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Communication and Control in the Co-construction of Depression: Women's Accounts of Their Interactions with Health Practitioners

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Issues of communication and control have been implicated in the evolution of mental health problems, the process of seeking help and the outcomes of this process. This paper explores control and communication processes in the course of women's help seeking for depression. Although depression rates are consistently higher for women than for men, there is little information on women's experiences of seeking support or treatment. Feminist theory and research highlight the centrality of power and control for women's health and wellbeing, but examination of mechanisms mediating power and powerlessness within treatment contexts is lacking. This study utilises a predominantly qualitative methodology to explore how 14 women diagnosed with depression describe interactions with health practitioners. Building on previous theoretical positions, we develop a framework to encompass the complexities of the women's accounts, providing insight into processes by which women and health practitioners co-construct healthcare interactions. The findings suggest that for these women, the commonly posited dichotomy between understandings of depression as either a biomedical or sociocultural construct was less salient than, and mediated by, issues of control and communication. Financial and systemic considerations emerged as contextual mediators of both the women's and health practitioners' degree of control in working towards improved health outcomes.

Key Words: *Depression, Communication, Help seeking*

> *Your doctor and you make up a very important "partnership". Your doctor will do their part by diagnosing your condition, prescribing treatment and controlling your program.*
>
> *Your part is also very important; it is essential you follow your doctor's instructions and advise your doctor of any changes in your condition, in order for your therapy program to be successful and easy to fit into your lifestyle.* (Pharmaceutical company information pamphlet, 2002, name withheld)

Issues of communication and control in relation to mental health have long been the focus of research in both feminist and social health circles. Variously described in terms of locus of control (Rotter, 1966), helplessness (Seligman, 1975), mastery (Pearlin & Schooler, 1978), silencing (Jack, 1993), availability of personal resources (Turner, Lloyd, & Roszell, 1999), or power/powerlessness (Perkins, 1991), a lack of perceived or material control has been implicated in the evolution of mental health problems. At the level of seeking help, the question of control is linked to communication processes, with many studies identifying power imbalances between professionals, notably medical practitioners, and patients as precluding optimal communication and jeopardising treatment outcomes (Shapiro et al., 1983; Mishler, 1984; Todd, 1989; Phillips, 1996). This paper explores the operation of control and communication mechanisms in the process of seeking help, by examining accounts by women undergoing treatment for depression of their interactions with a range of health practitioners.

Epidemiological data from diverse cultures indicate consistently that the lifetime prevalence of depression is at least twice as high for women than men (Desai & Jann, 2000; Culbertson, 1997); yet to date there is little information on the views of women themselves about their understanding of depression or experiences of treatment (Stoppard, 1998). Surveys of women's experiences in the psychotherapeutic domain (O'Connor, 1998) cite a sense of control and equal power relationships as critical components of good counselling/therapy. However, depression also encompasses the domain of medical treatment, where consumer consultation is rare. Lorber (1997) and Jack (1991) describe how the accounts of women with depression have been discounted on the basis that they reflect a lay understanding of clinical phenomena. But along with Stoppard (1998), these authors propose that conceptualisations of depression should begin from women's accounts of their depression and of their treatment experiences.

The medicalisation of women's experiences is central to any examination of the operation of gendered power and control in mental health, and is already well documented in relation to female reproductive biological processes; for example in constructions of post-natal depression (Oakley, 1986; Nicolson, 1992). Mishler (1984) describes the voices of the patient as representing the "voice of the lifeworld", and the physician's perspectives as representing "the voice of medicine". Parallel critiques of psychotherapy's individualisation and pathologisation of socially produced distress are also available (Prilleltensky, 1989; Kitzinger & Perkins, 1993). This dichotomy resonates with contemporary approaches to explaining high rates of depression among women, that typically involve two theoretical positions summarised within the notions of "women's bodies" and "women's lives" (Cosgrove, 2001; Stoppard, 1997; 1998). The "women's bodies" approach is aligned with a medical and biological model of depression commonly associated with the prescribing of anti-depressant medication (Halbreich & Lumley, 1993; Blehar & Oren, 1995). The "women's lives" approach is informed by feminist psychological and sociological perspectives related to the systemic sources of inequality in society that shape and constrain women's everyday lives (Brown & Harris, 1978; Astbury, 1996; Bostock, 1997).

Depression provides an example of an event defined as an illness within a medical model, but also encompassed by "women's lives" perspectives explaining depression as a normal response to stressful life conditions (Belle, 1990; Caplan, 1995). Stoppard (1997) argues for the development of "material-discursive approaches ... illuminating how women negotiate the tensions and contradictions that arise between their socially constructed lives and their material-embodied lives" (p. 29). We do not propose to adjudicate the debate directly in this paper, but to focus instead on how women negotiate their help-seeking interactions within predominantly medical, treatment-oriented contexts.

