer serve are noted. In addition, an attitudinal awareness and acknowledgement of the limitations and weaknesses of the clinicalization or medicalization of depression emerges. These changes appear to happen in an overlapping and iterative process which occurs over time and further facilitates the individual's awareness and understanding of their own relationship with depression, as well as, their personal understanding of being and living. Transformative learning is a characteristic of this period; individuals identify and critically scrutinize long-held and previously unexamined beliefs and assumptions supporting further growth and development.

Privatizing

> I was still holding everything together so well that the people around me had no clue. (primary participant, 2006)

The condition of privatizing is characterized by the intentional or unintentional veiling of one's depressive symptoms from self, from others or from both. It is also characterized by very little learning related to one's depression other than unintentional—for example, content knowledge related to symptoms and treatments from advertisements on numerous television and radio commercials and programs. Privatizing occurs within the generalized context of cultural and societal stigmas of mental health issues. As noted previously, this stigma is deemed by many as a key factor inhibiting ones awareness and further learning. However, many other covariant privatizing influences, such as the characteristics of depression and familial beliefs, are identifiable as well. Unprivatizing influences are also recognized in this phase. These influences, specifically symptom veil weakening and the medicalization of depression, support the beginning of transition from the privatized state.

Privatizing Influences

Personal shame or embarrassment of one's depression is common as is cultural disgrace Through acts of actual, observed, or experienced societal punishments such as job loss, rejection or exclusion. Together, these pragmatic and specific influences support privatizing of the individual's depressive symptoms and symptom veiling; thereby inhibiting awareness and acknowledgment of depression. In addition, less overt variables are also significant privatizing influences. These include societal minimizing of depression (as when people offer "simple" solutions like increase exercise) and depression guilt, which can originate from either oneself or can be stimulated by others (or both). This guilt may be epitomized in disguised-advocacy inquiries such as, "You have such a beautiful family and home. Why are you depressed?"

Individual and family beliefs or assumptions, perhaps more hegemonic in nature than not, may also support symptom veiling in more subtle, yet equally effective, ways. Examples of collusion with depression to veil symptoms and privatize pain include the exuberant individual embedded in a stoic and quiet familial culture, a young mother who perseveres diligently beyond her physical strength to support her family, or the family that loves each other but does not share private matters.

Characteristics of depression then compound the situation. As noted in the Surgeon General's Report on Mental Health Issues (1999) and experienced by many, depression is extremely complex and has no singular identifiable cause. Yet the symptoms of depression are described as ordinary feelings such as sadness, fatigue or loneliness. In addition, for many individuals, depression has been a long-term partner, bringing a normalcy to this state of being. Together, these factors inhibit discernment of depression by creating a "haze" that makes it difficult to identify when normal ends and depression begins.

Further confusing this situation is the negative reinforcing cycle inherent in many depressive symptoms and described by some individuals. For example, one is fatigued with depression, which leads to lack of movement, which leads to increased fatigue; or an individual feels sad, which leads to withdrawal, which leads to isolation, which leads to more withdrawal and more sadness.

Unprivatizing Influences

Suppression or veiling of symptoms, from self or from others, for a long period of time becomes increasingly difficult. Often individuals experience an increased intensity of their symptoms with a resultant inability to control symptoms, such as tears or anger, in desired situations. These periods of increased intensity of symptoms or unexpected loss of control indicate a weakening of the symptom veil and are often a significant factor that leading to recognition of depression—a recognition coming both from within and without, from self as well as from family or friends.

The current cultural medicalization or pathologizing of depression—such as classifying of depression as a disease, successful recent pharmacological treatments, and increased knowledge of depression pathophysiology—has provided an alternative perspective and unprivatizing influence upon the pervasive context of the cultural stigma surrounding depression and mental illness. In addition, increased public awareness and knowledge of depression through public health education and medical marketing have given the public a common language to discuss depression. As a result, it has become easier to talk about symptoms and successful treatments, and to build awareness of relatively easy access for help via the primary care physician.

Transition

There is no singular path or means by which an individual can become aware of and acknowledge his or her depression. It goes without saying, however, that finding a path is necessary if one is to learn about depression. Although not always an identifiable event at the moment, or even similar for all individuals, the experience of conceding and recognizing depression appears to occur within a definable range of conditions over a continuum of time, and is eventually identified as central to the transition from privatizing to unprivatizing.

For some individuals, detecting symptoms and identifying them with depression occurs almost concurrently and can often be associated with a very specific and memorable moment in time. For some individuals, the concurrent experience is driven by individual self-reflection and awareness. For others, the awareness comes more as a surprise and is sometimes first recognized by someone with an outside view (e.g., a healthcare worker or a family member).

