Irmeli Laitinen

DEPRESSION IN / BY / FOR WOMEN:

Agency, feminism and self-help in groups
DEDICATION

I dedicate this Ph.D. to my 92 year old mother, Maine Laitinen, who wouldn’t call hesrself a ‘feminist’ but I see a lot of feminism in her.
ACKNOWLEDGEMENTS

This research began in conjunction with the ‘Mieli Maasta’ (translated from Finnish as ‘getting up from feeling down’) Depression project which was a STAKES (National Research & Development Centre) initiative in 1994. Without this initiative, I would never have started this project. Many colleagues, academics and friends have helped me in this endeavour. I am grateful to them all. Here, I want to mention especially the people who made the Women and Depression Project (WDP) and this Ph.D. possible.

A ‘thank you’ belongs to the City of Helsinki Western Area Health Centre Psychiatric Unit where psychiatrists, Pentti Ouri and Marja-Leena Hauhia, encouraged me to start this therapeutic group work and enabled me to develop my research project. I am thankful to Finnish Student Health Service (YTHS) in Helsinki where psychiatrist Kari Pylkkänen helped me to obtain financial support for this research while I was working there and who also encouraged me to publish the first version of my group method, *Naisten Tiedostamisprosessiryhmän käsikirja* (Handbook on Consciousness process groups for women) (See Laitinen, 1999). Thanks also goes to colleagues at Women’s Therapy Centre (Naisten terapiakeskus) in Helsinki; The Family Counselling Centre in Lohja and Arinna Ltd. (Inhimilisen Kasvun Insitituutti) in Jyväskylä – all places where my group was facilitated with local psychotherapists.

My involvement with the WDP group method has followed me while I have changed my work places in two different countries, Finland and England. In some of these workplaces, I used this method. A ‘thank you’ belongs to colleagues at the Student Counselling Service, University of Plymouth, Devon, England who encouraged me to continue my research and my group work while I was working there as a Student Counsellor. They supported me to travel to a variety of conferences where I was able to present my research work. A special ‘thank you’ belongs to colleagues at my other work places in England including the Women’s Therapy Centre (WTC), London where I learned more about feminist approaches to psychotherapy. WTC in London was established already in the year 1975 and at that time, women working there paid attention to women’s depression. One of the authors of the first research on women’s depression in the UK, *Social Origins of Depression: A study of psychiatric disorder in women* (Brown & Harris 1978), Tirril Harris, is an active member of WTC and a current trustee. My other two work places, Cornwall NHS Partnership Trust, Eating Disorder Service in Truro, Cornwall and Share Psychotherapy in Sheffield have been supportive of my research activity. I am grateful to them all.

Besides the 11 women’s groups I ran before I left Finland in 1999, the following organizations to my knowledge have been running ‘newer’ versions of these groups and I am grateful to them for taking up my ideas: Helsinki Western Area Health Centre Psychiatric Unit, Mielenterveyden keskusliitto (Finnish Central Association for Mental Health) in Helsinki, Tampereen Yliopilaiden terveydenhoitosäätiö (YTHS) (Finnish Student Health Service in Tampere) (Hämeenaho 2007), Jyväskylän yliopiston täydennyskoulutuskeskus (Continuing Professional Development Centre in Adult Education, University of Jyväskylä) and Suomen Enskotien liitto (Women’s refuge organisation), Kangasalan mielenterveystoimisto (Mental Health Office, Kangasala), Niemikotisäätiö (Organisation for people without secure residence)
and KELA (The Social Insurance Institution of Finland). The latter organisation has started to support financially these kinds of groups run by Arinna Ltd. in Helsinki and Jyväskylä. These groups are called ‘Virtaa’ (meaning ‘power’) and are for both women and men (Bäck, 2007; Petäjä, 2007). While these groups are now open to men, I am confident that they still retain their gender sensitive focus.

Additionally, I am grateful to all the researchers and participants who have commented on my work while I presented papers at several conference venues including the Society for Psychotherapy Research (SPR), The Association of Women in Psychology (AWP), Nordic Student Health Care Conference, European Union for School and University Health and Medicine (EUSUHM), The Weissbourd Society of Fellows, University of Chicago, International Sociological Association (ISA), British Sociological Association (BSA), BSA Medical Sociology (BSA MEDSOC), Society for the Study of Social Problems (SSSP) and American Sociological Association (ASA). I am a psychoanalytic psychotherapist and I have enjoyed presenting my work in a variety of academic venues which included feminists, psychotherapists, psychologists, social workers and sociologists.

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Although, in the beginning, facilitating these groups was part of my daily work, I have done much of the basic research work in my own time besides being employed as a psychotherapist. It has taken me time to develop the Women and Depression Project (WPD) group method, collect the data for this research and publish my required research articles for my Ph.D. It was difficult for me as a non-academic to crossover the ‘invisible’ scientific threshold. At first, I was submitting my papers to ‘inappropriate’ journals for my research area. It was only when my first article was published after my participation in The Weissbourd Society of Fellows 2004 Conference at the University of Chicago, ‘Depression: What is it good for?’ that I was able to generate more interest in my academic work. With the help, advice and support of two colleagues, Dr. Gillie Bolton, King’s College, University of London and Dr. Colleen Heenan, University of Bolton, both experts and researchers in the field of psychotherapy and mental health, I was guided to mainly psychotherapeutic journals where I was able to publish my research.

I want to thank especially my colleagues and friends for giving me the support I needed. Thanks go to Prof. Auli Hakulinen, Psychoanalyst, Rauno Juntumaa, Psychologist, Fil.lis. Marja-Leena Meronen, Dr. Shiela Murphy, Dr. Linda Morrison, Prof. Barbara Katz Rothman, Prof.
Malcom Williams, and Dr. Ian Wilkinson. I am grateful to University of Helsinki, Department of Social Policy which has been the home for my research. I want to thank Prof. Elina Haavio-Mannila for introducing me as a young student to Eric Allardt’s ideas on the key dimensions of welfare. I was in the late 1990s a participant in Väestö, terveys, elinolot -tutkijakoulutusohjelman seminaari (Population, Health, Living Conditions Postgraduate Research Seminar) whose leaders were Ossi Rahkonen, Eero Lahelma and Tapani Valkonen. There I had my first opportunity to present my plan for my WDP research. In particular, I want to thank my personal tutor, Dr. Ossi Rahkonen, who consistently encouraged me to complete this Ph.D. and has given me invaluable support throughout this process. Professor J.P. Roos has had interesting discussions with me on this work, especially during the last phase of this process. I am grateful to him for his helpful comments and suggestions. Ritva Kekkinen and Terhi Kulonpallo, Administrators at the University of Helsinki, have been helpful in administrative matters for this Ph.D. I remember with warm feelings how when doing our business, we always had space and time to share our thoughts about our ‘old mothers’. A special thank you goes to my two external examiners, Prof. Eeva Jokinen and Docent Ilka Haarni for their profound reading of my text and critical but wise comments which have, I believe, made my work better.

Lastly, my research has been a companion for me during my holiday time over the years. The last time I took ‘it’ with was at the end of May 2008. After working hard, I wanted to distance myself from my depression work and visit the annual Guardian Hay Literature Festival in Hay-on-Wye, England. I went to listen to the ‘funny’ Irish writer, Marian Keyes. There I was listening to her talking about her depression which hit her every now and then quite badly. But, as she said in her lecture, she is used to depression and deals with it quite well with professional support. So, once again I understood that no woman’s life is without depression. Depression is inseparable from our lives.

Hay on Wye, 31 May 2008, on my Father’s birthday
ABSTRACT

Traditionally feminist scholars envisaged that feminist research should be ‘on, by and for women’. In terms of the Women and Depression Project upon which this PhD research is based, the focus is ‘on’ depressed women but includes implicitly the part men and the patriarchal welfare state play in their depression; ‘written’ ‘by’ depressed women who are the subjects and active participants and whose depressed voices need to be heard and ‘for’ depressed women who have the potential to use their work in this project to deal effectively with their personal feelings and social situations. The study was designed to engage depressed women in feminist therapeutic action research and to develop professionally guided self-help groups in a 10 session programme in both the statutory and non-statutory sectors in Finland. I had a dual role as a psychotherapist and feminist researcher and this dual role provided two foci to present (as a feminist researcher) the authentic voices of depressed women in these groups and to demonstrate (as a psychotherapist) how the group process had an effect on these women’s lives. Two questions guided the research process: Is it possible for depressed women who have been dealt with as objects of treatment to become active subjects in their own healing? and How do Finnish women experience depression? Embedded in the Women and Depression Project were multiple ways of gathering research from members of the group as well as therapeutic tools with elements of self-help, consciousness raising and group psychotherapy. Research methods were both quantitative and qualitative and included three questionnaires at different points in time; diaries and field notes. On the other hand, therapeutic tools included drawings of ‘My own tree’; a list of depression symptoms and video interviews.

While the project had a dual focus, both research and therapeutic, the findings reveal that women became empowered to understand themselves and believe in their potential as social individuals through their participation in the Women and Depression Project groups. In the long term, they altered their feelings and relationships to themselves and their environment as well as key embodied activities. They used diaries as a tool for self-reflection as well as a support in dealing with psychological and physical pain: this implied a movement away from, if not out of depression. Additionally, the findings also suggest that depression may be a consequence of invisible gendered tensions in a women friendly welfare state and reveal a type of ‘welfare depression’. According to Allardt's welfare typology, these women were somewhat secure in their "welfare having" (i.e. physical health), but lacked in their "being" (i.e. need for emotional well-being) and "loving" (i.e. wanting better personal relationships). If a new understanding of women and depression is to develop, it must explicitly include ideas on how depression is shaped at the public and private interface as well as how distress and well-being may have cultural as well as gendered variations. For depressed women, voicing long-silenced experiences can play a crucial part in their empowerment and healing. The type of women friendly care practices generated by professionally led self-help groups in this research enabled this process to begin at least for depressed women in Finland.
LIST OF ORIGINAL PUBLICATIONS

THIS STUDY COMPRISSES THE FOLLOWING PUBLICATIONS WHICH IN THE SUMMARY ARE REFERRED TO BY THEIR ARTICLE NUMBERS.

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ORIGINAL PUBLICATIONS

ARTICLE 1
The Women and Depression Project: Feminist action research and guided self-help groups emerging from the Finnish women’s movement

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Empowering depressed women: Changes in ‘individual’ and ‘social’ feelings in guided self-help groups in Finland

ARTICLE 3
Writing of sadness and pain: Diary work with depressed women in Finland

ARTICLE 4
Gaining agency through healthy embodiment in groups for depressed women
1. INTRODUCTION

This Ph.D. thesis is about how feminist therapy methods work in women’s depression and the therapeutic meaning of professionally guided self-help groups for women. I referred to this research as the Women and Depression Project (WDP). For the WDP, I created a group method and organised groups for depressed women in consultation with colleagues in Finland. These groups were held in the statutory and non-statutory (i.e. voluntary) sectors. The WDP was part of a national project on depression, ‘Mieli Maasta’, which began in 1994.

If I position myself and my study which is common in feminist research (See Letherby, 2005), I come from the mental health field where I have worked as a psychotherapist for all of my adult working life. I have been an active member of the Finnish feminist movement since 1982. I had connections with other Finnish feminists in Jyväskylä, Turku and of course, in Helsinki where I lived. I was an active member of the Helsingin tutkijanaiset ry, (Women Researchers of Helsinki). This was the first organisation of Women researchers in Helsinki founded in 1982 and it lasted until 1996. In 2006, an organisation of the same name was founded again), Dora group of Women researchers of Helsinki and Naisasialiitto Union (the Feminist Association Union). I also worked for 20 years at the Women’s Therapy Centre (WTC), Helsinki where my colleagues and I offered individual psychotherapy, groups and workshops for women. (We also shared for seven years the same premises with Women Researchers of Helsinki.) At WTC, I worked specifically with my colleagues as a consultant for women’s self-help groups, consciousness raising groups, feminist radical therapy (FRT) groups and women’s trade union groups. In this work, I learned to combine feminist group methods, consciousness raising techniques, psychoanalytic group therapy and Jungian therapy.

At that time, I had connections with academic Women’s Studies and the grass roots level of Finnish feminism with their alternative perspectives, such as Naisten itsehoito (Women’s self help). I was on the border of these ‘movements’ – straddling both areas. I was not an academic or a social theorist. I was not working in a university, but still I had strong links with academic feminist friends who were part of Finnish Women’s Studies. I was also a therapist for some Finnish academics including feminist researchers. While finishing my Ph.D., I have been reading recent Finnish academic publications on Women’s Studies and Feminist Studies (See for example Koivunen & Liljeström, 2004). I am slightly astonished that they argue (See Koivunen, 2004a: 93) that there have not been significant grassroots level movements of women’s activism in Finland as there have been in other Nordic and Western countries. In contrast to this assertion, Ingström (2007:38) has recently published a book about Swedish-speaking consciousness raising groups in Finland since the 1970s. She notes that an organisation such as Naisasialiitto Union existed where many grassroots level, Finnish speaking, feminist organisations were gathered together and there were active, independent women’s groups (i.e. feminist self-help groups, Extaasi, FRT, etc.) which could be identified as part of women’s activism in Finland. I remember being involved in three feminist political actions from 1980s-1990s such as ‘Naistentalo’ (i.e. an attempt to have a house for ‘women only’ in Helsinki), ‘Tupo-postikortti’ (Holli & Wartiovaara, 1991) (i.e. a protest against the sending of a sexist postcard to a feminist by politicians) and ‘Elizabeth Rehn for president’. These actions may come and go when they
are needed but the feminist influence remains. Therefore, I ponder and ask myself, ‘How large must a feminist movement be to be called or recognised as a feminist movement?’

As straddling both areas, academia and grassroots feminism, I feel as a ‘nomad’ (Braidotti, 1994) in bringing feminist methods to the mental health field in Finland. As a ‘nomad’, I have also brought my research outside of Finland by publishing my work in international journals and presenting papers at international venues. I am a feminist ‘nomad’ ‘wandering’ throughout Europe, America and elsewhere and my roots are in the grassroots feminist movement in Finland. I have done academic research but I am not an academic. I have worked consistently at a grass roots level in the Finnish feminist movement (and later in England) and feel that being this type of ‘nomad’ has allowed me to create feminist options for depressed Finnish women in the mental health field, but again, in an alternative way.

The following chapters are mainly descriptive with some analysis. They outline the areas which help to set the scene for the WDP research. Five separate but related chapters are included: Depression in different contexts with an overview on how I have framed both my research and therapeutic work; The purpose of the WDP research with its dual focus; Data and Methods; Research Results and Conclusions

2. DEPRESSION IN DIFFERENT CONTEXTS

In the following discussion, I will look briefly at depression in different contexts related to setting the scene for my research. These contexts include depression in Finnish culture; depression and ‘Mieli Maasta’ and depression and feminism. While the following will provide brief summaries in each designated area, the aim is to flag up a series of key issues which are linked to my research topic: how feminist therapy methods work in women’s depression.

Depression in Finnish Culture

If we look at Finnish cultural heritage represented in the epic poem, Kalevala, we see that this piece of Finnish folklore connects certain features such as ‘huoli’, (i.e. sorrow combined with joy) into the Finnish personality structure (Timonen, 2004). Linked with this notion of public sorrow is the fact that global statistics reveal that Finland has a relatively high suicide rate at 34.6 for men and 10.9 for women per 100,000 of the population (http://www.who.int/mental_health/prevention/suicide/suiciderates/en/).