A decision to focus on the interactions between women and their health practitioners necessarily encompasses consideration of communication patterns. A great deal of research has focused on communication processes between clients and health professionals, particularly medical practitioners (Ong, De Haes, Hoos, & Lammes, 1995; Stewart & Roter, 1989). Studies have repeatedly shown doctors to have poor communication skills, in spite of evidence that good communication skills on the part of medical practitioners can improve patient satisfaction, facilitate resolution of ethical problems and improve some health outcomes (Gilligan & Raffin, 1997; Maguire, Fairbairn, & Fletcher, 1989).

Empirical literature on programs to improve doctor-patient communication suggests that skills-oriented training can bring about positive change (Gordon & Edwards, 1995; Roter et al., 1995). However, findings from other studies, particularly concerning women patients (Ellingson & Buzzenall, 1999), caution that such programs need to be considered within a framework of gender-power relations which may constrain the application of best practice knowledge in specific contexts. Such contexts may include the inherent power structure of medical practice (Candib, 1995; Todd, 1989; Fisher, 1984); time pressures, sensitive or distressing issues (Kavanagh & Broom, 1997); and practitioner attitudes towards negatively perceived patient groups, such as obese women (Adams, Smith, Wilbur, & Grady, 1993), lesbians (Stevens, 1996), Aborigines and migrants (Copeman, 1989), lower-class women (Shapiro et al., 1983), and women with disabilities (Johansson, Hamberg, Lindgren, & Westman, 1996). Furthermore, conflict or difficulty in client/health practitioner communication is not necessarily overtly expressed, nor is it confined within the dyadic relationship. Shapiro et al., examining issues of power and information control in the obstetric encounter, suggest that "the normative expectations of both clinician and patient limit the likelihood of overt conflict" (p.140), with the result that women attending public hospital clinics who were reportedly satisfied with their treatment were also found to desire more, and receive less information than women treated in private health settings.

The analytical framework adopted for this study incorporates aspects of the work of Jurgen Habermas (1976; 1984). Habermas developed the complementary concepts of "communicative action" and the "lifeworld", which he proposed as basic categories of general social theory. Grbich (1999) describes Habermas' lifeworld concept as the "symbolic arena shared by members of a culture or community" (p.44), enabling mutual understanding and congruent communication, ideally free from coercion. Habermas' (1984) theory of communicative action suggests that access to knowledge is emancipatory in providing people with the opportunity to challenge oppressive belief systems. Such an ideal contrasts with studies such as that of Shapiro et al. (1983), where the gap between women's desire for information and its actual provision within a medical encounter remained wide.

Grbich (1999) outlines the fundamental developments of Habermas' work with respect to communication between clients and health professionals. She cites medical control as an example of his concern with "elements of our social structure and culture that deny individual freedom and growth by imposing unnecessary forms of social control" (p.46). Habermas (1984) argued that patients' access to medical knowledge is limited by health professionals, whose power-laden communicative techniques simultaneously override patients' subjective views and social contexts. This distorted communication leads to what he describes as the process of colonisation of the lifeworld, exemplified in the medicalisation and pathologisation of normal events (e.g., birth) to "illness" events requiring medical intervention.

In describing Habermas' notion of colonisation of the lifeworld, Grbich (1999, p.46) identifies four areas of potential conflict within the parameters of the client/health professional interaction:

- The patient/client view of the situation as "normal" (part of their lifeworld), compared with the health professional's view of it as pathological (medically-oriented).
- The (devaluing of the) individual's lifeworld knowledge versus (or in favour of a greater emphasis on) medical knowledge.
- Control of the situation by a health professional at the expense of individual control.
- Limited/restricted communication where patient/client questions are often ignored or labelled "neurotic".

There is a tension in this model between the implied dominance of the health professional and the ideal situation of negotiation between equals. Thus, congruence between the perspectives of both parties, for example over the degree of medical intervention required, could denote genuine shared agency, but could also be interpreted as demonstrating the successful colonisation of the patient's lifeworld by the power of the "medical world".

This paper draws on findings from a qualitative study that explored the accounts of 14 women who were being treated for depression, to examine their descriptions of their interactions with service providers, predominantly medical practitioners. We have located these descriptions within a framework based on the above four conflict areas identified by Grbich (1999). Our intention is to present the complexity of the women's accounts, with a view to elucidating the mechanisms mediating power and control in the help-seeking process.