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Others become slowly aware of depressive symptoms and depression over a period of time. Individuals are less able to pinpoint awareness and connect it with acknowledgment because it is more of an unfolding process. Rather, the individual experiences a slow dawning of awareness that the sadness, aloneness or pain one consistently feels might be depression.

For some individuals, the unfolding process is a linkage of trends, such as inappropriate crying on the way to work, fatigue and laziness. For others, the unfolding is an unlinking of often interdependent and confounding symptoms. Over time, individuals begin to unlink their depressive symptoms from other simultaneously occurring symptoms, events or illnesses, such as unlinking depression from anorexia. This can be a tedious and difficult process, and the unlinking does not negate the interdependence or synergistic nature of the other concerns.

Unprivatizing

> I think there's something incredibly valuable about talking about depression openly and learning to articulate your own depression and having somebody with empathy listen to you and be gentle with you. And I think that does help you to judiciously share. It helps you to understand when it's appropriate, when it's safe. (primary participant, 2007)

Unprivatizing also occurs within the generalized context of cultural and societal stigma toward mental health issues; however, the stigma appears to be less influential in this phase, which is clearly characterized by engaging an outside view. In addition, an acute awareness of the limitations and weaknesses of the culture emerges and is given voice.

Actual societal barriers within the culture, often enhanced by an unchallenged appreciation for individualism, are acknowledged and noted as impediments to mental health and wellness. Limited mental health access and reduced therapeutic visits (e.g. 10 minutes a visit) are examples. Unprivatizing involves three stages: Start Talking; and, Self-knowing. Although the stages are depicted as being linear and described as almost stepwise, they become somewhat fluid and recursive. The first stage, Start Talking, occurs initially either before or concurrent with Help-finding. Self-knowing follows after both Start-Talking and Help-finding. After initial experience of all three stages, the stages become iterative and flexible.

During unprivatizing, individuals value outside views, seek out discourse, and are able to critically self-reflect. Primarily during the first two stages, individuals gain much depression knowledge, mostly through informal self-directed learning. This general knowledge pertains to the medical model of depression as a disease, common symptoms associated with depression, and current medical standard interventions, such as talk-relational therapy and medication. The third stage, Self-knowing, is distinguished by increased learning which occurs primarily through experiential learning and is centered on one's knowledge of his or her unique personal experience with depression.

Start Talking

The beginning of the start talking stage, for most (although not all) individuals is recognized as a clearly defined moment in time. At such a moment, the subject of depression is broached, either directly or indirectly, with another individual or individuals and an outside view received. The movement toward unprivatizing and sharing one's story can be on the continuum ranging from either a very linear direct approach or a very circuitous indirect approach. The direct approach straightforwardly recognizes and situates one's depression. The indirect approach involves first talking about another issue, condition or situation and eventually turning to the issue of depression or depressive symptoms. For example, this might occur while talking about another condition, such as Adult ADD, or describing a related symptom, such as anxiety. The setting of the stage for disclosure appears to require establishing a safe environment and most often occurs with a professional or trusted friend or family member.

Help-finding

The Help-finding stage is characterized by discovering a method to support continued awareness and initial learning about one's depression and also involves an outside view. The healthcare system is the most likely—although not the only—place to find help. Primary care providers, mental health professionals, and specialists are common supports in the Help-finding stage. However, friends, family or religious leaders, separately or in conjunction with each other and the healthcare system, may also be utilized for support.

Although Start Talking and Help-finding differ, they may

coincide. The time in which individuals begin to talk and obtain an outside view of their experience might overlap with their pathway to help. Others find a gap, and so the experience becomes much more of a hunt or journey to find supports for learning about depression. One reason for this gap, other than the individual's desire for it, is that depression can easily become entwined or linked with other conditions and hence hidden. Therefore, the depression is not easily identifiable, creating a gap between expression, recognition, and help-finding.

Another reason for the gap comes from the healthcare system, which can unfortunately be experienced as an impediment that thwarts and delays oft times by misdirection, mistreatment or misdiagnosis. Other impediments from the healthcare system include lack of access (i.e., inability to schedule a timely appointment), poor service experience, and insurance limits or rejections. In worst-case scenarios, the healthcare system might even cause harm as a direct result of medical intervention.