Depression is a complex, multifaceted, multicultural phenomenon (Redmond, Rooney & Bishop, 2006; Falicov, 2003). To understand fully the material, embodied and subjective experiences labelled as depression demands drawing upon knowledge that is interdisciplinary (Stoppard, 1997) and sensitive to cultural diversity. Falikov (2003) contends that in contrast to an epidemiological or biomedical approach, a cultural, "ethnographic" one allows us to study a variety of experiences labelled as depression in each society with its own beliefs and meaning systems. Western constructions of depression (including Finland’s) vary and can be viewed as locally constructed and dependent upon circumstances and environment as well as other social factors. In the Finnish cultural context, we must take account of Finland’s geographical situation and appreciate how seasonal depression affects the overall occurrence of depression in Finland.
For example, in winter there is a period of kaamos or polar darkness which exists in few other countries. Kaamos is a time of mieli maassa (translated from Finnish as “one's mind on the ground”) when, what has been termed winter depression is quite common among Finns (Partonen & Magnusson, 2001). In my psychotherapeutic work, I find that it is more acceptable for Finnish women and men to seek help when the reason for their depression is viewed as a result of kaamos. For them, kaamos ‘pulls down’ not only your mind but also your body. (Article 1.)

Depression and ‘Mieli Maasta’

Psychiatry as a medical specialism has shaped the biomedical discourse on depression and it reflects a gender bias (Chesler, 1972). A national four year, depression project, ‘Mieli maasta’ emerged from Finnish psychiatry when there was a depression consensus meeting, ‘Depression: Recognition and treatment’ organised by the Academy of Finland and Finnish Doctors Association in 1994 (Suomen Akatemia & Suomalainen Lääkäriseura Duodecim, 1994). An organising principle of ‘Mieli maasta’ was to respect all local geographical districts with their specific knowledge and treatment cultures so that every district could fulfil its own treatment model (Stakes, 1998). In this consensus meeting, it was noted that women were more depressed than men and they used mental health services and medication more than men. But, there were no presentations on women’s depression. Rather, the participants raised the issue that men do not seek help for their depression and that service providers need to get more men into treatment and to consider the best treatment model for men. Here, as McMullen & Stoppard (2006) suggest, gender may be important enough to be mentioned in these sorts of contexts (such as conferences or consensus meetings) but not important enough for researchers and clinicians to want to understand it in depth. Having problems dealing with the long waiting lists of women in the mental health clinics where I worked, I thought (perhaps naïvely) that we should first offer gender sensitive treatment to women and then there would be clinical space to treat depressed men.

In this context, contemporary Finnish psychiatry evidences an interest in depression related to alexithymia (Honkalampi et. al., 2001); fish consumption (Timonen et. al., 2004; Tanskanen, et. el., 2001); dental problems (Anttila et. al., 2006) post natal depression (Tammentie, et. al. 2004; Gissler, Hemminki & Lönnqvist, 1996) and coronary heart disease (Ahto, et. el., 2007; 1997). In Finland, depression has been described as a state of mood, a special symptom in mental disorders, a syndrome measured by depression rating scales and a clinical category operationalised in diagnostic classifications (Lehtinen & Joukamaa, 1994). What we do know is that being down or feeling depressed is not necessarily equal to having a mental illness but can be a normal reaction to, for instance, disappointments, losses or experience of death: many psychiatric diagnoses conflate normality and pathology (Horowitz, 2007: 214). Interestingly enough, evolutionary psychology shares a similar position to a psychodynamic approach in psychiatry (Aalberg & Toskala, 1995) when it views depression as a positive adaptation in a difficult situation - it serves as a survival mechanism (Nesse, 2000). In this type of arena, depression is seen as a part of ‘normal’, everyday life, given that it is recognised that we can’t be happy all the time, even if happiness can be seen as the basic mode for a well-


functioning organism (Roos, 2007). More importantly, an underlying assumption here is that depression or sadness can tell us a lot about our happiness.

The psychiatric discourse on depression opens up a debate within Finnish social policy where depression is viewed as the greatest reason for sick leave, incapacity benefits and disability pensions. In response to this problem, the Finnish Social and Health Ministry in 2007 started the ‘MASTO’ project to prevent depression and incapacity leave based on depression (http://www.stm.fi/Resource.phx/hankk/masto/index.htx?locale=fi_FI).

Set firmly with this discourse, Stakes published reports in connection with Mieli Maasta: Valtakunnallinen depressioprojekti (The mind out of the ground. National Depression project). Dissertations, mainly in the nursing field have emerged from this project (See Suomala, 1998; Ristaniemi, 1998; Ahonen, 1998; Suonsivu, 2003). There has been other research on depression in Finland, such as The Helsinki Psychotherapy Study (HPS) which was launched by psychiatrists in 1994. It will be completed in 2009. In this work, different kinds of psychotherapy techniques are compared (Knekt & Lindfors, 2004), while other related research (Tontti, 2000) describes the type of depression experienced by those who participated in this Finnish national psychotherapy research. Related to the same study, Leena-Maria Ehlring (2006) focused on the data from semi-structured assessment interviews, while Jukka Valkonen (2007) focused on ‘inner’ depression narratives and Rauno Juntumaa (2008) looks at psychoanalysis as a part of the educational process.

The sociologist, Ilka Kangas (1999; 2001; 2002) concentrated on lay people’s views presented in illness accounts and their subsequent discursive constructions of depression narratives. Ari Haukkala (2002) carried out research on depressive symptoms and hostility in relation to socio-economic status, smoking cessation, and obesity. Around the same time, the main Finnish broadsheet, Helsingin Sanomat carried out research on its readers and published the results in its week end supplement, Nyt liite in 2002. Vilma Hänninen & Senni Timonen (2004) wrote an interesting article based on this data, by combining and comparing it with lyrics from Kalevala. The psychoanalyst, Pirkko Siltala (2006), has written about women’s depression in a psychotherapeutic context, while the sociologists, J. P. Roos & Eeva Peltonen (1994; Roos, 1994; 1995) have written about men’s depression and their at times, miserable lives. The psychiatric discourse of depression has been de-medicalised and along with psychotherapy, has become part of discussions in the media. In everyday Finnish discourse, literature and popular music, depression and melancholic themes are prevalent (Tontti, 2000).

My own psychotherapy training in Finland was within the psychoanalytic discourse which although related to psychiatry, originates from the work of Sigmund Freud (1917). Freud linked depression and melancholia and for women he saw depression as a form of female masochism. Depression involved guilt and self-criticism which was related to real or imagined loss during childhood. In psychoanalytical terms, unconscious anger, hostility and frustration, viewed as destructive feelings, were directed either outwards or turned inwards, leading to guilt which resulted in depression. The main contribution Freud made to psychoanalytic thinking was his discovery of the unconscious and how this unconscious can be used in psychotherapy and psychoanalysis. For Freud, denying the unconscious may lead to a depressive position. What is
interesting about Freud is that he admitted that he could not answer the question, ‘What do women want?’ However, he had power over them, a power which orthodox Freudians still use ‘over’ their patients today (Maguire, 1995; Orbach, 2007). As a sexist, anti-women, misogynist (Chodorow, 1989:166), Freud saw women’s depression as an almost inevitable result of their passivity.

Melanie Klein (1935) developed Freud’s idea on depression further and she posited the existence of two positions, the schizoid-paranoid and the depressive. The former position was viewed as more primitive than the latter position and this was because the schizoid-paranoid position was based on ‘splitting’ and ‘denial’. On the other hand, the depressive position was viewed as a more mature position for an individual because it implied that one accepted these ‘split off’ and ‘denied’ features and tried to integrate these features into one’s self. If Freud viewed women in a negative light, Klein, at least, allowed women to represent both good and bad (i.e. ‘good’ and ‘bad’ breast).

The hermeneutics of psychotherapy, in comparison to clinical psychology, has served an emancipatory purpose (Lesce, 1972), meaning it provides a sense of liberation for the client or patient. In clinical psychology, depression is viewed as being connected to a sense of learned helplessness (Seligman, 1975) or powerlessness (Gilbert, 1992) on the part of the ‘sufferer’. But, there is little effort to find out the roots of the helplessness or powerlessness. While these sorts of ideas may be helpful for a client in understanding one’s depressive position and managing negative thoughts and behaviour, they do not help to generate agency and empowerment of the client/patient. Rather, the focus tends to be more on clinical results, evidence and measurements and less on client’s/patient’s needs.

The current climate of research in psychotherapy reveals more evidence based material (Loewenthal & Winter, 2006) than in the past. In recent years, there has been research on the clinical effectiveness of psychotherapy as well as the implications of providing comprehensive, user-friendly, safe and cost-effective services (Aveline, 2006). There exists a body of work demonstrating that group therapy is an effective treatment form for depression and other mental health problems (Foulkes & Anthony, 1957; Yalom, 1985; Dies, 1993; Oei & Sullivan, 1999; Montgomery, 2002; Leichsenring, et. al., 2004; Svartberg, et. al., 2004). An extensive review of literature concludes there is substantial evidence on the efficacy of psychodynamic psychotherapy, including group therapy (See Leichsenring, et. al., 2006).

Recently, there have been evidence based studies on short-term therapy groups for depressive clients. Karin Egberg Thyme et. al. (2007) compared the outcome of short-term group psychodynamic art therapy to general group psychodynamic therapy for depressed women. They found at follow up that participants in both groups had few depressive and stress-related symptoms. Anne Jenning’s (2007) research shows that having ‘a planned ending’ noted at the group’s beginning presents a focus for change in itself and additionally, helps group members to cope with loss and separation which may have been one of the reasons why group members had sought help. While the group therapist’s role in this limited treatment group is more directive and active than in more open ended work, group leaders will need to keep a tight focus on planned endings in the group (Jennings, 2007).
**Depression and Feminism**

If we look at the literature on depression and gender, we see emerging a psychological model of depression which demonstrates that women are more depressed than men because women manage their depressive symptoms by reacting in a ruminative way and men’s depression is acted out externally (Miller, 1976; Nolen-Hoeksema 1990; 2000).

On the other hand, social models of depression imply that the social environment rather than personality traits or one’s biological sex accounts for the gender differences in depression (Brown & Harris, 1978; 1998). External factors such as low social status, learned helplessness or lack of control are associated with depression (Egberg Thyme, *et. al.*, 2007). In a recent article, Tirril Harris (2007) asks, ‘Is there something about depression that is feminine?’ She suggests that women’s higher rates of negative self-evaluation and in turn, depression are related to their experiences of ‘parental antipathy’ and ‘favouritism’ in childhood. In the end, she argues that what went wrong earlier between mothers and daughters (See for example, Friday, 1977) can be transcended in psychotherapy which can help women who are depressed. Other researchers have emphasized that there should be more biopsychosocial (Brown, 2002) and developmental studies in depression research which would help to clarify gender differences (See Castle, Kulkarni & Abel 2003).

Feminist consciousness in mental health became raised in the 1970s with the classic study on sex-role stereotypes judgments of mental health professionals (Broverman, *et. al.* 1970) and Phyllis Chesler’s (1972) book, *Women and Madness*. Feminists such as Juliet Mitchell (1974) began to be critical of psychology generally and the psychoanalytic way of thinking in particular. According to Pulkkinen (2000:54), Judith Butler criticises psychoanalytic theory for building up a heterosexuality hegemony which is not favourable to women. In this context, Lempiäinen & Liljeström (2000: 124-125) note that recognising this hegemony, Elizabeth Grosz, argued nevertheless, that the structure of psychoanalysis and psychoanalytic concepts (i.e. imagination, desire, pleasure and sexuality) can be helpful to women. In terms of early theorists, women’s position in society and the psychological ramifications of their position was looked at closely in Dorothy Dinnerstein’s (1976) *The Mermaid and the Minotar: Sexual Arrangement and Human Malaise*, Nancy Chodorow’s (1978) *The Reproduction of Mothering* and Carol Gilligan’s (1982) *In a different voice: psychological theory and women’s development*.

Briefly, Dinnerstein (1976) believed that in their early years, boys and girls see and feel their mother’s powerful, omnipotent position. In later years, while they are attending to their lives in the public sphere, they realize that their mother’s power is ignored. To resolve this conflict, men tend to deny female power. It is easy then for them to identify with other men who have patriarchal power in both the public and private spheres. Thus, men tend to deny and forget their early caring and loving years. On the contrary, women struggle with this and experience femininity as a contradiction. Women feel betrayed as they see their mother’s powerful position diminished. This may cause identity problems and low self-esteem for women. Here, I argue that Dinnerstein is emphasizing this schizophrenic experience of girls’ and boys’ identity development.

Nancy Chodorow (1978) believes that because women’s relationships are the centre of their lives, their experiences of lack of separation in these relationships has been interpreted as a
failure in their psychological development. On the other hand, for men, development of masculinity is based on separation and therefore, men are viewed as mature.

Gilligan (1982) believes that psychology has consistently misunderstood women, their motives, their moral commitments, the cause of their psychological growth and their priorities in life. Simply, she saw that women manage relationships through the lens of morals and ethics, while men tend create hierarchies using laws and rules. What is important here for women can be seen in feminist groups when supporting and helping the other person is more important than the power structure or leadership of the group.

In the United States, Jean Baker Miller published her classic book, Toward a New Psychology of Women in 1976 and she wrote about involuntary depression in women and paradoxical depression in men. Subsequently, she became the first director of the Stone Center at Wellesley College in Massachusetts in 1981. This later became the Jean Baker Miller Training Institute which dealt with a ‘new’ approach to women’s psychology, specifically a relational cultural model of women’s development (See Jordan, et. al. 1991; Jordan, 1997; Miller & Stiver, 1997; Walker & Rosen, 2004; Jordan, Walker, & Hartling, 2004; Robb, 2006). Briefly, a relational cultural model of women’s development implies that those without power (i.e. women) are more aware of the needs of those who are in power (i.e. men) and this tends to be one way those without power can survive. In 1980, Maggie Scarf (1980:357) recognized that depression was a huge problem and ‘predominately a women’s disease’. By that time, depression was considered mainly to be a problem for middle aged women (Bart, 1971). In more recent years, Puglesi (1992) suggests that feminist scholarship on mental health has followed either a social causation approach, investigating women's lives that enhance or undermine well-being or a social constructionist one, involving critical analysis of methodology and conceptions of mental health. For her, a model for blending both approaches is found in feminist therapy that reflects the concerns of these two approaches.

In the UK, the Women’s Therapy Centre (WTC) was opened in 1975 and since that time WTC has offered individual and group therapy for depressed women (Eichenbaum & Orbach, 1983; See also, Ernst & Goodison, 1981). The founders of WTC, Louise Eichenbaum and Susie Orbach, linked women’s oppression with object relation theory. In their view, the psychoanalytic way of thinking on human development allows a social psychological dimension to emerge and furthermore, is tailored specifically to understand women’s development (i.e. it focuses on the mother daughter relationship; envy and rivalry between women and women’s relationships) (Laitinen & Piippo, 1989). In a similar feminist vein of thought, Kathy Naire & Gerrilyn Smith (1984) published, Dealing with Depression which is based on an empirical study of depressed women in England. This was one of the first times women’s depressed voices could be heard authentically via interviews. The authors contend that women’s depression is a feminist issue that needs to be viewed as a political and public problem rather than as a personal and private secret.