Method

To assist in developing the parameters of the project, a reference group of health professionals including general practitioners, a psychiatrist, psychologists, and health researchers was established. A notional profile of women to be included in the study was developed through this consultation process. The project proposal, including details of informed consent procedures, risk minimisation strategies and interview protocols, was approved by Victoria University's Human Research Ethics Committee. Participating women were accessed through staff at four community health agencies in the western suburbs of Melbourne, Australia, a region marked by significant socioeconomic disadvantage. The guidelines for referral of women for interview in the project were as follows:

- The woman had been prescribed one of the following medications within the designated dose range: Tricyclics 75mg plus; SSRI 20mg plus; MAOI 300mg plus.
- The medication had been prescribed within the past 1-6 months, though the woman need not necessarily still be taking medication.
- The woman needed to be currently accessing a support service.
- The depression had not been diagnosed as post-natal depression.

- The woman was not currently at risk of suicide.
- The woman would not require an interpreter for the interview process.

Thirteen of the 14 women who participated in the study were aged between 30 and 65; the remaining woman was 81 (group mean age 46; median 45). She was included despite falling outside the intended age range, because her account offered a counterpoint from an older cohort, with some experiences in common with younger participants, and some divergence in her responses. All women were interviewed at home except one who was interviewed at her local community health centre. All but one of the participants were currently taking anti-depressant medication, while the remaining woman had stopped in the previous month. All had been prescribed anti-depressants within the past six months though several had been taking them for much longer and/or had done so for periods of time in the past. All had sought assistance from a variety of health practitioners, including general practitioners, social workers, psychologists, psychiatrists, community nurses, and other specialist counsellors.

Eight broad questions were used to elicit the women's stories during a one-hour interview which formed part of a larger study examining constructions of depression by both women patients and a range of health practitioners (Hood, Egan, Gridley, & Brew, 1999). The women were first asked in non-directive terms about their understandings of how they came to be prescribed anti-depressant medication. Three women associated their depression with unresolved grief over the death of a child or other close family members. Nine disclosed that they had been suicidal at some point, often coinciding with a major life event. Three also spoke of having experienced post-natal depression in either the recent or distant past. Five of the women indicated that they had been sexually abused as children, all by family members. Three others spoke about physically and/or sexually abusive relationships with current or previous partners. Since the women were not directly asked about abuse experiences, it is likely that these figures understate the incidence of abuse in their histories. (All three interviewers were experienced health professionals who were able to respond appropriately to these disclosures.)

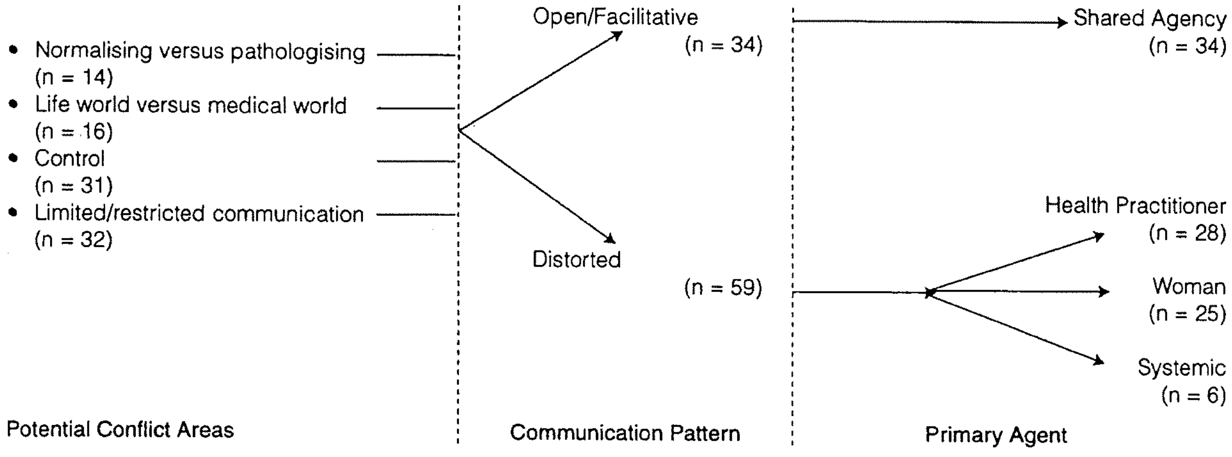
The questions which provided the data for this paper pertained to the women's experiences of seeking help with their depression—what attempts had been most or least useful, how "people could help you get well", and finally, "Could you describe the process of getting well?"