There is a noticeable "fit factor" within the Help-finding stage. This "fit factor" appears to have three aspects: a fit with personal beliefs, a fit with an individual's specific situation and desired characteristics, and a fit with wanted structure. A good fit corresponds with an individual's personal religious or philosophical beliefs and is also compatible with the unique situation and desired characteristics of the individual. For example, if one is part of a bi-cultural family living in different countries, a multi-national awareness might be desirable. Or if one is a professional, then an understanding of professional needs and requirements would be essential. Overall, a non-condescending and supportive, yet also challenging, environment is most desired. In addition, the type of structure favored is related to fit. Help-finding might be short-term, as in meeting with someone once or twice, or long-term help over several months. Structure needs might be acute and episodic or continuous and systematic. A bad fit can inhibit learning and cause delay, if not damage.

Self-knowing

Self-knowing is characterized by the individual's growing knowledge of the unique manifestation of depression in their lives, as well as the specific characteristics of their relationship

with depression. Environmental, relational, and meaning precipitants are explored. These precipitants or contributors are multiple, non-hierarchical, and converging. Symptoms are more clearly identified; physical, emotional, and self-worth symptoms merge into a distinctive and unique symptom complex. For some individuals, symptom progression is eventually recognizable. An individual, personal, and unique "depression footprint" emerges.

Interventions are created, analyzed, and adapted. These individualized interventions range from minor changes in diet and exercise to major lifestyle changes, from learning specific skills to situational avoidance, from creating a life history to psychodrama . One's own physiology, in relation to and apart from depression, is studied and becomes more understandable. Others, also become more acutely aware of the unintended aftermath of their depressive episodes, such as damage to their relationships, may seek to learn about healing this damage.

Transition

Although the phase of unprivatizing is distinguishable from integrating, the actual transition between the two is less clear. Since integrating is a more inclusive, overlapping, and iterative, then perhaps the transition is as well. Three characteristics, however, do appear evident in individuals who move to the third phase. First, the clinicalization or medicalization of depression becomes insufficient to contain and describe the entire lived condition. Second, transformative learning (Mezirow, 1991, 2000), at least at the process level, becomes evident. Third, the individual characteristic of an unbending intention to persevere, reflect, learn, and unlearn habits of mind and patterns of behavior that no longer serve is asserted as a coherent commitment.

Integrating

> Part of it was learning for me…learning that I had gifts and I had things to contribute. Learning that they were worthy, and that they're notable and that they should be used instead of shrugging them off and not believing in me or them or truly the outcome of what they could do.(primary participant, 2007)

Integrating is much less influenced by the ever present cultural and societal stigma of mental health issues and characterized by an acknowledgment of the limitations of the medicalization of depression. This phase is further distinguished by the entrenched

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value of and developed structure for personal reflection and for obtaining a consistent outside view. Integrating also consists of three stages: Self-discovery,Self-caretaking, and Meaning-making. These stages overlap and are integrated. In addition, they are distinguished by profound personal awareness. The learning in integrating, however, is centered not on depression as much as on the individual's being in the world—situating his or her essence, nature, personality, and behavior, both healthy and unhealthy, in context.

Self-discovery

In the stage of Self-discovery, participants identify their own patterns of behavior that often exacerbate or contribute to their depression, such as unrelentingly self-judgment, striving for perfection, over accommodation and minimizing hurtful behavior. Furthermore, assumptions and beliefs that can contribute to depression, or drive unhealthy or uncomfortable behavior patterns, are surfaced and examined; for example, changing from a dichotomous thinking of "I either succeed or I fail—there's no in between" to a more understanding and compassionate stance with oneself; or, the realization that laziness is not experienced fatigue and resting, nor love expressed by over-accommodating in relationships.

In addition, individuals in this phase become more aware of what they value and from where they draw energy. For example, being aligned in "heart, mind, and body," deriving energy from being creative or spending time with nature or animals. Finally, although not lastly, individuals in this stage often seek and learn about their worth and purpose; for example, becoming aware that unfulfilled dreams and goals were related to, although not the total cause of, ones depression; or learning to not only to recognize one's gifts core to one's being, but also to appreciate (and act on) their worth.

Self-caretaking

Learning in the phase of integrating is not solely focused on depression (as it is in unprivatizing); however, in the stage of self-caretaking, a profound learning occurs about one's relationship with and sharing of his or her depression. Individuals in this stage learn to disclose their experience with depression more thoughtfully—a "wise" unprivatizing. This wise unprivatizing contains two aspects. First, there is a judicious management or

"being strategically authentic" and acknowledging the potential effect of cultural stigma against mental heath issues, while not deciding to disclose solely on that issue. The other aspect of "wise unprivatizing" is related to the oxymoron-like characteristics of depression as both complex and near-normal, both common and unique. Individuals who learn about their depression know the insipid nature of the condition, how common it looks, how complex it is, and how easily it can be missed. They also know well their unique "footprint" and share it wisely with others who love them and help them feel safe. This wise unprivatizing creates a vigilant comrade, who willingly shares the responsibility with the individual to continually observe for that "footprint." It is quite contrary to the phenomenon of co-dependency.