The Australian feminist, Janet Stoppard (2000a) emphasizes the importance of ‘women’s subjective accounts of their depressive experiences and a contextualization of these accounts within the broader social and cultural frameworks of women’s lives’. In a key text, Stoppard (2000b) focuses on the significance of the material, discursive, and intra-psychic factors of
women’s depression. She also argues that in understanding women’s distress, we must neither deny the body nor elevate depression to a single cause.

In a Scandinavian context, the book, *Kvinder og Depression* (Women and Depression) was published in 1981 which was based on a ‘themed day’ held in October 1980 in Copenhagen, Denmark. As a result, the issue of women and depression became more visible in a public arena in Scandinavia. However, in Finland, Finnish psychologists or psychotherapists were not attracted generally to feminist ways of thinking or women’s psychology. Nevertheless, there was the possibility of studying women’s psychology at the University of Turku in the 1980 and 1990s. A key academic player here was the psychologist, Pirkko Niemelä (1991) who published a now classic chapter ‘Kvinnors depression: En följd av föremekad vrede och ett falskt jag’ (Women’s depression: the consequence of suppressed anger and the false self) in *Kvinnors hälsa och ohälsa* (Women’s health and illness). Niemelä (1991) contends that women are in a subordinate position because of the gender system. This causes anger for women. This anger is dealt with by them becoming passive and apathetic. When women have courage to be themselves they can start to change their environment. They can be in harmony with their real selves and then, there is no need for them to neither hide behind their false, passive selves nor experience themselves as worthless and depressive.

In Finnish feminist contexts, there is a paucity of work on women and depression. The work that does exist tends to combine depression or sad feelings with bodily, somatic sensations or illnesses. For example, Kaskisaari (2004) has written about burn-out experiences and depression. In Ettorre & Riska’s (1995) sociological study, they found that in Finland the reasons for female depression remained invisible and linked with private issues, while for men these reasons were socially acceptable and linked with external issues, such as work. Other Finnish feminist writing which deals with women’s distress include: Eeva Jokinen (1997) on tiredness; Annika Lillrank (2003) on back pain and Marja-Liisa Honkasalo on pain (2000), suffering (2001) and depression (2002).

Since 1982, ‘grassroots’ feminists in Finland have paid more attention to women’s depression than academic feminists (See Laitinen, 1998b). In this context, there has been interesting research in Finland on academic women (Husu, 2001) and their identity where they are typed as being involved in ‘feminine femininity’ in their private lives and ‘feminist femininity’ in their professional lives (Wager, 1994). If keeping one’s ‘private’ depression away from the public eye is standard and part of ‘feminine femininity’ in Finland, it is understandable that depression remains hidden in the feminist, academic or public world which is part of ‘feminist femininity’.

In general, there has not been a lot of research on depression and women’s consciousness raising, although I was able to find research on the feasibility of feminist groups as having a therapeutic role for women. Rose Weitz (1982) carried out research on consciousness raising groups in 1980’s and concluded that these groups were beneficial to women in a psychosocial context because they helped to increase women’s sense of control and self-esteem as well as helped to reduce depression.

In a more contemporary setting and in the ‘current zeitgeist of feminist therapy’, Laura Brown (2006) challenged feminist therapy and evidence based groups to deal with the politics of
the personal and women’s experiences of power and powerlessness. In this context, the message is that groups for women have the potential to empower them and provide a setting for them to develop a sense of agency. A recent report from the Women’s Therapy Centre (2005) in London noted that groups for women provided a space where acceptance by others could help women to accept themselves. Colleen Heenan’s (1995) work with women also has a distinct feminist focus and shows the importance of reflection on the part of the therapist. This means that power is able to be shared on a collective level in groups. In related work, Saunders & Kashubeck-West (2006) found that a developed feminist identity was related positively to psychological well-being. Here, the implication is that groups for women have the potential not only to empower women but also to allow feminist identity to become visible in a collective context.

Given the above, when feminists ask the question, ‘Why are therapy groups for women needed?’ their answers can range from political to psychological or personal reasons. For example, they include that women are isolated and should be ‘social’ and connected to other people (Miller, 1976). Being in a group is crucial for women to gain self-esteem. Women begin to understand in groups the social context and construction of their individual problems (Heenan & Seu, 1998). Women, on a cultural and unconscious level, represent motherhood, sexuality, fertility, innocence and sin (Daly, 1978; Griffin, 1978; Korte, 1988; Koivunen, 1995; Utrio, 1984; 1985). Therefore, these representations will enter a group consciously or unconsciously if men are present and in a women’s group they can be free from being sexual or feminised objects. Last but not least, women are raised to take care of the needs of other people, especially men (Eichenbaum & Orbach, 1982). In women-only therapy groups, they allow themselves to take care of their own needs and desires.

Here, it is not possible for me to go through all of the therapeutic thinking and ideas which I used when developing professionally guided self-help groups. All of the above mentioned thinkers have influenced my work and the feminist as well as therapeutic literature on both depression and groups has been important in providing the framework for this research. I would contend that consciousness raising groups, self-help groups and psychoanalytic ways of thinking all share a common element, that is to understand oneself is a part of the process as well as the goal of the process. Achieving this sort of understanding is done by a reflective subject in a social context. This is ‘feminist therapy as empowerment’ (Sesan & Katzman, 1998). It involves gaining agency and empowerment in, by and for yourself. I refer to a type of psychological agency which means understanding your own problems, owning them, having self-authority and recognising that healing is in your own hands. Gaining agency (toimijuus) in this way is what empowerment (voimaantuminen) is about: empowerment is both the process and the goal.

3. PURPOSE OF THE WOMEN AND DEPRESSION PROJECT RESEARCH

When I carried out my research there was a great demand for depression treatment as there was for psychotherapy in both the public and private sector in Finland. The WDP women’s groups were offered to fill this former demand. The 10 session ‘group treatment’ was offered also for women who were on a waiting list for psychotherapy, those who were not sure whether or not they needed long or short term therapy and those who had been in treatment for a long time and
The WDP methods were not called feminist *per se* and potential members were informed that research would be carried out on the groups. Members did not know which part of the group process belonged to the research and which part to the therapy. The information sheet emphasized the introduction of self-help techniques and skills to be learned such as communication skills and understanding one’s own behaviour or dependency on other people. I also had an information sheet for group facilitators about the purpose and the function of the pre-group interview. (See Appendix 2.)

The purpose of my research can be viewed through the lens of a wider, political and personal context and includes a dual focus. As the youngest child of a big family, I can remember already asking myself when I was young, ‘Why aren’t all of the adults around me happy?’ As a young student, the same question followed me. As my life moved on, I asked a similar question of my feminist friends, heterosexual, bisexual or lesbian. I thought not only that my ultimate purpose in life was to be happy, but also that everybody was aiming to have a reasonably good life by minimizing the suffering and pain in their lives (Rowe, 1983; 1991; Roos, 1987a). Later in my life, after I became a trained psychotherapist, I still asked similar questions, ‘Why aren’t Finnish women happy?’ and ‘Why do they have these kind of painful, unhappy feelings, such as not feeling good enough, feeling guilty or feeling low and lonely?’ I asked these questions knowing that Finnish women are the envy of other women in the world with all the political gains we have made and the level of equality that we have in relation to Finnish men (See Hausmann, Tyson & Zahidi, 2007).

These same questions about happiness motivated me to do the WDP research. In the first group interview, the women who wanted to join what I called at that time, ‘the depression groups’ were asked why they wanted to join these groups. All these women wanted to get to know other women who shared the same kinds of problems and unhappiness. Many also asked, 'How do I gain self confidence and happiness?' and 'How can I express my feelings?' Coping with fear and hate; knowing their own needs and taking care of their own bodies were also issues related to why they wanted to join ‘the depression groups’. My response in trying to support them out of their dilemma was to offer membership in professionally guided self-help groups and I hoped that many if not all of these women would find suitable answers to their initial questions in these groups. WDP represented a concerted effort to bring feminist methods into Finland’s mental health services and specifically to establish professionally guided self-help groups for depressed women seeking those services (Laitinen, 1999). With the above in mind, I designed WDP with a dual focus: 1) to engage depressed women in feminist ‘therapeutic’ action research and 2) to develop professionally guided self-help groups for them in the Finnish mental health system.

**Feminist ‘therapeutic’ action research**

What has been termed, ‘participatory action research’ (PAR) or ‘participatory research’ has roots in liberation theology, community development and human rights activism (Kemmis & McTaggart, 2000). I transferred this type of research into the WDP therapeutic setting. According
to Kemmis & McTaggart (2000: 568) the attributes of participatory research are: shared ownership of research projects between the researcher and the researched, community based analysis of social problems and an orientation toward community action.

In participatory action research, researchers give results back to service providers, while employing a multi-method approach to collect data (Regehr, 2000). This type of research sees social action as political and a necessary aspect of human social life and the subjective and objective in terms of mutuality not polarity (Kemmis & McTaggart, 2000: 578). Action researchers continually process changes, and document these in order to identify issues that might have an impact on service delivery. Similarly, feminist ‘therapeutic’ action research combines a range of methods and documents ongoing activities and changes, feeding this information into service working and research. In this way, feedback becomes a way of empowering the women or others who are researched by giving them knowledge and allowing them to shape results of research as well as change the standpoint of actions being observed. Indeed, involvement, activism and social critique for the purpose of liberatory change are the standards of feminist action research (Gatenby & Humphries, 2000). For women respondents, these are particularly helpful strategies in that it is important to identify those factors that cause changes in their lives and influence service delivery (McKie, 1996:10).

Criteria such as problem solving, collaboration, participation and self-evaluation (Kemmis & McTaggart 2000, Sarantakos 1998) became embedded in WDP as feminist ‘therapeutic’ action research. Before data collection methods were decided upon, I received continual feedback from a pilot group about what issues they wanted to deal with in the final groups. While the women responded with a list of topics, their topics were incorporated into the group work programme (See Appendix 3.). The pilot group also provided important comments on questionnaires used for subsequent groups. Key questions were developed for the main WDP questionnaire as it was being constructed and refined. For instance, for the question related to what they do when they are depressed, they wanted to include questions on their religious practices such as reading the Bible or praying.

At various stages of the research, women were fed back some of the findings as well as the progress of the study. As a result, they were able to discuss these within the group and become involved in the continual evaluation of the research. In this context, it is important to explore my role as simultaneously a feminist researcher and a social worker/ psychotherapist and the dynamics of the therapeutic space where the research was carried out. (Article 1.) My writing in these roles began in the mid 1980s and was reflective in an attempt to develop myself and my relationship with clients (Graybeal & Ruff, 1995; Neuman & Friedman, 1997). I started to produce reports about the nature of work with my clients and I see this as my first experience of doing, what Engeström (2005) describes, as ‘developmental work research’ (i.e. kehittävä työntutkimus). This tradition has been strong in Finland especially among social workers (Karvinen, 1993). Through this kind of activity, I ‘developed’ myself as a social worker (Laitinen, 1985a; 1985b; 1986; 1989a; 1989b; 1992; Laitinen & Mai, 1987; Laitinen & Viskari1997; Viskari et. al, 1995. ), a psychotherapist (Laitinen, 1990, 1997, 1998, 2006a, 2006b, 2007) Laitinen & Piippo, 1991), feminist consultant in a trade union context (Laitinen et al, 1990) and subsequently feminist researcher in WDP ( Articles 1-4). I wanted to recover an
archive of work and a sense of memory and reflection from different workplaces which I brought with me when carrying out the WDP research including the skills of writing reports, field notes and articles, collecting data, analysing therapeutic situations, keeping diaries, developmental planning, etc. This has all been helpful in doing this research.

In feminist research, there is an awareness of the importance of being able to identify in a transparent way with one’s research material as a researcher and also being clear about the relationship one has with the ‘subjects’ one is studying (Oakley, 1981). In the beginning of my research journey, I wondered how well I would be able to relate to my material and to understand women group members, given that I had never suffered from depression myself. However, this changed during my research journey and I don’t any more have to be afraid that I don’t have a personal relationship with my research area. In the year 2000, I myself went through a very serious, reactive depression episode after major losses in my life. I had just moved from Finland to England in June 1999. In October of the same year, my older sister (and dear feminist friend) and father died within the same week. My mother stayed with me for Christmas 1999 and she felt totally lost. The following year I had a major operation and at the same time, I was being seriously bullied in my workplace. I felt totally alone in a strange country with the feelings of losing my dearest relatives, my favourite country (Finland), my body, my research, etc. I felt too depressed to continue to live. But, I survived. It was a very scary experience and even now when I am writing about it, this old experience which I will never forget, I feel afraid. This severe experience deepened my understanding of my research field and the women I worked with in the WDP groups.

In a research context, Schön (1995) divides reflection into two types: reflection in action during the research process and reflection on action which happens afterwards. Feminist research such as WDP produces knowledge in a dialogue with the respondents (i.e. group members), in a reflective relationship (Ronkainen, 2004, 63). Here, Stanley (1990) contends that one main principle of feminist research is that the participants do not become objects but more like subjects with whom the researcher is able to have a relationship. For me this meant that part of my reflexive role was to be non-authoritarian as a feminist researcher but also to maintain professional boundaries as a psychotherapist. Oinas (2004: 215) argues that feminist research creates equal relationships such as subject to subject relationships. As a feminist researcher/psychotherapist this was not totally possible. However, we (me, other group therapists and members of the WDP groups) approached this question of ‘subject to subject relationships’ by participating in ‘feeling circles’ at the beginning and end of the group sessions where both participants and therapists shared their present personal thoughts and feelings. Thus, a strong element included reflexivity throughout the whole research process both for the researcher/therapists and the participants.

In the WDP research, exploring the therapeutic space as somewhat separate from but linked to the research process is crucial. This involved my dual role as a psychotherapist and feminist researcher and the data and issue of psychotherapeutic knowledge all were integrated into the therapeutic space. This dual role has given me the opportunity to develop a viable way in which a researcher chooses parts of the group’s therapeutic material to serve as research data. I had two foci in my mind: to present (as a feminist researcher) the authentic voices of depressed
women in these groups and to demonstrate (as a psychotherapist) how the group process had an effect on these women’s lives. These two foci enabled me to engage with these women as subjects of the therapeutic process. Given that thirty therapeutic, self-help exercises were included in the group (See Appendix 4), women had the freedom to choose what ‘worked’ best for them, a necessary component of empowering therapy (Sesan & Katzman, 1998; Marecek & Kravetz, 1998).

The research data and group material was collected in a therapeutic space which consisted of different kinds of embodied, technological and therapeutic processes whether visible or non-visible, audible or non-audible, verbal or non-verbal. I developed therapeutic tools which included visual images (i.e. members’ drawings of ‘My own tree’); written texts (i.e. members’ list of their depression symptoms – Appendix 5) and videos (i.e. members’ individual video interviews – Appendix 6) – all focusing on either the unconscious or conscious and individual or collective level.