Findings

Interview transcripts were stored and analysed using NUD*IST (QSR Version 4, 1998). Each line of text represents one text unit, and the 14 interviews provided 9156 text units. Of the total text gathered, 29% (2615 units) related to their interactions with health practitioners. Through a process of ongoing dialogue between the four research team members, 80% of this text was coded within the developed framework. These percentages provide one indication of the amount of "airspace" the women gave to their help-seeking interactions. The research team consisted of three health professionals and a data manager. The primary author of this paper, together with the data manager, were initially responsible for coding the text according to the original four-category framework, and storing it via NUD*IST. The other two researchers then examined the text against the proposed categories, including the 20% of "interactions" text not considered relevant to the framework. They interrogated the initial choices, discussed overlapping categories, and made alternative suggestions. All four then engaged in a series of reflexive discussions that eventuated in the refined framework presented in Figure 1.

Figure 1 presents a schematic overview of the data organisation, with the line-by-line text units collapsed into the number of actual responses per category. The four potential conflict areas outlined by Grbich (1999) formed the foundation of analysis. Each of these conflict areas could be identified within the dialogue as associated with either negative, distorted communication (DC) or facilitative, open communication (OC). Analysis of the text in the areas of distorted communication identified three potential agents for that distortion. Agency was defined as a position from which a party was described as taking an active part in the construction and understanding of the interaction. Where women reported interactions they believed had been controlled by the health practitioner, these were coded with health practitioner (HP) as agent. Women (W) also represented themselves as agents, in some cases this being described as a deliberate strategy. The third agent for distortion was systemic issues (S), which pervaded all four conflict areas.

Figure 1: Coding framework for women's descriptions of interactions with their health practitioners.



Numbers in brackets indicate number of responses per category. Communication patterns associated with each of the four conflict areas are described below with textual examples of open and distorted communication. Where the communication is distorted and the health provider is nominated as agent this is identified as DC-HP, while distorted communication with the women as primary agent is labelled DC-W. Examples of open communication are simply identified as OC, as there is shared agency between the practitioner and woman. A separate analysis is provided for textual references to systemic agents (DC-S) of distorted communication.

Conflict area 1 - Pathologising versus normalising of woman's experience/ symptoms

This area of conflict identifies the communication patterns salient to the fundamental construction of depression as either a pathological/biological process dictating a medical response model, or a sociocultural phenomenon, where the experience of depression was normalised as an appropriate response to a stressful environment. Distorted communication resulted from incongruence between the parties' constructions of the depression; for example where the HP pathologised an experience the woman felt was normal (designated DC-HP):

> *He asked me how I was feeling, I said "I feel suicidal" well he jumped out of his chair, he almost went hysterical. He said, "I'll have to call the CAT (Crisis Assessment Team) team in"... I had to change my whole situation and build a picture that he was happy and comfortable with. So I had my three sessions with him and was offered three more and I said, "well thank you very much, but no thank you".*

Medication was also frequently offered to women with little acknowledgement of their life experience. An example was the prescription of antidepressants without any accompanying grief counselling for a woman experiencing the death of her brother:

> *I wanted someone to talk to me and tell me that what I am feeling is normal...she just sat there and listened to me and gave me a whole heap of pills, and kept telling me to take more...and of course I did.*

In contrast to the above examples, four women in the study demonstrated the reverse of this understanding; they wanted their distress validated as a medical condition, and perceived the HP's normalisation as devaluing their own experience of symptoms (designated DC-W):

> *I came in here one day and I said "... I need some help, and don't tell me to go away and be brave, because I cannot be brave any more, I need help." ...I knew I needed something...I was a mess.*

OC: Open communication between the health practitioner and client emerged where women felt validated by the practitioner's representation of their depression:

> *I can sit there and talk through about it and she tells me, "Oh it is a very hard situation", she will tell*

> *me that I am normal and "it is not bad to feel the way you feel". Because you want reassurance from people, you don't want to sit there and someone "yes, yes, yes..."*

Identifying depression as a biological illness with pharmacological interventions provided one woman with an end to her fear of physical illness and her struggle to manage and make sense of symptoms:

> *... I thought I had many different things... I thought maybe I'm sick, maybe something's wrong with me, having all those pains... my blood pressure was OK, nothing wrong with the heart... I didn't have cancer... I just went to the specialist (ear, nose and throat) he sort of pushed me on the right spot ... he said this sounds like a nervous problem ... it sort of led me to think, "yeah that might be depression"...being on the tablets has helped those feelings ...I woke up and I (thought) "Oh I feel nice, I feel okay, this is working"...I don't have a fuzzy feeling in my head...those physical effects I don't have anymore, I don't have headaches, I don't have those pains and aches.*

Conflict area 2 - The individual's lifeworld knowledge versus medical knowledge

This area is closely associated with conflict area 1 in that the women's experience was medicalised, with an accompanying lack of acknowledgment of the women's lifeworld knowledge. However, conflict area 1 relates more to the way the woman and the health practitioner initially engage, which could be aligned with diagnosis of symptoms within a medical model. Conflict area 2 relates to ongoing emphases in the interactions between the woman and health practitioner, which could be aligned with treatment approaches.