During this stage, individuals also move from a depression focus to a "being" focus, and learn to change personal and ingrained patterns of behavior or habits of mind, often becoming more comfortable with joy and embracing more compassion toward their own selves. While the old habits might have served the individual well in the past, they no longer do so. Synergistic to this learning of changed behavior is learning to recognize one's physiological, psychological or social needs independent of depression, and then to take actions to fulfill them.

Finally, individuals learn to consciously challenge assumptions and then purposefully choose to hold, revise, and even abandon them. These assumptions or beliefs might be personal, such as beliefs about one's unique ability, intelligence or core being; or they might be cultural, related to one's being or place within the culture. They might also be familial or societal beliefs about appropriate behaviors or patterns of contemplation: such as reflection on one's heterosexuality, examination of dichotomous thinking patterns, or a critical investigation of the traditional beliefs of one's profession or practice. The assumptions may or may not be associated intimately with the experience of depression, but they are all associated with the matter of living.

Meaning-making

The meaning-making stage of integrating consists of two approaches: making sense of depression and reaching out. Individuals struggle to make sense of depression in their lives often by utilizing multiple frames. Some individuals make sense

of the experience by identifying the individual benefits of self-discovery. For example, identifying that self-knowledge stems from one's experience with depression or that depression, although not wishing it on anyone, can be a great teacher. Other individuals make sense of depression in a socio-cultural or familial context, identifying cultural oppression and suppression of emotions as contributors to depression, along with trauma such as physical or sexual abuse, neglect, and abandonment.

In addition, many individuals make sense of depression in a physiological manner, such as the familial tendency associated with depression. Others understand their depression, at least initially, through the use of the medical model of depression—describing it as a "disease of distortion"—as "treatable" but not "curable." Finally, some individuals describe a religious or spiritual approach to making sense of their depression. Some use a more traditional religious frame, describing both God and the devil in depression; others assume a more undefined, less traditional spiritual perspective.

Reaching out to others about the depressive experience is identified as a significant second dimension to meaning-making. Two reasons surface the desire to share. First, sharing one's story with individuals who also appear to be experiencing depression seems driven by compassion. It is highly personal, and most often occurs with family members or close friends. Second, helping to increase awareness of depression and mental health in one's culture and society is more akin to social action, which may challenge and change the prevalent paradigm of mental health. Neither reason is done carelessly; both spring from the mindfulness of cultural and societal stigmas, as well as one's own health. Although reaching out publicly is characterized by concern, caution, and forethought, it is also noted as empowering.

Discussion

A significant discovery of this study was the transitional learning process that the participants underwent as they learned about their own depression. This transitional process fits and is relevant to the literature and research on the phases and transitions within the experience of depression (Amankwaa, 2000; Beck, 1993, 2002, 2006; Regev, 2001; Schreiber, 1995, 1996). The discovery of the phased learning process expands current theory on the experience of depression by making more

visible the less understood perspective of "how people actually go about understanding and organizing their recovery from depression" through learning (Ridge & Ziebland, 2006, p. 1038).

In privatizing, awareness and acknowledgment of depression by the participants in this study were inhibited by multiple confounding psychological, physiological, sociocultural, and depression-specific factors, which are also noted in the depression literature (Amankwaa, 2000; Beck, 1993, 2002, 2006; Beck et al., 1979; Burns, 1999; Goldman, Nielson, & Champion, 1999; Kessler et al., 2003; Murthy, 2001; O'Connor, 1997; Pignone et al., 2002; Regev, 2001; Schreiber, 1995, 1996; Surgeon General's Report on Mental Health, 1999). Learning about one's depression is boxed in by these forces and does not effectively begin until privatizing ends. This inhibiting of learning by lack of awareness and engagement in experience is recognized and supported in the adult learning literature (Boud, Cohen, & Walker, 1993; Brew, 1993; Jarvis, 1987, 1992; Kolb, 1984; Mezirow, 1991, 2000). Specifically, the research of Jarvis (1987, 1992) on meaningful and meaningless experience and non-learning helps explain this evident lack of learning in the participants.