It was extremely challenging for me to deal with this rich data and material because the therapeutic space is filled with ‘tacit knowledge’ (Koivunen, 1997). Psychotherapeutic space is filled with and explores not only observable and conscious material but also tacit, silent, unconscious material. Daniel Stern (2004: 192) the internationally known psychoanalyst, contends that this therapeutic space is jam packed with language as the vehicle for putting experience into told narratives, involving not only words but also tacit knowledge. This can be called ‘beyond talk therapies’ in which implicit experiences will be pulled into the ‘explicit open’ (Wiener, 1999). The key to psychoanalytic processes as a foundation of psychotherapy is to make the unconscious conscious. Psychoanalytic psychotherapy is based on the client’s ‘free associations’ which reveal to her, her subconscious or unconscious, internal world and brings this to the psycho-semiotic level (Keinänen, 2006a; 2006b). Psychotherapeutic knowledge and processes are based on thinking and talking (e.g. ‘the talking cure’) between therapist and client/patient. But as, implied above, ‘this talking’ can be a silent talking, body talking, gesture talking, art talking (as in making a piece of art) or unconscious talking (as in transference and counter transference). The basic task of talking therapy is to strengthen the unconscious ‘body-mind continuum’ so that the patient can bring this internal material to verbal symbolism (Keinänen, 2006b). In talking, words are not only important but also the voice is important. This voice carries its different ways of expressing herself. In this context, the Finnish researchers, Timonen (2004) and Honkasalo (2004), have paid attention to voice and the importance of this ‘voice’ including its hidden messages in research.

The therapist’s own counter transference is a good example of how the unconscious, unknown, voiceless, ‘not yet existing knowledge’ is able to become conscious for the client. For instance, this happens when the therapist links a client’s depression with anger or an oppressive situation, even though the client may not feel anger or oppressed at that moment. In the WDP, this kind of psychotherapeutic knowledge as ‘tacit knowledge’ was considered as part of the group therapeutic process and not as research material because it was a therapeutic intervention and worked as a ‘container function’ (e.g. it helped clients to contain difficult, therapeutic material and was not related consciously to the research data.)
In WDP groups, many different kinds of knowledge were being exchanged between the group members as they became ‘subject to subject’ to each other. This was mainly through group discussions and pair work. They had their own type of sharing with each other which is the main purpose of group therapy. (Article 2.) This was their conscious choice which enabled the group members to be in touch with each other and also to be in touch with their own internal worlds. Members were involved in expressive techniques (Weiner, 1999), such as art work, role play, bodily touch via shiatsu massage, free association, diaries, a variety of creative writing methods and creative artefacts and objects such as dolls, representing Jungian archetypes. (Article 4.)

Establishing professionally guided self-help groups for depressed women
In establishing professionally guided self-help groups, my active interest grew from my daily work in a psychiatric setting in Helsinki. I was curious why in many psychiatric contexts in which I worked there was the claim from professionals that depressive people had no words, voice, or way to describe their depressive moods. I was interested to know how accurate this claim was. I wanted to hear how depressed women would describe their low moods with their own voices. My concern was that perhaps we, mental health professionals, do not hear their voices but that these voices do exist. Were we making them into objects of treatment and not subjects with their own voice? I wanted to give them a chance to express their depression and learn to express their own ‘depression’ language. In my group work, I included different kinds of ‘clinical’ language including ordinary speaking, writing, drawing, playing with shared images, free association, reading alone, reading aloud in a group, feeling circles etc. But, I saw this type of language as ‘feminine’. In this context, Luce Irigaray's (1977) contends that language is patriarchal and therefore, not women’s ‘mother tongue’. Thus, there is a lack of a language to develop ‘the feminine’. This lack created the need for a ‘new’ language. In the case of depressed women, their shared, common language in the group was expressed in the semiotic order (e.g. preverbal) instead of the standard symbolic one (e.g. verbal) (Kristeva, 1980). Professionally guided self-help groups allowed members to hear these preverbal and verbal ‘voices’ of other women who had been diagnosed as ‘depressed’ or who considered themselves to have ‘depression’.

As stated earlier, the WDP began in 1994 as part of a national research program, ‘Mieli maasta’, on depression organized by the National Research and Development Centre for Welfare and Health (STAKES) and WDP consists of both research (my Ph.D.) and a guided self-help group programme (Laitinen, 1999, 2000). WDP was set up by me in consultation with a psychiatrist, group analyst, psychiatric nurse, feminist sociologist and two psychologists. It began in a large mental health clinic in Helsinki. These groups combined feminist self-help group methods (Eichenbaum & Orbach, 1983, Orbach, 1982, Ernst & Goodison, 1981, Gomez, 1988), consciousness raising techniques (Brodsky, 1977), psychoanalytic group therapy (Bion, 1961, Foulkes, 1948, 1964), cognitive behaviour therapy (Carter & Minirth, 1995; Copeland, 1992; 1994), Jungian methods (Bolen, 1984), therapeutic writing (Rainer, 1978), and problem solving therapy. In my first group method book (Laitinen, 1999), I presented the weekly program of the group and what it involved. There is an interview guide for group leaders (See Appendix 7); information which should be given to the potential group members about the group; the group
process and norms of this kind of group; basic qualifications of WDP group therapists; how they can evaluate group members’ progress and how therapists can be reflexive in a group process.

The idea that a research framework modelled on feminist therapy adds to our knowledge about women and mental health was an underlying principle of the development of WDP. Guided self-help groups were gradually incorporated as a therapeutic intervention into the daily regime of the mental health clinic. Two experienced, group leaders facilitated the groups. Having two group leaders presents an expansive type of psychotherapeutic group model (Sitolahti, 1996). This allows for various projections and diverse, intersecting forms of power relations which engender authority in the group (Burman, 2001; 2004). Furthermore, co-leaders’ work ensures, what Neri (2006) calls ‘syncrctic sociality’. It means that the group work is kept alive and well, given that co-leaders may exchange roles as ‘operative leader’ (e.g. who takes care of timetable and group structure) and ‘genius locus’ (e.g. who concentrates on tacit knowledge) (See Neri, 2006) at various stages of the group’s development. These guided self-help groups helped to maintain the groups’ identity by allowing members to experience agency in depression. They also confirmed the evolved sociality of the group as well as its sensory, effective and embodied elements for members (Neri, 2006).

For each group, sessions, lasting one hour and forty-five minutes, were held once a week over a ten-week period. While the focus of each session was on a particular topic (See Appendix 3), self-help techniques such as CR, assertiveness and straight talking were learned through a series of 30 therapeutic exercises (See Appendix 4.). The therapeutic purpose of learning these techniques was that these would extend beyond the group. For this research, eleven groups were organized from 1994 until 2000. The groups varied in size from 5 to 13; the average size was 9.

Overall, two key questions guided the research process: Is it possible for depressed women who have been dealt with as objects of treatment to become active subjects in their healing? And How do Finnish woman experience depression? Other related questions included: What is Finnish women’s depression and where does it come from? What does women’s depression consist of – how do Finnish women describe it?; What do women ‘do’ with their depression? And what effects do professionally led self-help groups have upon their depressed lives?

4. DATA AND METHODS

Participants
WDP participants (N = 101) were adult women who had defined themselves as being depressed and/or had been treated for clinical depression. A clear majority (n=66) had at some point in their lives received a psychiatric diagnosis. While participants were recruited mainly through leaflets advertising the groups distributed in local family counselling offices, health centres, social work offices, alcohol and drug clinics, mental health centres and unemployment offices, the majority (73%) were recruited through mental health services.

Those women who expressed an interest in the groups contacted the group therapist and were offered a short interview which lasted thirty minutes. The interview gave the potential group member the opportunity to meet the group therapists. It gave us as group therapists the
opportunity to provide the potential group member with information about the group method and the topics of the group. Also, it gave us the opportunity to evaluate whether or not membership in the group would be beneficial for a potential member at this point in her life. Basic information was gathered such as name, address, previous experience of any groups and the reasons why she was interested in the WDP group. A potential member was able to decide whether or not she felt able to use this group method for her own personal development. It was during the first interview that a joint decision between the potential member and the group therapists was made as to whether or not a potential member would join the WDP group. It should be noted here that no one who wanted to join the group was turned away.

In this context, these groups, as stated above, were openly advertised to clients in a variety of service organisations. In a few organisations, professionals encouraged some of their clients to be interviewed for the groups. Some clients contacted the group therapists directly after seeing information about the groups. Regardless of how clients came forward, they had one thing in common – all were looking for help and were motivated to change their depressed lives in some way. It is widely known in clinical circles that if there is motivation for change in potential members before group therapy, a better outcome is ensured (Whitaker, 1985; Yalom, 1985).

In order for the therapy process to begin immediately and to test the member’s motivation and capability to work on her problems, the group member was asked in her interview to mention three changes she would like to make during this group. A year after the group ended, she was reminded of these three changes during the follow up session.

After the interview, the group member received an invitation to the group which included the date of the first group session, a member’s agreement to become a group member, her consent form agreeing to participate in this research (See Appendix 8) and the first WDP questionnaire (See discussion below) which participants were asked to bring to the first group session.

The research on which this Ph.D. thesis is based received ethical approval from the Helsinki City Health Office LREC in December 1995 (Appendix 9) and Finnish Student Health Service (YTHS) in 1998 (Appendix 10).

Data Collection

The research paradigm of the WDP was constructed to hear the voices of the depressed women in the groups rather than measure how depressed they were at a particular point of their lives. Dorothy Smith (1987:107&110) contends that allowing the voices of women to be heard is all about taking the standpoint of women. This ‘method’ creates space for an absent subject and an absent experience that will be filled by actual women speaking. In this way, I wanted to cover many, if not all the possible ways that one is able explore, describe, analyse and understand women’s depression as ‘absent experiences’.

I made a clear decision to use a combination of research methods, ‘triangulation’, to achieve this. Through triangulation the researcher observes her participants at the point of observation, while interviews and questionnaires record what participants say and write at the point of response (David & Sutton, 2004). This type of ‘data focused analysis’ works best when researchers collect authentic data from their participants. Data collection is finished when the saturation point has been reached and when specifically; no new data bring new knowledge to the
phenomena being studied (Denzin, 2000:520; Eskola & Suoranta, 1998: 63). In the WDP study, the saturation point occurred after the diaries were completed in the groups.

Before the start of the group sessions and the finalising of data collection techniques within the pilot group in 1994, I developed multiple ways of gathering data from group members. However, these ways of gathering data also functioned as therapeutic tools. Significantly, I knew that in terms of psychotherapeutic research, innovative work emphasises clinical significance and favourable outcome over statistical significance in research design (Høglend, 1999). I was aware that not every woman would want to fill in questionnaires or write in diaries. Additionally I wanted to offer participants the space to be creative with their questionnaire answers by giving them open questions and to use their diaries as they so wished (Eskola & Suoranta, 1998: 123). As noted above, collecting research data served a therapeutic as well as research role. For example, when a group member answered a question on the questionnaire about her depression, it provided her with a deeper understanding of it. Answering these sorts of questions gave participants an opportunity not only to learn about themselves and to own psychologically their depression and problems but also to be reflective about themselves (Eskola & Suoranta, 1998: 129).

Gathering quantitative and qualitative research data
The methods employed were both quantitative and qualitative and included a pre-group questionnaire (Q1) (See Appendix 11), a post group questionnaire (Q2) (See Appendix 12), a follow up questionnaire (Q3) (See Appendix 13) and members’ diaries. These were the key methods for generating data for the research. Articles 1-4 are based on this data. There were also my notes of observations during and after the groups and feedback discussions/peer supervision with co-therapists. This latter ‘visible’ material (e.g. my notes and records of feedback discussions) along with my invisible, immaterial ‘memory work’ affects my writing (Vilkko, 1997: 190). I will discuss this visible material below.

WDP Questionnaires
All of the questionnaire data both quantitative and qualitative were collected through participants’ direct, active contact with the researcher (Alkula et al.,1994) and ‘measurement tools’ (i.e. WDP questionnaires) were designed and developed in conjunction with members of the pilot group. It was clear that members’ participating in this pilot group wanted to include not only standard tick box questions but also open ended questions, enabling them to elaborate fully on their responses. Also, by devising questionnaires distributed to participants for self-completion outside of group sessions, I wanted to eliminate group pressures or influence. The workings of this early pilot group helped to determine that established instruments were inappropriate due to their insensitivity to both feminist and Finnish contexts (Article 1).

I spent a lot of time within the pilot group and with my research colleagues designing data collection ‘tools’ and the study timetable. Because the subject of depression is within the biomedical arena (as discussed above), measurements of clinical depression such as Beck’s Depression Inventory (Beck et. al., 1961) were seriously considered. After discussions with research colleagues and pilot participants, I decided that data from these types of tools would not shed new light on this research. This research was not meant to focus on how severely or mildly
depressed the participants were. As mentioned earlier, the main aim of a psychodynamic approach upon which this group work was based is for group members to understand their depression ‘in themselves’. This understanding helped them to cope with their depression and in turn, to live with it. Thus, I was more interested in how they managed or lived with their depressed moods and what this meant to them. In this way, it was appropriate to develop questionnaires based on other depression literature such as self-help (Copeland, 1992; 1994) and autobiographical ones (Styron, 1995; Wurtzel, 1994).

The first questionnaire was included with a letter inviting a member to the first group meeting. The second questionnaire was given to members during the final group meeting and this included information on the video interviews (See below.). Members were asked to bring this second questionnaire back to the video interview. The third questionnaire was sent to members with the invitation to attend a follow-up session, a year after the group had finished.

As noted above, I developed a measurement tool in conjunction with members of the pilot group (Article 1). It reflected individual/ psychological and social/structural elements of their depression. I collected survey data at three points in time: just prior to beginning of the group or pre-group (n=101) in questionnaire 1 (Q1); ten weeks later as the group sessions finished or post-group (n = 72) in questionnaire 2 (Q2); and twelve months after the group sessions finished or follow-up (n = 47) in questionnaire 3 (Q3). Given the time period of the study, I expected a decrease in response rate at each data collection point because this can be expected when conducting psychotherapy research (DuBrin & Zastowny, 1988). Furthermore, that group members did not attend a follow up group could be interpreted positively. Perhaps, some group members were in fact getting on with their lives and had no further need of contact with the group.

Also, while we can see the attrition rate especially for the follow-up questionnaire (Q3), profiling of respondents and non-respondents did not reveal any significant differences in social characteristics with the exception of partnership status where a higher proportion of those who had a partner responded to both Q1 and Q3. (Article 2). This could be interpreted as these group members having learned the benefits of commitment, although this cannot be proven. On the other hand, perhaps they needed the group because partners were not fulfilling their social needs and they wanted to be heard in a women’s arena.

Some qualitative data were the result of my decision to have more than a mere totting up of numbers from the group (as discussed above and below), such as open ended questions, etc. Other qualitative data were the result of respondent’s group activity such as diary writing. A qualitative research plan, such as this, ‘lives its life with the research project’ and my type of open research plan emphasized that data collection, data analysis, interpretations and reporting were all entwined (Eskola & Suoranta, 1998).

WDP Diaries
For the past 30 years, social scientists have used diaries as a data collection method. Diaries can be either ‘spontaneous’ or ‘task orientated’. In this research, participants were able to use diaries either way. During the first group session, each member received a personal diary. In total, 61 out of 101 group members kept diaries. Every week, members were given a diary task to perform outside of the group (See Appendix 14). Time (i.e. fifteen minutes) was allocated in each group
session to discuss diary tasks and how difficult or easy it was to keep the diary (Article 3.) In the final group session, members returned their personal diaries to the group leader. Some wanted to keep their diaries after the group finished. Those diaries were photocopied and then diaries were returned to group members at the follow up session. Of course, participants gave written, informed consent for me to use extracts from their diaries.