DC-HP: From the women's perspective distorted or unsatisfactory interactions occurred when the HP did not incorporate their lifeworld into the treatment plan. The women appeared not so much to reject the medical approach as to want it accompanied by a realistic assessment of their life circumstances, which were often exceedingly stressful and abusive.

> *... the psychiatrist came to visit me whilst I was in hospital and he hardly talked to me at all. He didn't talk about any of the issues that were happening. He just said that I need to stay on the Arapax and that "you've just got to face these things and deal with them yourself". So I haven't seen him since.*

DC-W: The women were identified as having some agency within this conflict area when they rejected HP's medical knowledge as inadequate:

> *...The first couple of months I actually got a lot worse. I went into deep depression, major anxiety. I found it really hard to get information, I went back to my doctor and said "Look, is it possible that this medication could increase my anxiety?" He said no, he said it would all be in my mind. That I'm thinking it is increasing it and so therefore it is. And I wasn't satisfied with that because I know myself reasonably well ...*

OC: Open communication within this potential conflict area occurred where the lifeworld of the woman became incorporated into the strategy of assistance and was supported by the expertise of the health practitioner. An optimal example of this integration was one woman's description of the process of getting well:

> *Well, being able to get help and take tablets so that I could figure out what was going on in my brain, confronting my father and dealing with being abused. Getting the right help with counselling.*

Conflict area 3 - Control

The third potential conflict area, focusing on who exerts primary control in healthcare interactions, emerged as a key issue for all women interviewed.

DC-HP: Agency for the distorted communication was attributed to the practitioner when the women referred to feeling intimidated or silenced by the HP's assumption of control of the encounter.

> *And I went to my GP and she sent me to the social worker attached to the health centre. And at first I thought it was good because I was able to vent all my feelings and stuff. After a while she had all these solutions for me, ready made, and she got quite cross with me in the end because she wanted me to take one of them.*

Further examples of HP control were described by women who felt they had no agency in determining the focus of the therapeutic encounter:

> *I told him that I was gay and the whole issue became that I was gay, not that I was depressed. And I couldn't get through to him that that wasn't the issue, that wasn't what made me take an overdose, it was my whole life situation ...*

DC-W: Examples of distorted communication initiated by the woman commonly related to prescription drugs, with six women describing how they had acted to maintain their supply:

> *I saw just about every doctor you could see. I had all these clinics that I would go to. At least five days a week I was at the doctor somewhere, getting tablets.*

> Interviewer: *And you would just say you had migraines?*
>
> *Yeah ... Most people gave them to me if I told them I had a migraine and everything. They would just give it to me, I wouldn't even have to lie.*

OC: Open communication occurred within this potential conflict area where women felt they were gaining control over the depression through the assistance offered. One woman contrasted her experiences with a psychiatrist and a sexual assault counsellor:

> *Psychiatrists ... I know that they assess but I needed feedback ... that's why I found the counselling, because you need a view more ...*
>
> *What I found with CASA* [sexual assault centre] *is, I know how the abuser works. So I can understand the game ... I needed something to work with, a practical method ... I've regained my strength and I've got no baggage to hide ... So I'm in control of myself.*

Conflict area 4 - Limited/restricted communication

The fourth coding category, focusing around limited or restricted communication, related primarily to how much or how little information was divulged in the interaction. Again the framework encompasses the agency of both parties in the interaction.

DC-HP: Distorted communication with the HP as agent commonly related to perceptions by women that treatment did not include explanation or information provision.

> Interviewer: *What did you mean by saying you thought you were a worrier sort of person and you probably will always be like that?*
>
> *I panic and I get tensed and* [the doctor] *said "you will always be like that". So I don't know what he really meant by that, because he didn't explain himself. He just said "you will always be like that for the rest of your life". So whether I have to stay on them* [anti-depressants] *for the rest of my life I don't know!*

DC-W: The deliberate withholding of information from the HP was a major theme to emerge from women's accounts. For some this meant a reluctance to disclose a history of abuse.