Although a difficult process, all individuals in the study transitioned from privatizing into unprivatizing. The transition was often stimulated by a disjuncture in their experience and supported by their exposure to the widely available and medically reliable information on depression. This disjuncture in experience and interaction with an extant body of knowledge initiated help-seeking, provided an alternative perspective, enhanced communication, and facilitated learning. The impacts of such disjuncture is well documented in the adult learning literature (Boud, Cohen, & Walker, 1993; Brew, 1993; Jarvis, 1987, 1992; Kolb, 1984; Mezirow, 1991, 2000) as well as in the depression literature (Hanson-Lynn, 2005; Karp, 1994; Moreta, 2007).

In the Unprivatize phase, individuals began dealing with the complex and problematic issue of their depression by interacting with others, engaging their emotions, and acting on their experience. All individuals in the study utilized a self-directed, informal, experiential learning which is described in the adult learning literature as well (Boud, Cohen, & Walker, 1993; Jarvis, 1998; Kolb, 1984; Marsick & Watkins, 1990). The result was deeper learning and a more expanded meaning perspective entailing a reconstructed and more useful frame for making

meaning of their experience with depression (Merriam & Caffarella, 1999; Mezirow, 1991, 2000).

Not all individuals in the study transitioned into integration, which is characterized not only by a challenge to the clinical pathologized view of depression, but the ability and practice of the participants to reflect on perspectives, both theirs and others, associated with depression and worldviews. The depth of this self-directed, informal, experiential learning led to a profound personal awareness centered not only on the individuals' experience with depression, but with their constructed being in this world; this then supported transformations of their prior meaning perspectives. This perspective reflection is noted in the depression literature associated with recovery (Granek, 2006; Ridge & Ziebland, 2006; Schreiber, 1995, 1996) and noted in adult learning literature related to transformational learning and development (Brew, 1993; Merriam & Caffarella, 1999; Mezirow, 1991, 2000).

Merriam and Caffarella (1999) note that "to extract deeper and more expanded learning from some of our most difficult times, adults often need an extended period of time and the active support and caring from others" (p. 108). That was the case for the individuals in this study as their learning occurred in phases over time, was supported by a safe environment, and facilitated by an outside view. The result was a profound and more complex learning through difficult times.

Limitations

This exploration into a number of personal experiences of individuals with depression yielded not only information on how these individuals became aware of and acknowledged their depression, but also on what and how they continued to learn about their depression over time and about the factors that facilitated or impeded their learning. Both privatizing and unprivatizing emerged rather early as conceptual categories of importance with many related sub-categories and properties. The concept of "unprivatizing" was not recognized as the core variable until late in the coding process. This led to further theoretical sampling to develop concepts and categories related to the continuing learning process of integrating. This concept is perhaps not as well developed, or saturated, as unprivatizing, yet it is sufficiently developed to be included in the emerging theory.

Conclusion

> I would say my whole life has transformed in the last seven years, where I felt I was living life from an ocean of depression and able to get to the surface periodically—and now I feel like I live my life in the sunshine and periodically I step into some deep pool and go [laugh] whoops, I need to get myself out of this. So it's been a lifelong sort of transformation of the way I experience myself within it. (primary participant, 2007)

This study contributes to the small but growing body of grounded theory research using qualitative data which is focused on the relevant issue of personal meaning that people attribute to depression and how they understand and organize their experience of living with and recovering from depression. Merriam (2004) notes that the link between development and learning is clear in transformational learning theory and that growth and development are recognized outcomes of transformational learning. The growth and development of all the participants in the present study were evident by the reconstructed manner in which they made meaning of their relationship with depression. For some, the development also entailed a deep shift in their frame of reference, a transformation to a more developed meaning scheme which was more useful and complex, more connected to self and to others, and more reflective of assumptions—both personal and cultural, both prescriptive and paradigmatic.

The contribution of this study provides an enlarged framework from which to view learning about one's depression as a progression over time verses a quantitative knowledge dumping. It provides actionable items which could be used to assist learning, such as the unique foot print and the fit factor. However, to the authors, the most valuable contributions are encouragement to providers and adult educators, as well as individuals who are experiencing depression, and their families, to take hope that learning matters, meaning can be found, recovery can happen, and growth can occur. Life can be worth living.

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Authors

Virginia Leigh Hamilton Crowe, RN, MS, Ed.D.
Principal, Hamilton Consulting, LLC
Email: VLHC@HamiltonC.org

Jeanne Ellen Bitterman , MA, MA, Ed.D.
Lecturer, Teachers College, Columbia University

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