Anna Makkonen (1993) tells us that diaries have their roots in Japanese pillow diaries, European formal documents and sailors’ or soldiers’ notes. In the late 19th and in the beginning of 20th centuries, diaries focused on private feelings and intimate matters. One well-know writer who emerged from the diary genre is Anaïs Nin who published her diaries from 1931 until 1955. According to Gunther Stuhlmann who wrote the preface for Nin’s diaries, the diary was her logbook of her journey through the labyrinth of herself (Nin, 1977). Diaries are also important because they bring the forgotten personal histories into the present (See Haavio & Koskimies, 1992). Eeva Jokinen (2004) believes that the diary creates a space where the writer is able to reveal herself and that without the diary, this process would be inappropriate or even scary. She suggests that women need to use their diaries as a support, a safety net, their ‘own room’ and a holding environment. Jokinen refers to the work of Susan David Bernstein who emphasises the confessional functions of the diaries. In this sense, the diary is like a double-edged sword. While the writer confesses and reveals her bad sides, impulsive actions and unacceptable thoughts, she also produces her subject - herself. Thus, this writing subject is getting knowledge of herself, exploring herself and experimenting with new pathways in her life (Jokinen, 2004) as well as being involved in a process of ‘reflective withdrawal’ (e.g. looking at a distance by writing in diaries helps you to be reflective) (Lukinsky, 1995).

The tradition of women’s diary writing reached public visibility in Finland during the years 1990-1991. The results of 600 Finnish autobiographies were published in 1992 as Satasärmäinen nainen (One hundred edged women). Among the different writing styles, three different groups of writers were found: ‘analysers’, ‘describers’ and those ‘true to their habits’ (Ahola, 1993). Overall, female writing style is more fragmented than men’s because women do not concentrate on themselves as men do (Kosonen, 1993). According to Makkonen (1993), the writing process involved in diaries can act like a ‘homemade’ or ‘do it yourself’ (DIY) psychoanalysis. Diaries are a form of healing writing (Bolton, 1999; 2001; 2004; Laitinen, 2006a). Furthermore, while autobiographies and/or diaries are ‘written, premeditated speech’ (Roos, 1987b), having to write in one’s diary is an authentic way of dealing with the self and may be seen for the self as ‘more than the truth’ (Vilkko, 1997).

In the WDP, these ideas were important given that group members knew that they would eventually give their diaries back to the group leader at the end of the group sessions. Inviting participants to write in their diaries is a good way to get authentic knowledge of their everyday life, feelings and thoughts (Roos, 1987b). In analyzing the WDP diary data, there were two main ways in which group members used their diaries: 1) as a tool for self-reflection and 2) a support in dealing with psychological and physical pain. (Article 3)
I want to discuss briefly here the visible materials (e.g. my field notes and records of feedback discussions) which were not included in the articles but which, as I said earlier, affects my writing.

I wrote my observations and field notes during and after the group sessions. I collected these in a systematic way on forms which I had created specifically for the groups and which were based on earlier group work (Whitaker, 1985). (See Appendix 15). For instance, I was interested in analysing communication between group members and the language they used. I wanted to look at the level of psychological safety in the groups; power issues; conflicts and disagreements and emotional expressions such as belonging, aggression, frustration, etc. Also, I had many dreams about the groups, the group process and the research and I also recorded these when I remembered them. I felt as if my body, mind and soul grew older and wiser with this research. Sometimes, it caused me overwhelming feelings of being trapped and depressed within the research process, the data and writing about it. On the other hand, this also enabled me to learn how to think, write and present my work to different kinds of academic and other audiences. In fact, I lived with this data for 13 years and it was part of my life like a companion.

During the groups, we, the group therapists had our own feedback discussions before and after the group sessions where we shared our thoughts and feelings. After the group sessions, we often discussed the therapeutic atmosphere in the group and we decided who would be the ‘operative leader’ and ‘genius locus’ for the next group session. After the final session, co-therapists had a longer discussion about the group, us as group leaders and our ideas on the group method which was a new model for all involved. One co-therapist said that ‘even though members of the group were depressed, they worked effectively and thought about what was most important in their lives and worked actively between sessions’.

Data Analysis
Because most participants’ mother tongue was Finnish, all data both qualitative and quantitative were first collected in Finnish and translated by me into English prior to data analysis. (It should be noted here that two participants were Swedish speaking and their responses were also translated when appropriate.) Responses to open-ended questions on the questionnaires were analysed on the basis of categories identified as key themes by both participants and authors. For example, key themes were discussed in the groups and the group leader kept records of these discussions. When the qualitative analysis began, the group leader’s notes were used as a basis for discussion between the authors who developed key themes further. This was especially true when the diaries were analysed. Throughout the whole study, qualitative analysis was mainly descriptive, an important contribution considering the paucity of information on depressed women.

For the quantitative data which was repeated on all three questionnaires, I undertook with the help of my co-authors, Carole Sutton and Elizabeth Ettorre, data entry and data analysis using Statistical Package for the Social Sciences version 12.01 (SPSS V 12.01) for Windows. The data use a 3 point ordinal scale. We applied the Wilcoxon matched-pairs signed-ranks z-test, a non-parametric test to the data to statistically assess between the three time periods. The comparison time periods were: pre-group to post-group, pre-group to follow-up, and post-group to follow-up.
To assess reliability of the measurement tool, we adopted the Cronbach’s alpha statistic to determine internal reliability (Cramer & Howitt 2004:79). (Articles 2 & 4.)

5. RESEARCH RESULTS

As discussed above, the Women and Depression Project (WDP) consisted of professionally led self-help groups and data collection for this research project in Finland was a six years enterprise from 1994-2000. The project’s dual purpose: to engage depressed women in feminist ‘therapeutic’ action research and to develop guided self-help groups for them in the Finnish health system facilitated the development of the research results.

Both purposes of the research have been fulfilled. The former purpose was fulfilled in that depressed women were able to become more active and reflective in their lives and evidenced a type of ‘depressed agency’, referring to their agency which helped them to understand their problems, to ‘own’ them, to have self-authority, and to recognise that healing is in their own hands. The second purpose was fulfilled as there are still in the year 2008 depression groups which employ this method in the statutory and non-statutory sector in the mental health field sector, in Finland.

Related to the dual aims of the research were key questions, ‘Is it possible for depressed women who have been dealt with as objects of treatment to become active subjects in their healing?’ and ‘How do Finnish women experience depression?’ In the light of the aims of the research as well as the key research questions, the research results revealed empirical outcomes on three levels for group members, group therapists and mental health services.

Empirical outcomes

The findings of the WDP research revealed descriptive accounts from women who experienced depression, wanted to help themselves to manage their depression and became involved actively in groups which were at the heart of the WDP research and therapeutic process. From the first interview, women who wanted to be members of the group took responsibility for their own participation in the group. They answered motivational questions related to why they were interested in the group at this time in their lives; what kinds of ideas and attitudes they had towards a therapy group in comparison to individual counselling or therapy; what specific issues they wanted to deal with in the group; what problems they wanted to bring to the group and most importantly; the key problems which they wanted to change by their own participation in the group. (Article 1.)

The WDP groups were very popular and it was acceptable for the participants to be depressed. Usually, it is difficult to get depressed people to attend group therapy sessions on a regular basis but attendance was high for these groups. Additionally, there were queues to get into the WDP groups. Generally, the groups facilitated positive feelings for participants and potential participants. Finding agency while depressed for these women was a big step forward in their lives. (Articles 2 & 4.) Already from the initiation of the pilot group, feminist ‘therapeutic’ action research was employed to help women to become empowered agents and to develop a suitable treatment for their own depression. The core idea of the WDP group method was that
the more the participants knew about the group process, the clearer they would be about their own suitability for the group. In this way, depressed women were their own agents in this process. They themselves choose to be a member of the WDP group in consultation with the group therapist. While this was a joint decision, their empowerment was the primary focus of their involvement in the WDP groups. (See Article 2.) In this context, Brown (2006:20) contends that while empowerment is at the heart of feminist therapy, including group therapy, the epistemic core of feminist practice is consciousness raising. The process of consciousness raising in the WDP groups was supported from the beginning of the group. From that time, members were told ‘the basic tasks’ (i.e. the group programme and therapeutic tools and interventions) of the group (Bion, 1961): they were active participants in the group process, ‘specialists’ in their own depression and capable of being reflective about being depressed women. By constructing these gender sensitive understandings, women who had traditionally been dealt with as objects of treatment were more able to become active subjects in healing their depression.

Depressed women whose reasons for depression included family, existential, work-related and chronic health problems (See Article 1) became active agents during the group sessions when they were offered the opportunity to write their own diaries. This was a way of helping depressed women to tell their ‘depression’ narratives and to make their voices heard. (Article 3.) Group members used their diaries as a tool for self-reflection and a support in dealing with psychological and physical pain. Engaging with the ‘home tasks’ such as ‘what can I do for myself’ in order to feel more positive’, ‘straight talking’, or ‘learning how to say ‘no’’, participants became better able to practice the ‘new empowering’ tools which allowed them to take better care of themselves (i.e. empower themselves) during their depression.

In WDP group sessions, participants had space to talk with each other about a variety of relevant topics such as the psychology of women; their communication difficulties; the basic needs of human beings; owning their own depression; experiencing difficult emotions and women’s empowerment and contemporary embodiment in the therapeutic encounter (See Shaw, 2004). Within groups, participants were able to construct a new understanding of their depression experiences and see this understanding through the lens of a collectivist (Calnan, 1987) rather than individualistic model of health. Similar to others, their narratives were shaped by shared cultural knowledge and conceptions of depression (Kangas, 2001). (Article 1.) By telling and retelling their experiences and stories in groups, women became experts on depression with female authority (Young-Eisendrath & Wiedermann, 1987). While storytelling can be a way of dealing with inner disturbances (Rennie, 1994), the process of telling their stories allowed these depressed women's voices to become audible.

In the WDP groups, women expressed their desire for healing and became better able to develop their psychic lives (Bolen, 1984; Brinton Perera, 1981). That feminist principles were utilised in group work, a method that had been used successfully in self-help contexts (Holland, 1992; Corob, 1987), meant that the focus was on the WDP participants to change. Group work has been shown to make depressed women more aware of themselves and their social situations (Schrieber, 1998). In the case of the WDP groups, the agency of depressed women was not only supported but developed further by the participants themselves.
Coming to the professionally guided self-help groups was perhaps for some women their first step in belonging to a community where they could experience firsthand ‘welfare loving’ and ‘welfare being’ (See Allardt, 1975; 1993). On the other hand, women could be in solitude (i.e. olla yksin) in their quest for empowerment. Regardless of their mieli maassa (i.e. depression), they were on their way to finding sisu (i.e. courage or guts). In a real sense, depressed women, as participants, did the research and helped to construct the meanings that became data for interpretation (Olesen, 2000). Their collaboration in the WDP ensured that they were able to express and reflect upon these meanings in relevant discursive contexts. (Article 1.) Thus, the picture of depression that emerged from the WDP groups was different from the traditional ‘expert', biomedical one (Stoppard, 2000a: 411). It was subjectively meaningful while being collectively constructed in a women's milieu.

With the help of the group process, which involved individual tasks and different group exercises, participants were facilitated in generating changes in relation to their experience of their feelings and their depression. The WDP groups helped them to make positive changes in their depressed lives and to look towards their future lives. The groups allowed them to have dreams for a better future, to consider how they would be able to fulfill their own needs, to learn communication skills and to analyze their own therapeutic needs. Most importantly, with ‘depressed agency’, the participants were able to generate a sense of embodied and empowered hope.

For the group therapists who facilitated these professionally led self-help groups, the group experience offered a shared work opportunity for those who often work in solitude and furthermore, settle for small sample research (Harris, 2006). Involvement in the WDP groups helped us to break down the isolation of the therapeutic milieu. Group therapists were able to be active participants in the WDP group sessions by their lively contribution to ‘feeling circles’ which occurred before the start of and at the end of every group session. Given that group therapists were able to reveal things about themselves, this helped to break down therapeutic barriers between ‘us’ and ‘them’ and therapists and patients. This enabled members to own their own subjectivity because therapists, as subjects themselves, did not treat members as objects.

As group members were learning new things about their depression, group leaders were learning new group methods for future groups such as exercises to strengthen group members’ communication skills and working in pairs. Group therapists involved in the WDP were also concerned with sharing on a personal and professional level with another colleague (i.e. the other group therapist). As we saw earlier, the WDP experience also gave them a forum to have peer supervision after the WDP groups. Common feedback from co-therapists has been that facilitating a group with another therapist enabled them to develop their therapeutic skills with the help of a colleague. The most striking feedback was that co-therapists reported after every group session that they never felt tired. On the contrary, they felt ‘energised’, ‘uplifted’ and even, ‘happy’. They too were empowered by the group methods. Perhaps, this is a measure of the WDP groups’ success. In this context, Hämeeaho (2007), a psychologist at Student Mental Health Service in Tampere (YTHS) reported to me that she has facilitated these groups since 1999 and the groups have been so popular that YTHS offers two groups per year. She was obviously energised by these groups.
In light of the above, for mental health services or clinics, the WDP group method is an effective tool which offers a healing experience for those waiting for individual psychotherapy or counselling. The WDP group process offers self-help strategies as ‘a first aid kit’ and allows these sorts of services to consider that patients or clients who are unable to have psychotherapy or psychiatric treatment because of the time factor (i.e. waiting list) can be helped by their involvement in this group process. The group process allows patients/clients to be engaged in their assessment from the beginning of the treatment process and to learn to be reflective about their problems. This type of group offers an active partnership between the patient and the mental health service (Articles 1, 2, 3 & 4) and emphasises a user-centred philosophy which is viewed as an essential part of world class plans in response to treatment for those with mental health problems (Home Office & Department of Health, 2005).

Bringing these groups into the public sector encourages the use of a self-help philosophy for mental health patients in the present era of mental health services in Finland. This influence and input from service users, ex-users, carers and allied health professionals are vital to developing the next generation of mental health services. A treatment model for depression based on WDP groups makes it possible to bring service providers and customers closer together. It also helps users to become active consumers (i.e. subjects) of mental health services instead of turning into chronic, dependent, depressed patients. Finally, in a society where stress, anxiety and depression are the major reasons for sick leave and incapacity leave, this low cost but effective treatment model has proved its place in both the statutory and non-statutory mental health services in Finland.

With regards to the above mentioned empirical outcomes, the WDP groups can be seen as part and parcel of evidence based feminist therapy (Brown, 2006). Brown (2006:16) argues that evidence based feminist therapy should be used to expand the cultural competence of all involved (i.e. participants, therapists and services) and provide the capacity to think about the current and historical, personal social locations of the client and their experiences - experiences which inform both distress and resilience for the client (Brown 2006:18). For therapists and services, patients’/clients’ satisfaction is a key variable in evidence based therapy. If the WDP group model is adopted, clients/patients will feel that they are seen, heard and known. It will be resonated throughout mental health services that they feel more satisfied which is the ultimate goal of effective group therapy.