> *When I think back now, it was stupid of me ...but because I hadn't divulged that I was abused to the GP, that was the outstanding thing to treat, so, I don't know how I got through that ...*

For others, withholding of information related to their use of prescription drugs.

> *Well I was getting migraine so I was taking very strong pain-killers and that sort of defeats the purpose of taking anti-depressants.*
>
> Interviewer: *So did your psychiatrists talk to you about that?*
>
> *Well see it was very complicated because I kept it hidden from a lot of people. I actually was, how should I put it, (laugh), I was addicted to the pain-killers and the Valium.*

OC: All 14 women described some level of open communication with at least one health practitioner. A number expressed relief at finding a health practitioner with whom they could disclose events and thoughts they had previously kept hidden. For some this involved seeking help with feminist agencies where they felt their issues were heard and understood:

> *I know that when things keep going wrong, going to CASA has helped me.*
>
> Interviewer: *Because?*
>
> *Because I feel safe there. And I can tell them everything I want to.*

For other women the gender of the HP was an important factor:

> *I'd never really been to a woman doctor. I always prefer to go to men because I can con them, which I think is a dreadful thing to say, but I found I could get more out of them, like a medical certificate or bits and pieces, by being a lost, helpless woman. And the funny thing was, when I went to* [woman GP] *I didn't try any of that ... I just came away and I thought, this is so different. I'm actually talking to another women who understands what I'm talking about.*

Alternatively, one woman reported that support from a male HP in relation to her domestic violence situation enabled her to move forward:

> *... I ended up getting a male nurse and we spent nearly an hour and a half on the phone ... and when I got off I thought to myself, this is a man's point of view and he's telling me what's happening is wrong ...so then after I spoke to him I started thinking about it.*

Another appreciated receiving information on how her anti-depressant medication worked:

> *The psychiatrist explained to me about the effects of what it really does ... the idea of the medication is*

> *that it virtually kick-starts your brain. He explained it very well ....*

Systemic factors influencing communication

This additional coding category related to distorted communication resulting from systemic issues controlling the quality of the interaction (DC-S). The most frequently cited issue was access to appropriate services:

> *These people are so busy that you really feel like you are just a ball in the line and that's not their fault, and it is not your fault, but you get the impression that you are just one of a line in a million that are going down there and they really don't have the time and you get the impression that they don't have any interest. Now I don't think that's right, I think that they have the interest, they just can't get on with it.*

This issue of time constraints was further compounded by socioeconomic factors that limited access to appropriate care:

> *With their limited time they listen to you but we need more people, professional people who you can grab hold of and talk to. In my case I couldn't afford to go to a private psychiatrist you know. For me that is out of the question.*

Limited availability of specialist services meant that women often felt that, despite the willingness of their HPs to provide support, they had limited training or skills:

> *The two male doctors couldn't really help me because I would just go in and give them a whole load of bullshit and cry and carry on and con them, because all I really wanted was tranquillisers and I don't think they could, ... they were GPs. They just didn't have the depth of experience. ... They tried to help, but they were better with other elements. Like if there was something wrong with me gynaecologically they could refer me to a gynaecologist... But mentally they couldn't really help me.*

Discussion

While feminist and social health approaches to health and illness typically and appropriately take a macro perspective, such explanations can be initially disempowering to those most affected, by constructing them as victims of forces beyond their control. In the case of women experiencing depression, feminist theorists such as Jack (1991), Lorber (1997), and Stoppard (1998) argue that the production of explanations for women's disproportionately high rates of depression should begin with the accounts of women themselves, maintaining the personal-political nexus at the heart of feminism. Similarly, Cosgrove (2000, p. 247) calls for a rapprochement between phenomenological approaches that privilege agency and emphasize "the richness and complexity of an individual's lived experience", and social constructionist strategies highlighting "the discursive production of power, femininity and psychopathology".

The data in this study consist of the accounts by 14 women diagnosed with depression of their interactions with health practitioners. Our analysis locates these descriptions within a framework based on four conflict areas identified by Grbich (1999) as products of distorted communication (Habermas, 1984), in order to examine mechanisms of power and control in the help-seeking process. The quantitative fit between the framework and the mass of data is impressive in accommodating 80% of the women's descriptive accounts of their help-seeking interactions. The framework itself provides a way of appreciating the complexity and elucidating the process of "getting well".