The limitations and strengths of the Women and Depression Project

There are limitations which exist in this research. First, the study was restricted geographically to mainly urban areas in Southern Finland. Second, since a majority had at some point in their lives received a psychiatric diagnosis, I am unable to evaluate how well this sample represents depressed women in Finland as a whole. Thus far, there are not any substantive Finnish data on depressed women with which to compare the WDP data. Third, recruitment was by self-selection and I did not use a clinical definition of depression, resulting in a potential selection bias. However, I looked at women's experience from a specific feminist epistemological stance which began from depressed women's descriptive accounts and their 'voices' (Naire & Smith, 1984; Stoppard, 2000b). Because I wanted these accounts to be viewed as a legitimate source of
knowledge, the standpoint of my research originated with women's experiences rather than experts' concepts and theories (Stoppard, 2000a). Fourth, as a piece of practitioner-based research, and because of the consensual methodology, it was not feasible to construct a control group which could be seen as a weakness particularly from psychologists’ point of view. Fifth, it is not possible to ascertain within the findings the proportion of changes that may have occurred as a result of spontaneous recovery. Had a control group and randomization of group membership been appropriate and available, it might have been possible to address the issue of spontaneous recovery. Sixth, the sample was biased towards the highly educated. This is an artefact of the data, given that 23 per cent of respondents were students, but provides important knowledge: although Finnish women have opportunities for higher education, this welfare provision does not protect against stress, anxiety or depression. Finally, I did not use Beck's Depression Inventory (BDI) with the groups for a variety of reasons: some authors (Sloan et al., 2002) claim it is a better predictor of global psychic distress rather than depression as specifically defined by current diagnostic criteria; the self-report scales may be gender biased (Cohen, 1998) and our respondents were already overly exposed to using the BDI. Many said they did not want to fill in any more psychological measures. Another reason I did not use BDI was that it does not reveal the *psychodynamic depth* of one’s depression. Implicitly, it attempts to describe ‘the structure of the mind’ (Tähkä, 1993) and the behavioural consequences of one’s depression (See also Articles 2, 3 & 4).

As far as the strengths of this research, the most obvious one is that this is the first Ph.D. on feminist group psychotherapy in Finland which means that this sort of feminist knowledge (Seu & Heenan, 1998) can finally be heard in Finland. Certain features of the WDP helped the research and therapy groups to be effective. These features included my roles as psychotherapist and feminist researcher; the roles of the group therapists; the shared, common goal of the participants and that the groups were set in a variety of therapeutic contexts.

Firstly, as mentioned earlier, I had a double role as a psychotherapist and feminist researcher. This dual role allowed me to move in and out of the research as well as be aware of the complexities of the therapeutic process. For example, as a psychotherapist, I adapted feminist consciousness raising to the feeling circles which occurred at the beginning and end of every group’s session. Problem solving therapy was introduced with the home tasks. Diary tasks represented input from cognitive behaviour therapy or therapeutic writing, while in one session, looking at archetypes of women based on Greek goddesses inculcated a clear Jungian approach. The psychoanalytic approach was embedded in the groups through the basic interpretive methods of psychoanalytic therapy. For instance, if a group member had left her diary in her handbag for a week and forgotten to write in it, the therapists gently interpreted this forgetting as perhaps, her forgetting to take care of her own needs for a week.

My therapeutic work did not interfere with my feminist research role or vice versa. On the contrary, although I created a specific group method for depressed women, I was able to collect reliable data for this research, as the group programme was replicated for each group. All the group members were aware that I was gathering research data within the ‘Mieli maasta’ project. While, at first, a few were feeling a little bit suspicious that I was ‘only using them’, the majority felt proud and important that they had the opportunity to be a part of this research. Some
participants asked me when this research would be completed because they were interested in it. I saw this curiosity as part and parcel of their desire to know more about their own depression. My feminist researcher lens became active especially when I was starting to analyse the data and saw how these women lived with their depression.

Secondly, all of the group therapists involved in the WDP groups were an active and important part of an effective group process. In reality, we were putting the group programme into practice by being group leaders. By sharing our thoughts, feelings and emotions in the group, we helped to break down barriers which can exist between therapist and patient in either a group therapy or individual therapy setting. We, therapists, by sharing something personal, whether a feeling or a thought in feeling circles, were involved in the group process on a personal level. We shared what was happening in our inner lives and who we were ‘at that moment’. This allowed group members to sense that we as group therapists were participating in the groups as ‘subject to subject’. Thus, we all – therapists and clients- worked for the successful completion of the group programme.

Thirdly, while the participants were a heterogeneous group of depressed women, they shared a common goal – to explore their depression with others similar to themselves in a group context. As a result, they had a keen interest in raising their ‘depression consciousness’ as women, to bolster their self-esteem and to explore their lives in-more depth. This meant that they were actively involved in a visible form of conscious-raising whether or not they saw this activity as feminist.

Fourthly, by the end of the WDP research I was aware that the same method worked in a variety different social contexts. Simply, these groups worked not only in mental health clinics and settings but also in educational, information and social settings. I believe that the reason that groups worked in these settings is that the groups were not separated off from participants’ lives. Simply, it was quite easy for participants to integrate these groups into their everyday lives. (Article 2 & 4.)

6. CONCLUSIONS

This Ph.D. thesis focused on how feminist therapy methods work in the Finnish mental health field for depressed women and the therapeutic meaning of professionally guided self-help groups for them. Traditionally, it was envisaged that feminist research should be ‘on, by and for women’ (Stanley and Wise 1993:30-36). In terms of my research, the focus was ‘on’ depressed women but included implicitly the part men and the patriarchal welfare state played in their depression; ‘written’ ‘by’ depressed women who were the subjects and active participants and whose depressed voices needed to be heard and ‘for’ depressed women who used the groups to deal effectively with their personal feelings and social situations.

Intuitively, I also incorporated these ‘on, by and for’ principles into my therapeutic framework. By using the words ‘on’, ‘by’ and ‘for’, I suggest depression is ‘on’ and more specifically, ‘in’ women’ and that they should consciously own it. Otherwise, they are unable to understand it and deal with it. ‘By’ women means that group members are ‘doing’ depression for themselves. Depression has a function in their lives: they constructed it themselves in an
oppressive social context. ‘For’ women means that depression works for these women and helps them to develop their own empowerment and agency (Marecek & Kravetz, 1998).

Recently, a notion emerged from Finnish feminism that depression is political and that the early stage of feminist resistance is represented in sickness (Liljestrom mentioned in Koivunen, 2004b: 66). If politics is about survival and depression is a way of saving oneself, the idea that depression is political for women may not be so farfetched, given mental health professionals’ and psychotherapists’ inability to comprehend thoroughly this phenomenon (Miller & Stiver, 1997). Indeed, as early as 1976, the feminist psychologist, Jean Baker Miller (1976: 95) wrote that ‘everyone in the various psychological fields would readily admit that we do not fully understand depression or fully understand anything else for that matter.’ Added to this, let’s look at women's experience of depression within a socio-cultural context, specifically a Finnish one and consider what this experience means if contextualized in relationship to women's overall social status in a Nordic welfare state. Here, a question arises, ‘Is ‘welfare depression’ the price Finnish women pay for equality in the market place or workforce?’

Finnish women are well educated and enjoy a high participation in the labour force. Nevertheless, they are still perceived as the main providers of personal services in the private sphere of families, a fate shared by their African American counterparts (see Harris-Lacewell, 2002, 2004). The consequence is that Finnish women more than men are the carers and carriers of emotions. Although public services are provided alongside private ones (i.e. family resources), health is not culturally assured in Finland. On a welfare level, the WDP women were satisfied with their material and economic status. They had enough material support in their lives. Rather, these women were in search of social and emotional and in some cases, physical well-being as the reasons for their depression included family, existential, work-related and chronic health problems.

Here, I find Eric Allardt’s (1975; 1993) welfare typology useful, regardless of it being set within a neo-liberal/social democratic framework (Julkunen, 2007). According to his typology, depressed women are somewhat secure in their ‘welfare having’ (i.e. physical health), but lack in their 'being' (i.e. need for emotional well-being) and 'loving' (i.e. wanting better personal relationships). Their depression is not due to lack of economic support, as perhaps may be true in other countries. Improvements in relationships, belonging to a group of workers and being a healthy citizen were group members’ goals and their active work in groups were directed at finding ways to achieve these goals.

Depressed women, similar to Finnish women generally, are not passive victims of the welfare state (Rantalaiho, 1993). Perhaps, they experience private ‘feminine’ distress (Wager, 1994) shaped by public processes, structural relations and gender inequalities which still exist in the Finnish welfare regime. Indeed, for some women private distress results from experiencing inferior, relational or emotional positions which become visible in the public domain (Bostock, 1997). While Finnish women's experience of welfare may be both a liberating and subordinating process (Rantalaiho, 1993), depression may be a consequence of invisible tensions in the Finnish gender system. Thus, the term ‘welfare depression’ is useful. It implies that Finnish women may have houses to live in and food to eat, but some women feel lonely and not appreciated as citizens in this contemporary welfare regime. Perhaps, ‘welfare depression’ is for some Finnish women
their first step in resisting social suppression and a clear saying ‘No’ to social inequality. Thus, ‘welfare depression’ becomes the first step to empowerment and agency in their own depression as women.

While it has taken a long time to carry out this research, the combination of empirical materials may reveal new question about women’s depression: Is there a type of ‘feminist depression’ which has two faces, one positive and one negative?; Is depression for women able to be a ‘killing factor’ (i.e. it can destroy a woman) as well as a ‘loving factor’ (i.e. it can help a woman to love herself)?; Can women learn to use depression constructively and psychoanalytically in order to get to know themselves on a deeper level as well as those sides of themselves that they tried to suppress?; Can there be mentally healthy depressed women?; Is depression for women always abnormal?; Does inequality produce depression?; and Do present mental health services re-enforced women’s dependency on authority and depression? Of course, these questions were unable to be answered in this research and clearly warrant further exploration.

In conclusion, more work which exposes women's experiences of depression in cultures privileging equality as well as diversity and difference needs to be carried out. We need to further our knowledge on women and mental health by using cultural ethnographic approaches which view depression as a multidimensional, multicultural phenomenon. (See Article 1.) If a new understanding of women and depression is to develop, it must explicitly include ideas on how depression is shaped at the public and private interface as well as how distress and well-being may have cultural as well as gendered variations. We know that for depressed women, voicing long-silenced experiences can play a crucial part in their empowerment (Waterhouse, 1993) and healing (Brandis, 1998). I hope that the women friendly, therapeutic practices generated by the WDP groups enabled this process to begin at least for depressed women in Finland.
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Appendix 1: Information Sheet about WDP group

The Service intends to start a psychotherapy group for women who are interested in developing strategies, which will help them to manage their lives more effectively. The aim of the group is to explore issues that may lead to depression. Confidentiality of group members will be respected.

The group is recommended to those women who want to develop their communication skills, increase self-confidence and self-knowledge. In the group we will use a variety of methods: open group discussion; presentations and discussion based on them; creative exercises and diary work.

The purpose of the group will be to explore together in a safe environment:
- communication skills combined with relationship issues;
- self limiting behaviour e.g. dependence on others;
- identifying and satisfying personal needs;
- how best to take control of one's own life.

Women who are interested in joining the group are requested to make an assessment appointment by phoning. And please indicate to the receptionists your interest in becoming a group member. Interviews will be used to select 10 -12 group members who are thought to be at such a stage in their lives that they could benefit from this kind of group work. After the interviews letter will be sent to participants giving details of the first session.

It is proposed that the group will be held on …

The group facilitators will be Irmeli Laitinen and ….
Appendix 2: For group Facilitators for Pre-group Interview

The main purpose of the pre-group interview is:
1) to allow both the group members and the group facilitators to get to know each other
2) to ensure that the member is suitable for this kind of group therapy, using a cognitive-psychoanalytic approach and that she will have some benefits out of it
3) to give to the member more information about the aim of the group process and about the methods which will be used in a group
4) to motivate the member to participate in the group and to help her to make a commitment to the group process
5) to help the member to address her main problems and become focused on specific issues which she wants to bring to the group

Criteria for a group member:
1) The group is for those who feel themselves depressed or moody and/or are motivated to work on the following issues:
   - communication skills combined with human relationships
   - to understand one's own behaviour, for instance, dependence on others
   - to learn to pay attention to one's personal needs
   - to learn to control one's own life.
2) The group member must have a sense of her own self, who she is, where she is. Simply, she should understand what has been said and able to give answers to questions (i.e. she is not psychotic, suicidal and severe clinical depressed.)
3) The group member should have a minimum amount of self-reflection.
4) The group member should have some basic ability to share her inner life.
5) The group member must have a minimum amount of rational thinking.
6) The group member should be free enough from any addictions that she is able to attend on regular bases to the group meetings
7) The group member should have the motivation and readiness for intra-psychological, personal work in an inter-psychological context.
Appendix 3: Topics for the Women and Depression Project groups*

Topic 1. Getting to know each other and doing ‘feeling circles’: conscious speaking and conscious listening
Topic 2. Women's psychology: Born as a women and becoming a women
Topic 3. Feelings of fear and hate: feeling and expressing them
Topic 4. Communication: to have expertise in a conflict situation with 'straight talk'
Topic 5. Assertiveness: Exercises in straight talk
Topic 6. Getting to know my own needs
Topic 7. Embodiment: How can I take care of my own body?
Topic 8. The 'tree' of the future
Topic 9. 'Fulfilling' joy: What are the obstacles to my joy?
Topic 10. The end of the group: the way forward

*Also in Article 1 as Figure 1
Appendix 4: Exercises of the Women and Depression Project Groups

Exercise 1.
GETTING TO KNOW EACH OTHER
Individuals introduce themselves and focus inwards. Imagine what animal you might be or a character in a story, a film or on TV show. Tell the group. Leaders draw members’ attention to the variety and richness contained within the group.

Exercise 2.
THE FEELING CIRCLE
There is a feeling circle at the beginning and end of each group. Group members share in turn how they are feeling in the moment. Other group members cannot interrupt, question or give advice. The first person has right to add to her/his statement when all other members have shared their feelings or thoughts.

Exercise 3.
PEER WORK
Choose a partner and decide who will speak first. These statements will be discussed in the big group.

Exercise 4.
CONSCIOUS COMMUNICATION
Choose a partner who you do not know. Decide who will speak first and who will be the conscious listener. The leader will always tell you when to change roles. Find a quiet area of the room and sit so that you are able to see each other comfortably. The speaker. Take responsibility to share with her/his partner a degree of personal information. If you finish before the leader asks you to change roles, sit quietly and learn to be with yourself and your partner in silence, in silence you both might have new insights. The listener. It is important that the listener just listens and does not lead the talker by questioning, by nodding, gesturing, making facial expression etc. The listener needs to listen consciously and explore what feelings are aroused in her/him by the words she hears. The listener does not comment when she/he changes role or becomes the talker. The partners are a discrete pair and must maintain confidentiality. Individuals can share their own insights but cannot disclose the content or what their partner talked about.

Exercise 5.
GROUP DISCUSSION

Exercise 6.
DECISION MAKING
The elements of decision making are information, assertiveness, analysis, synthesis, tolerance of others opinions, tolerance of alternative opinions, ability to express opinions in a variety of ways.

Exercise: Each group member is allocated a card containing a statement and she/he must find a partner with a statement which is opposite to the one she/he has. Each person speaks in support of the statement that is on her/his card. The group leader will time the exercise allowing each person for 5 minutes. After this the pair will create the statement that incorporates the opposite statements.

Exercise 7.
THE END OF SESSION FEELING CIRCLE
The process is identical to the feeling circle at the beginning of the session however the functions are different.

Exercise 8.
NAMING AN EMOTION
This exercise could be used at any point during a group session. For instance if time is short this exercise can be used instead of the end of session feeling circle. Using a single word group members are asked to identify and name an emotion experienced in response to what has happened before.

Exercise 9.
TO DRAW ONE'S OWN TREE
Group members are asked to draw one's own tree. Similar to a family tree but this time focus on yourself and represent your life in your tree. There is no right or wrong way to do this exercise. Group members can use their own symbols, draw, write or even just use colours to describe their life. Group members are encouraged to reflect their life since childhood until now, and represent events such as childhood memories, school memories, adolescence, the sorrows and joys of life.

Exercise 10.
THE ART EXHIBITION
Group members are asked to display their life trees on the wall. The room becomes an art exhibition. The scene is set in a way that enables group members to get into role quickly. It effectively becomes the opening of art exhibition. Each member is asked to describe briefly her/his own tree.

Exercise 11.
LOCATING THE SOURCE OF EMOTIONS IN YOUR OWN TREE
Group members are asked to come face to face with their tree in order to identify situations in which security and fear were experienced. Security - consider where the feelings of security came from. What aspects of your life combined to evoke your sense of security? Was there anyone else present, if so, who was it? How did it make you feel, how intense was the experience? Was the feeling of security located in your body, if so, where? What increased or decreased the intensity of the feeling? Repeat the above exercise in relation to fear. Symbolize these feelings in your tree by either, drawing them, using colour, writing about them or express them in any other way.

Exercise 12.
SHARING INSIGHTS
Group members are asked to share in the full group any insights gained during any of the exercises.

Exercise 13.
RELAXATION AND BOUNDARY EXERCISE
In pairs decide who will be offered relaxation through massage. The receiver sits in a relaxed upright position. The massager first warms her/her hands by rubbing them briskly together. Now stand behind the receiver and place the hands gently on her/his shoulders. After a few minutes the
massager slowly takes her/his hands away and vigorously shakes them in order to separate and clarify the boundaries. There is no discussion during this exercise.

**Exercise 14.**
LEARNING TO SAY ‘NO’ AND REALLY MEAN IT!
It is often hard for women to say no when they are being asked to do a favour. A woman has learned to respond to other's needs and therefore it can be difficult for women to express their reluctance to say they do not wish to do what is being asked of them. For example if women are asked to make coffee or make a phone call, they tend to do what they are asked, even when they are engaged in doing something important. In this exercise we will practice behaviour based on our own needs and emotions even when pressure is put on us to respond to other's needs. Choose a partner. One will be the person who asks for something to be alone, and one will practice saying "no". The task of the "asker" is to beg, cajole, pray, to pressurize the other one (the denier) to do something for her/him. The task of the denier is to say, "No, I am not going to do it". "No, no I am not going to do it" are the only words that can be used. Physical contact is forbidden.

1) The denier's friend asks her/him to lend her/him money to buy alcohol. The denier refuses by saying "no"; I am not going to give you money".

2) The asker approaches a woman on a train that is apparently sitting in her/his reserved seat. She/he asks the denier whether she has also reserved a seat and eventually, when she/he discovers that the denier has not reserved a seat, to move.

**Exercise 15.**
"NO NO" HOME TASK
At least once during the following week you are asked to say "no" in a situation where you would normally say "yes". Do not give any explanation.

**DIARY WORK**
At the end of the first session, group members are asked to bring a diary of their choice to the next session.

The group leaders explain to members the purpose of the diary i.e.

**Exercise 16.**
WOMEN'S ROLES AND NEEDS
Which Goddess is most hidden in me and which is most visible?
Which was the most visible in the past?
Which would I like to be most visible in the future?
We will be helped to identify these aspects of ourselves by using Greek goddesses.

**Exercise 17.**
THE DISCUSSION ABOUT THE DISCUSSION
How does it feel to talk and listen to members in the group?
What have I found in myself in relation to group discussions?
What feelings were evoked?
How I feel about the group.
What do I think about the way it works?

**Exercise 18.**
WHAT I LIKE/DISLIKE ABOUT MY BODY?
What do I like about my body?
What do I dislike about my body?
In pairs discuss or write in your diary for 5 minutes "what I like", the other woman listens.
The 2nd one starts - "what I don't like about my body".
Repeat.
Group discussion: Only say what you said!
Where did these ideas come from - did someone make comments to you?
Is there something you said today that no one made comment about and you have discovered yourself?

**Exercise 19.**
**READING ALOUD IN A GROUP**
The listeners’ exercise ‘conscious listening’ while listening to the text.

**Exercise 20.**
**I AM/I AM NOT THE DAUGHTER OF MY MOTHER!**
In a big group we are standing in a round circle and we take ‘a talking circle’ and we continue the sentence:
1st round: "I am my mother's daughter because......"
In a big group we continue the sentence:
2nd round: "I am not any more my mother's daughter because......"

**Exercise 21.**
**HOW DO I TAKE CARE OF MYSELF/ MY BODY?**
"How do I take care of myself/ my body and learn to be sensitive to myself/my body"
Home task: take care of self in a way that feels right for you! You should be able to think what it is that you need. What you wants in order to feel better. Write list in diary! Usual weekly exercises are not to be counted.

**Exercise 22.**
"TREE OF THE FUTURE"
Draw on your own tree the significant relationships in your life - childhood, youth, and adulthood. Discuss in pairs or in a small or big group.

**Exercise 23.**
**ONE SIGNIFICANT RELATIONSHIP**
Pick up one relationship from your history, which affected your life either positively or negatively. Mark or draw it on your tree. Circle discussion and tell the group how it affected your life. Focus on the characteristics of the relationship. Write them down. Discussion and identify any splitting that occurs.

**Exercise 24.**
**WHAT YOU VALUE/ARE AFRAID OF IN YOUR FRIENDSHIPS**
Write down three things, attributes, that you value in your friendships. Write three things you are afraid of in your friendships. The group leader can write these different things on a board and there can be a discussion about this. At the end, the exercise shows what you are missing at his moment. In the conclusion, it could be mentioned that the above things which we normally link
with friends could in the future be linked with our own diaries (like safety, listening my inner self)

**Exercise 25.**

**FEELING CIRCLE: TELL THE GROUP A TINY JOY YOU EXPERIENCED TODAY.**
Everyday shares a little joy, which they had had today. With this exercise you can notice little, everyday joys and this helps us to be more conscious of them and be happy about them.

**Exercise 26.**

**THE LITTLE AND BIG JOYS OF ‘MY OWN TREE’**
Take your own tree drawing and draw or add there all your little and big joys in your life. You can add them with colours, pictures, with words etc. Share this with your peer - what kind of joys you have had and during what time of your life.

**Exercise 27.**

**HOMETASK: MAKE YOURSELF HAPPY DURING THE FOLLOWING WEEK!**
Plan something exceptional for yourself, what can make you happy. While doing this explore your feelings and thoughts while you are doing something special for yourself and explore your feelings also afterwards.

**Exercise 28.**

**VOICES OF YOUR CHILDHOOD**
When we were children our mothers, fathers or adults around us gave us advice or forbid us to do something. Some of them are fresh in our memory, some of them we will remember if we try to concentrate a little while. The group is standing in a circle and everybody shares these memories by free associations. It may be better that we keep our eyes closed and then we can concentrate to listen to our voices from our childhood. The group leader starts the exercise and finishes it when there is no more sharing.

**Exercise 29.**

**WHAT DID I GET FROM THIS GROUP? WHAT IS THAT I DID NOT RECEIVE? WHAT I AM STILL MISSING?**
Share in peers what you gained in the group and what you did not get. After the peer work this could be shared in a big group.

**Exercise 30.**

**WRITE IN YOUR DIARY FEEDBACK ABOUT THIS GROUP**
Write in your diary five things that you have learned during the group process and five things you still need to explore more. At the end there will be a group discussion about this. This allows the group members to share their feelings with others and also it is opportunity to get feedback from other group’s members.
This exercise will also bring hope - that there are things, which we may be able to do in my life and thus be happier in my life.
### Appendix 5: A list the symptoms of the group members

<table>
<thead>
<tr>
<th>Down and depressed</th>
<th>Compulsive behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t want to do anything</td>
<td>Inability to concentrate</td>
</tr>
<tr>
<td>Decreased sexual needs</td>
<td>Inability to take risks</td>
</tr>
<tr>
<td>No appetite</td>
<td>Suicidal thoughts</td>
</tr>
<tr>
<td>Weight loss</td>
<td>No pleasurable experience</td>
</tr>
<tr>
<td>Sleeping problems</td>
<td>Slowness</td>
</tr>
<tr>
<td>Waking too early</td>
<td>Forgetfulness</td>
</tr>
<tr>
<td>Feeling heavy in legs, ache in back, mussels and head</td>
<td>Feeling like shit</td>
</tr>
<tr>
<td>Guilty</td>
<td>Afraid of people</td>
</tr>
<tr>
<td>Feeling unsuccessful</td>
<td>Sensitive hearing</td>
</tr>
<tr>
<td>Wanting to die</td>
<td>Nightmares</td>
</tr>
<tr>
<td>Nervousness, worried</td>
<td>Wasting money</td>
</tr>
<tr>
<td>Afraid of being sick</td>
<td>Worried about money</td>
</tr>
<tr>
<td>Speaking and thinking area slow</td>
<td>Repetitive masturbation</td>
</tr>
<tr>
<td>Morning more difficult than evening</td>
<td>Messiness</td>
</tr>
<tr>
<td>Evening more difficult than morning</td>
<td>Stomach pain</td>
</tr>
<tr>
<td>Being in unrealistic or dreams pace</td>
<td>Disgusting feelings about myself</td>
</tr>
<tr>
<td>Unsuspicious towards the people/paranoid</td>
<td>Getting irritated easily</td>
</tr>
<tr>
<td>Checking out behaviour</td>
<td>Indecisive</td>
</tr>
<tr>
<td>Physical symptoms when worried</td>
<td>Difficult to make little decisions</td>
</tr>
<tr>
<td>Too much alcohol consumption</td>
<td>Mood swings</td>
</tr>
<tr>
<td>Eating sweets</td>
<td>The world troubles will kill me</td>
</tr>
<tr>
<td>Isolation</td>
<td>Everything feels vain</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Angst</td>
</tr>
<tr>
<td>Too much of use drugs</td>
<td>Wordlessness</td>
</tr>
<tr>
<td>Difficult to concentrate to read even a newspaper</td>
<td>Panics</td>
</tr>
<tr>
<td>Unspecified fear of everything</td>
<td>Difficult to breath</td>
</tr>
<tr>
<td>Not willing to contact with my own carer/therapist</td>
<td>Weepiness</td>
</tr>
<tr>
<td>Anger</td>
<td>Wish to gamble</td>
</tr>
<tr>
<td>Too much smoking</td>
<td>Brains are dead, the thoughts do not move</td>
</tr>
<tr>
<td>No hope for the future</td>
<td>Slowness in being</td>
</tr>
<tr>
<td>Difficulties to keep the home in order</td>
<td>Feeling of numbness</td>
</tr>
<tr>
<td>Not wanting to open the daily mail</td>
<td>Bandage around my head</td>
</tr>
<tr>
<td>Low self-esteem</td>
<td>State of my is not depressed</td>
</tr>
<tr>
<td>Impatience</td>
<td>Unable to take care of things</td>
</tr>
<tr>
<td>Insecurity</td>
<td>Memory does not work</td>
</tr>
<tr>
<td>Difficulties to get up</td>
<td>Everything is stuck</td>
</tr>
<tr>
<td></td>
<td>Fear that I can’t mange my work load</td>
</tr>
<tr>
<td></td>
<td>Fear of authorities</td>
</tr>
<tr>
<td></td>
<td>Fear of everybody</td>
</tr>
</tbody>
</table>
I hear hostile marks  
The people are looking me with judgement  
Fear of travelling  
Wish to die  
Desire to self harm  
Desire to cut myself  
Hard to see  
All noises are disturbing  
Wanting to end my treatment  
Difficult to eat  
Headache

Desire to kill somebody  
Fear that I will attach somebody  
Desire to harass somebody, like with the phone call  
I experience only negative things  
I feel myself ugly and fat  
Fear that I cannot manage in the future  
Feeling tired from the morning till the evening  
Compulsive behaviour before leaving the house
Appendix 6: Psychotherapy Video Interview

The meaning of this interview is to evaluate your present situation in your life. Linked to the above, you will view your life problems and treatment you have had. You are welcome also to talk about your future.

How do you see yourself, understand yourself and your problems and troubles?

Why have you had to seek support from a professional helper?

What do you think of the treatment you have received here or somewhere else?

Additional questions (if above questions not answered):

Have you ever felt yourself to be depressed?

How did it appear?

How did you react to it?
Appendix 7: Interview guide for group leaders

**Background knowledge:**
Basic information *(if not known i.e. name, address, phone number, e-mail address)*
Basic information on a living situation.
Basic information about studies and work.
Earlier treatment/counselling/therapy experiences.
Use of medications and substance use.

**The ability to make a commitment to the group:**
Earlier commitments to different kind of groups (i.e. therapy, hobbies etc).
(Does she own the feeling of responsibility and confidentiality for the group?)
What time is best for you to come to the group? Is the group time, Tuesdays 2pm-3.30pm, all right?
Is there any knowledge you have already which would make it difficult for you to participate in a group session (trips, exams, hospital)?

**Motivation for the therapy group:**
Why you are interested now in the group?
What kind of attitudes do you have towards the therapy group in comparison to individual counselling?
What are your issues for the group, what problems are you willing to bring to the group?

**Please, name at least three of your problems in which you want to have change!**

**Description of a therapy group:**
The group is a workshop group with a special theme for every session. In a group there is also the possibility to work alone, with peers and in a small group. In some sessions, there are little presentations on the subject by facilitators. Some themes are: the psychology of woman, communication skills, emotions, our own needs and so on.
There is also a possibility to work home with your own diary and with some other home tasks.
We demand confidentiality for all of us. Everything we do during the group session and outside of it is on a free choice. You don’t have to do anything if you don’t feel that you want to do it. It is you who can decide how open you are with other group members. You yourself are responsible to protect your own boundaries!
This group is part of an international depression group project and Irmeli Laitinen is making a research on it, but the identity of the group members will be not revealed.

**Any questions:**
Are there any questions you want to ask from us or/and is there anything that we did not ask, but would be good for use to know?
What kind of emotions, thoughts, and visions you have in your mind when you are thinking of this group?

**The beginning of the group:**
The invitation (the consent form and questionnaire) for the group will be sent to you as soon as possible.
Appendix 8: Invitation to the Group

Service name                     date

Name of group member

With this letter we invite you to the Women’s Group which starts in (month). Along with yourself, 9 other women have been invited with 2 group facilitators. We expect you to participate in every group session so that the group would be beneficial for everyone as much as possible. We will remind you once more that the group is confidential and we ask you to let us know in good time if you cannot attend one session. If for some reason you want to interrupt coming to the group, it would be good if you would let us know in the previous group session. Then, the group has the opportunity of saying goodbye to you.

Group is gathering on: (date and time)
The first gathering is: (date and time and place)

We still ask you to confirm your place by returning your consent and commitment form to the group. Also, we ask you to fill the attached questionnaire with care and return it with this consent form in the self-addressed envelope.

Group Facilitators: Irmeli Laitinen and (other co-therapist)

Cut here

Consent Form

With this form, I commit to the group which begins on (date and time) and thus, I give my consent to use the group and all the material which is linked to the group research of the Mieli Maasta project. My intention is to be present at every session and if I am absent I will let you know in good time.

Date:
Name:
Address:
Telephone number:
PÄÄTÖSLUETTELONOTE

Terveysjohtaja

29.12.1995

§ 00.136/95 TEJO
Irmeli Laitisen tutkimus


Päätösluettelonote Irmeli Laitiselle, Läntisen terveyskeskuksen psykiatrian yksikön ylläkkäriille, Mieli maasta -projektin vastuuhenkilölle ja Läntiselle terveyskeskukselle.