While the starting point for the data analysis was Habermas' (1984) critique of medical dominance, it proved necessary to acknowledge the agency of the women themselves in the interactions. From the frequencies reported in Figure 1, the number of instances where the woman was designated as the agent of a distorted communication, or where her perspective reversed that which might be expected by a unidirectional model, almost equals the number ascribed to the health practitioner. When the responses implicating systemic factors are included, it appears that the onus of control of potentially conflictual communications does not rest exclusively with the individual health practitioner.

We define agency as a position from which a person takes an active part in the construction and understanding of their experience. The health practitioner's agency predominates where there is a lack of respect for or acknowledgement of the woman's perspective, thus exacerbating the power imbalance inherent in the relationship, and contributing practically to distorted communication. The agency of the woman service user is evident where her (re)actions represent a rejection of, or departure from, constructions available from the health practitioner or health system, although her choices are more limited in imposing her construction on the encounter itself. Sometimes the woman's agency takes a direction opposite to what might be expected from a dichotomous "lifeworld versus medical world" model, for example in expressing a preference for biomedical explanations of her distress. In the data analysis we illustrate how shared agency between service user and service provider can result in open and constructive communication.

The coding framework is not to be viewed as four mutually exclusive conflict areas, as overlap between them is evident. Rather, the women's accounts tend to resonate with some areas more than others. However, the weight of evidence suggests that the salient issues for these women are not so much a matter of conflict between the medical ("women's bodies") and lifeworld ("women's lives") perspectives, as a battle for control within the relationship. This battle serves to limit or restrict the chances of open, coercion-free communication as advocated by Habermas (1984). The number of responses allocated to conflict areas 4 and 5 was more than double the number allocated to areas 1 and 2 (refer Figure 1), notwithstanding the acknowledged overlap between all four. Furthermore, areas 1, 2 and 4 can be subsumed under the heading of control (conflict area 3), but not vice versa. For example, it follows that when a woman experienced her situation being pathologised, or failed to receive relevant information, the health practitioner could be seen to exert control over the relationship at the expense of supporting the woman in gaining control over her depression.

The first two conflict areas, reflecting the first two styles of relating outlined by Grbich (1999), parallel the literature around the medicalisation and pathologisation of women's experiences, whereby distorted interactions might be expected to set the woman's lifeworld against the practitioner's medical world. Distorted or unsatisfactory interactions occurred when what the woman thought of as normal had been pathologised by the health practitioner, or when their lifeworld was not valued or incorporated into the treatment plan. Insofar as the woman views her depression as a normal response to a stressful environment in line with Belle's (1990) analysis of depression, while the health practitioner construes it as pathological, her experience confirms Habermas' (1984) and Mishler's (1984) critiques of medical service provision.

While some women found an overly medical response alienating, and few were unequivocally happy to be taking medication, others attributed part of their progress to the naming of their problem as a depressive but treatable illness, and perceived health practitioners' reluctance to do so as not taking their experience seriously. This accords with Stoppard's (1998) recognition of the value of medically naming women's experiences, which "not only legitimises women's complaints but offers the promise of some form of treatment to alleviate their distress" (p.13). In some instances the health practitioner's medical knowledge was not deemed adequate by the women. It is arguable that the expectation of a medical "solution" is evidence of successful colonisation of the individual's lifeworld by the dominant medical world. However, the agency demonstrated, for example, by one woman calling the pharmaceutical company when she was dissatisfied with her doctor's response to her queries cannot be construed as acquiescence. This added dimension acknowledges the woman's role in the interaction with the health practitioner, and raises the question of congruence between her expectations and her experience of treatment. As one woman declared, "I would gladly go to anyone that would understand what I am talking about."

Tensions between lifeworld and medical world constructions were certainly present in some women's accounts, but the key area of conflict raised by all participants was the pervasive issue of power and control in the help-seeking process. Accounts by the women that were coded in terms of health practitioner control commonly described situations where there was a solution focus in the service provision, with instances of practitioners becoming angry when their proffered options were not followed. In a review of the literature around doctor-patient communication, Ong et al. (1995) suggest that if a doctor-patient relationship is paternalistic, with high physician control, then instrumental/task-oriented behaviours are likely to be salient. This is supported by descriptions of distorted interactions where the health practitioner assumed control of the process at the expense of the woman's agency. While the literature typically refers to such control being exercised by medical practitioners (Shapiro et al., 1983; Mishler, 1984), the women also gave examples of social workers and other practitioners behaving in a controlling manner. There was also an example of appropriate control exerted by a practitioner when a woman was in crisis and likely to overdose, supporting Perkins' (1991) argument that professional power need not always be characterised negatively: "Power does not have to be repressive - it can actually facilitate better, more satisfying lives for people" (p. 136).