Tapio Väre
terveysjohtaja

LÄNTISEN TERVEYSKESKUS
Stakesin Mieli maasta -depressioprojektin osatutkimus ”Naiset ja depressio”

Teol. ja valt.kand. Irmeli Laitinen on jättänyt tutkimussuunnitelman työnimeltään ”Naiset ja depressio”. Tutkimus kuuluu osana STAKESin valtakunnalliseen Mieli Maasta -projektiin, jonka tarkoituksena on luoda depressiopotilaan alueellisia tutkimus- ja hoitomalleja.

Tutkimukseen on tarkoitus koota Helsingin terveydenhoitoaseman mielenterveyspotilaista 8 -10 depressio-oireista käräivän opiskelijajärjestön ryhmä, joka kokooontuisi 10 kertaa. Rylmässä käytetään lyhyterapeuttista hoitomallia.

Todettiin, että tutkimus on eettisesti sovelias YTHS:n toimipirissä toteutettavaksi tutkimussuunnitelman mukaisena.

Vakuudeksi

Kari Pylkkänen
Appendix 11: WDP Questionnaire 1

Irmeli Laitinen.

Questionnaire for WDP groups:
Questions:
1. Your name: ___________________ and your birth year: ___________________

2. Why you wanted to participate in the women’s group?
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

3. Why were you treated in psychiatric unit; why did you search for self-help group; why did you go to the therapy?
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

4. Your civil status
   1. Unmarried
   2. Married
   3. In an open couple
   4. Separated
   5. Widow

5. Are there children under 15 years living with you?
   1. No
   2. Yes, how many _____________ and how old are they ____and____ and ___and____

6. What is your basic training?
   1. Primary school or less
   2. High school
   3. Collage/university degree

7. Have you any other professional training or education?
   1. No other training
   2. Professional or other courses
   3. Professional examination
   4. High school examination
8. Are you in this moment?
   1. Working
   2. Unemployed or forced time off
   3. Housewife
   4. Student
   5. On retirement
   6. Other, what? _______________________________________

If you have a partner answer following questions. If not, move to the question 12.

9. When you are feeling bad or you are in bad condition, how your partner reacts to you?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

10. When your partner is feeling awful, how you react to her/him? What you do?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

11. What happens in your relationship or in your family when you are depressed?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

12. Do you feel depressive?
   1. Yes
   2. No, but I feel myself
______________________________________________________________________________

13. Why you got depressed –what do you think?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

14. Did your life change after being depressed? If your answer is yes, how?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If your answer is no, why not?
15. From whom you got support and help, when you went to the treatment:

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your partner</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Your friend</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Your work college</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Your neighbour</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Your doctor</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Your nurse</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Professional help giver</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Civil servant</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Your relatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>From whom:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. Can you mention any feeling which you would attach to your state of mind, when you feel yourself depressive (i.e. the feeling that comes at once into your mind when you think of depression)? List at least 5 feelings/emotions what comes into your mind. For instance: unhopeful, guiltiness, sadness, ”don’t care” attitude, to give up, to fight, shame, tenderness, emptiness, love, sweetness, anger……

1. ______________________________________________________________________
2. ______________________________________________________________________
3. ______________________________________________________________________
4. ______________________________________________________________________
5. ______________________________________________________________________

17. What do you do **in this moment** when you feel yourself depressed? List your actions. Circle your answer in every place!

<table>
<thead>
<tr>
<th>Action</th>
<th>Almost always</th>
<th>sometimes</th>
<th>never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I call somebody</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. I lay in bed</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. I take medication</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. I write in my diary</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. I go for a walk</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. I start to iron</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. I go to the restaurant</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. I think by myself what’s goes on</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. I call my therapist</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. I drink alcohol</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. I spend time with myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. I meet my friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. I go to the movies</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. I contact some relatives</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
15. I arrange an appointment 1 2 3
16. I go shopping 1 2 3
17. I watch TV 1 2 3
18. I go back to my hobbies 1 2 3
19. I jog or have exercise 1 2 3
20. I sleep 1 2 3
21. I eat 1 2 3
22. I listen to the music 1 2 3
23. I only sit at home 1 2 3
24. I go through my life 1 2 3
25. I think of suicide 1 2 3
26. I can’t do anything 1 2 3
27. I want to be alone 1 2 3
28. Something else, what 1 2 3

18. Underneath is a list from different feelings or states of mind. Choose in every alternative which circle best describes you:

- almost always
- sometimes
- never

1. happy 1 2 3
2. valuable 1 2 3
3. satisfied with myself 1 2 3
4. unsuccessful 1 2 3
5. guilty 1 2 3
6. hopeful 1 2 3
7. self-destructive 1 2 3
8. excluded 1 2 3
9. miserable 1 2 3
10. pains in my body 1 2 3
11. anguish 1 2 3
12. helplessness 1 2 3
13. stress 1 2 3
14. nervous 1 2 3
15. tired 1 2 3
16. energetic 1 2 3
17. attractive 1 2 3

19. Are you using any medication in this moment? If you don’t use medication move to question

20. List your medication and when you started to use them:

drug 1. _______________________________________, month/ year ___________________
drug 2. _______________________________________, month/ year ___________________
drug 3. _______________________________________, month/ year ___________________
20. How often you take these medications?
1 = every day, 2 = not every day, but sometimes during the weeks, 3 = more seldom, 4 = I don’t remember.

<table>
<thead>
<tr>
<th>Drug 1</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug 2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Drug 3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Drug 4</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Drug 5</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

21. Have you used medications earlier, what?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

22. How much money are your medications in a month? Did you pay for your medication or are you getting support from somewhere?

______________________________________________________________________________
______________________________________________________________________________

23. Are some of the following events connected to your beginning your psychiatric treatment?

<table>
<thead>
<tr>
<th>Event</th>
<th>No</th>
<th>Yes</th>
<th>Not able to say</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. my own sickness/hospital treatment</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. the illness of the other member of the family</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. death event in family among friends or acquaintances</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. loss of the workplace</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. unemployment</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. the change of the workplace</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. stress in work</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. change of apartment or living place</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. economic problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>j. divorce or the end of a relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>k. the problems of a relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>l. the birth of a child</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>m. the problems of friendships</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>n. the problems of some relatives</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>o. either you or your relative has been in accident of a robbery</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>p. you have made important decisions which</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
24. What has helped you most in your difficulties?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

25. If there would be a miracle and suddenly your difficulties were gone what change would have happened in your life?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

26. Have you hobbies, if so, what kind of?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

27. What else you want to add:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
Appendix 12: Questionnaire 2: Women and Depression Groups

Irmeli Laitinen

With this questionnaire we collect information on how you feel at the present moment. All the given information will stay confidential and will be used only by the group therapist for the research. The answers will be used to give feedback to yourself and to develop the group therapy.

Questions:

1. Your name: ________________________________

2. Why did you want to participate the women’s group and has the group fulfilled your needs and wishes?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. What do you do **in this moment** when you feel yourself depressed? List your actions. Circle your answer in every place!

<table>
<thead>
<tr>
<th></th>
<th>Almost always</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I call somebody</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>I lay in bed</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>I take medication</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4.</td>
<td>I write in my diary</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5.</td>
<td>I go for a walk</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.</td>
<td>I do housework</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7.</td>
<td>I go to a restaurant</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8.</td>
<td>I think by myself what’s goes on</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9.</td>
<td>I call to my therapist</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10.</td>
<td>I drink alcohol</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11.</td>
<td>I spent time with myself</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>12.</td>
<td>I go to church</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13.</td>
<td>I go to the movies</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14.</td>
<td>I contact to some relatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15.</td>
<td>I arrange a appointment</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>16.</td>
<td>I go shopping</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17.</td>
<td>I watch TV</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>18.</td>
<td>I go back to my hobbies</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>19.</td>
<td>I jog or do exercise</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>20.</td>
<td>I sleep</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>21.</td>
<td>I eat</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>22.</td>
<td>I listen to music</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>23.</td>
<td>I read books at home</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
24. I go through my life
25. I think of suicide
26. I can’t do anything
27. I want to be alone
28. I pray
29. I read the Bible
30. Something else.. what?

4. Underneath is a list from different feelings or state of mind of feelings. Choose in every alternative and circle the right alternative.

<table>
<thead>
<tr>
<th></th>
<th>Almost always</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>happy</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>valuable</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>satisfied with myself</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4.</td>
<td>useless</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5.</td>
<td>unsuccessful</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.</td>
<td>guilty</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7.</td>
<td>hopeful</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8.</td>
<td>sorrowful</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9.</td>
<td>self-destructive</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10.</td>
<td>weepy</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11.</td>
<td>irritated</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>12.</td>
<td>isolated</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13.</td>
<td>miserable</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14.</td>
<td>painful feelings</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15.</td>
<td>anguish</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>16.</td>
<td>headache</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17.</td>
<td>over-stressed</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>18.</td>
<td>depressed</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>19.</td>
<td>nervous</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>20.</td>
<td>uptight</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>21.</td>
<td>powerless</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>22.</td>
<td>tired</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>23.</td>
<td>sleepless</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>24.</td>
<td>short memory</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>25.</td>
<td>energetic</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>26.</td>
<td>attractive</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

5. Has group helped you in any way or helped you to change anything in your life?
   1. No
2. Yes, in what way

_________________________________________________________________________
_________________________________________________________________________

Do you want to express anything else?

_________________________________________________________________________

Thank you for your participation in the group work!
Appendix 13: Questionnaire 3: Women and Depression Groups

Irmeli Laitinen

With this questionnaire we collect information on how you feel at the present moment. All the given information will stay confidential and will be used only by the group therapist for research. The answers will be used to give feedback to yourself and to develop the group therapy.

If you have any questions: Irmeli Laitinen, phone number 0400-103 926 (answering service)

Questions:

1. Your name: _____________________ and your birth year: ________

2. Did group help you in any way or did it help you to change anything in your life? In what way?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

3. What do you remember from the women’s group (as an important, as a pleasant and/or unpleasant matter)?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
4. Has your treatment continued some way after the women’s group finished?  
How and where?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. What do you do in this moment when you feel yourself depressed? List your actions.  
Circle your answer in every place!

<table>
<thead>
<tr>
<th></th>
<th>Almost always</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I call somebody</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>I lay in bed</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>I take medication</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4.</td>
<td>I write in my diary</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5.</td>
<td>I go for a walk</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.</td>
<td>I do housework</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7.</td>
<td>I go to a restaurant</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8.</td>
<td>I think by myself what’s goes on</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9.</td>
<td>I call to my therapist</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10.</td>
<td>I drink alcohol</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11.</td>
<td>I spent time with myself</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>12.</td>
<td>I go to church</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13.</td>
<td>I go to the movies</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14.</td>
<td>I contact to some relatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15.</td>
<td>I arrange a appointment</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>16.</td>
<td>I go shopping</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17.</td>
<td>I watch TV</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>18.</td>
<td>I go back to my hobbies</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>19.</td>
<td>I jog or do exercise</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>20.</td>
<td>I sleep</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>21.</td>
<td>I eat</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>22.</td>
<td>I listen to music</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>23.</td>
<td>I read books at home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>24.</td>
<td>I go through my life</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>25.</td>
<td>I think of suicide</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>26.</td>
<td>I can’t do anything</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>27.</td>
<td>I want to be alone</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>28.</td>
<td>I pray</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>29.</td>
<td>I read the Bible</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>30.</td>
<td>Something else.. what?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Underneath is a list from different feelings or state of mind of feelings. Choose in every alternative and circle the right alternative.

<table>
<thead>
<tr>
<th></th>
<th>Almost always</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. happy</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. valuable</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. satisfied with myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. useless</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. unsuccessful</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. guilty</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. hopeful</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. sorrowful</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. self-destructive</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. weepy</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. irritated</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. isolated</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. miserable</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. painful feelings</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. anguish</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. headache</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. over-stressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. depressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. nervous</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. uptight</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. powerless</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. tired</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. sleepless</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. short memory</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. energetic</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. attractive</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

7. Are you using any medication in this moment? If you don’t use medication you don’t have to answer to the question. Name your medication and when you started to use them (in years).

List your medication and when you started to use them:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Month/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>drug 1.</td>
<td></td>
</tr>
<tr>
<td>drug 2.</td>
<td></td>
</tr>
<tr>
<td>drug 3.</td>
<td></td>
</tr>
<tr>
<td>drug 4.</td>
<td></td>
</tr>
<tr>
<td>drug 5.</td>
<td></td>
</tr>
</tbody>
</table>
8. How often you take these medication?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Every Day</th>
<th>Sometimes</th>
<th>Not Often</th>
<th>I don’t Remember</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug 1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Drug 2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Drug 3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Drug 4</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Drug 5</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Thank you for your participation in the group work!
Appendix 14: Diary tasks - directed by facilitators.

1) During the following week record all your symptoms that create physical or emotional discomfort, pain, disease, unpleasant thoughts, difficulties for you, as well as all the positive events, unexpected positive outcomes and your successes.

2) Make a list of negative thoughts and feeling each day. To help you, we have provided list of common symptoms but you may have different ones and can add to the list.

3) Again record your daily symptoms and choose the five most troublesome which you experience most often.

4) Monitor these five troublesome symptoms and write down each day the thoughts and feelings that accompany them and what your behavioural responses were.

5) Continue to monitor your five symptoms daily but this week focus on what happens before and what happens after. Consider what, if anything, you could have done to ease your pain or even make it go away. Record these details.

6) Continue to write down daily your five symptoms. Think about and record what happened before you experienced each symptom. Now record what happened afterwards.

7) During the following week write in your diary who or what helped to alleviate your symptoms. Was it a friend, colleague, the group, receiving a good grade, winning the lottery.

8) Refer back to the first week your completed your diary and compare how you feel now to how you felt then. Write down all the changes and identify whether there is something new that is positive and how that has happened. Are you doing something differently that is easing your pain?

9) List the difficulties that perhaps will always be with you and consider what you can change to make things better and what you cannot change.

10) How will you manage yourself and live with those things that you cannot change.
Appendix 15: Group Process Evaluation Forms

Irmeli Laitinen

Group: ____________________________________________ Date: ________________

Perceiving connections between group and individual dynamics:
Monitoring the level of sense of safety of the group and the individual; group power, individuals’
power, conflicts and disagreements, mediations, emotional experience, aggressiveness, groups
destructive behaviour towards the individual group member, the group therapist.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
_____________________________________________ etc.

Irmeli Laitinen

Group: ____________________________________________ Date: ________________

Within group dynamics being in every session and in its time: to observe every phase of the
group: formative phase, middle and termination phase.

Groups atmosphere, topics, norms, beliefs, common defences, the group process, group’s
cohesion, working atmosphere, usefulness of the group structure, mutual trust, the amount of the
resistance and sharing, non-destructive behaviour.

Group’s restrictive solutions: support one another in intellectualizing; get one member of the
group to fill the space, thus allowing all others to feel safe; express personal concerns indirectly
or in symbolic terms; remain silent; talk about the problems of someone not present; interact only
with the leader; ignoring all others; withdraw into solitary activities (if structure allows for
this); talk about ‘problems’ which are not one’s real concerns; fill all the available time by
challenging the value of the group or the competence of the leader; disown one’s problems, that
is, deny them or blame them on some outside agent; talk only to one’s neighbour and not to the
whole group.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Irmeli Laitinen

Group: ____________________________________________ Date: ________________