Unidirectional understandings of professional power risk overlooking the degree to which the client may act to retain control of the interaction. In the current study, there seemed to be a difference between control on the women's part which served to maintain distorted communication, and their exercise of choice in ways which enhanced interactions and the efficacy of their treatment. For example, there were a number of instances where the women described themselves as exerting control at the expense of open communication with a health practitioner. This control could be exercised by seeing a series of doctors, or else was maintained within a single long-term client-health practitioner relationship.

The fourth coding category around limited or restricted communication relates to how much or how little information is divulged in the interaction. For the women's part, the deliberate withholding of information from their health practitioner appeared to represent a form of passive control of the encounter. In retrospect, they generally viewed this restricted communication as being to their detriment, in that they came away unclear about treatment options, or without having disclosed significant information which later proved critical to their progress. Sometimes the woman would wait until she trusted the health practitioner sufficiently, or until she felt she had established some control of her symptoms. "All I said was I was sick. All these tests she gave me and she still couldn't work it out until about the fourth visit. I just sort of let it all out."

The literature linking the nature of health practitioner-client interactions with outcomes for engagement in a treatment plan (Waitzkin, 1984; Stewart, 1995) emphasises factors which enhance compliance, and typically focuses on physician virtues (Gilligan & Raffin, 1997) or the agency and behaviour of the health practitioner. This study has focused on the client's perspective, in the specific situation of women with depression. The women's accounts highlight the complexities of shared and contested agency within such interactions. One woman who had previously overdosed accepted a prescription for a large supply of tranquillisers, then resisted taking them from the pharmacist when she knew she felt at risk; her concern was overruled, resulting in a subsequent overdose. This example confounds one-way conceptualisations of the patient's level of compliance with prescribed medical treatment, although the marketing power of pharmaceutical manufacturers casts a shadow over the agency of all parties in such a scenario.

The findings of this study appear to confirm the centrality of power and control issues in health practitioner-client interactions. While the women offered numerous instances where they acted to gain or retain control of the process by withholding information, "doctor-shopping", or seeking alternative or multiple sources of support and information, rarely did their agency extend to a direct questioning or confrontation of the health practitioner's authority. Gridley, Johnson, Moore, and Higgins (1998) reported similar responses on the part of women describing a negative encounter with a medical practitioner. Genuine agency on the part of the women still needed to be supported by the practitioner's lead, whether by referring to other practitioners who specialised in counselling around the woman's life circumstances (such as grief or sexual assault), tailoring treatment to take account of her expressed wishes, or simply by giving her permission to "ring him ... anytime I am down and need to talk".

Financial and systemic considerations also need to be included as limiting the agency of both parties, given the concerns expressed by several women, and echoed in the findings by Shapiro et al. (1983) and Lambert et al. (1997) about the ways in which organisational constraints limit the implementation of optimal patient-centred care. The women in our study described the health system as exerting control over their interactions with health practitioners by limiting the time available, or by not rebating the prohibitive costs of private counselling services. O'Connor (1998, p. 47) observes that "what women value as good practice" is jeopardised by policies designed to reduce public sector costs or privatise service provision.

Available evidence (Ellingson & Buzzenall, 1999; Lambert et al., 1997; Stewart & Roter, 1989) indicates strongly that open communication and shared agency enhance treatment efficacy and promote quality of life and health status. The experiences of the women in this study were mixed at best. While Habermas' proposed solution of a shared understanding may "fail to take into account that all interaction and communication are inherently incongruent and paradoxical" (Grbich 1999, p. 45), such a goal seems worth pursuing if it leads to better outcomes for women with depression. An emphasis on shared agency or genuine partnership emerges from this study as a pointer to best practice within an acknowledged context of power differentials and systemic limitations working against the ideal. Conditions which appear from the women's accounts to promote open communication include time, a sense of safety, a partnership approach based on shared information, same-gender (in some cases), and an understanding of and willingness to engage with the client at an affective level. In sum, the women's accounts bear the message "Take me seriously, treat me seriously".

This small-scale study provides a framework to explore and reconceptualise women's accounts of the complex interactions occurring as they seek help in their pathways out of depression. The shift away from dichotomous positions to focus on power and control mechanisms represents an attempt at a materialist-discursive account as advocated by Stoppard (1998). It affirms the validity and vagaries of the women's journeys, locating them as active, though not equal, partners in healthcare interactions, while acknowledging systemic agents distorting the help-seeking process. For health practitioners it provides an opportunity to reflect on their potential contribution to shared agency and open communication as key elements enhancing the quality of life and health status of women experiencing depression, at least within the crucible of the help-seeking encounter.

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