"She can be a super hero, but she needs her day off": Exploring Discursive Constructions of Motherhood and Depression in Emerging Adult Talk Surrounding Maternal Depression

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“She can be a super hero, but she needs her day off”: Exploring Discursive Constructions of Motherhood and Depression in Emerging Adult Talk Surrounding Maternal Depression

A Dissertation
Presented to
The Faculty of Social Sciences
University of Denver

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

by
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Dr. Elizabeth Suter
ABSTRACT

Despite studies demonstrating the impact of health on the family and the family on members’ health, research exploring this intersection remains scant in both family communication and health communication. This study explores the nexus of health and family by examining constructions of motherhood and depression in emerging adult talk surrounding maternal depression. Using relational dialectics theory as the theoretical lens, the study examined talk collected in 36 one-on-one interviews with emerging adults asked to describe their experiences of having a mother with depression. Participant talk surrounding motherhood voiced two primary discourses of motherhood: (1) the discourse of real mother and (2) the discourse of ideal mother. Participant talk surrounding depression included four primary discourses of depression: (1) the discourse of depression as sadness, and (2) the discourse of depression as illness, (3) the biomedical discourse of depression, and (4) the psychosocial discourse of depression. Participant talk surrounding both motherhood and depression was a dialogically rich site of study with a high degree of diachronic separation, synchronic interplay, and transformative dialogue. Results demonstrate that meanings of motherhood and depression remain highly contested in emerging adult narratives.
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At its core, this project was and is for my participants. Your resilience, compassion, and bravery demonstrate that every individual, no matter how young, has a powerful and beautiful story to share.

To my mentors: Beth, thank you for teaching me more than I thought possible about research. Erin, thank you for teaching me more than I thought possible about teaching. Jill, thank you for continuing to advise me ten years beyond that first meeting.

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To my family: Keith, Krista, Joe, and Andrea, thank you for always welcoming me home with open arms and letting me be a part of Owen, Cason, Lucas, and Emily’s life. Dad, thank you for agreeing to pay for my car insurance as long as I had my first car or was in school, not realizing I would do both for twelve years.

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CHAPTER ONE

INTRODUCTION

Along with providing individuals their first and often longest-lasting relationships, the family has long been regarded as a primary and powerful socializing unit for its members (Dunn, 2015; Grusec & Davidov, 2007). Parents, and in particular mothers, are integral to these communicative socializing practices (Ebersole, Miller-Day, & Raup-Krieger, 2014). We learn about our family through our family stories (Koenig Kellas & Kranstuber Horstman, 2014). We develop ideas about gender roles and expectations and learn patterns of relational interaction by communicating with family members (Stack & Burton, 1994; Wood, 2012). Even after leaving our families of origin in adulthood, we recall memorable messages from family members that continue to impact the ways in which we live and understand our lives (Lucas & Buzzanell, 2012; Medved, Brogan & McClanahan, 2006).

It is not surprising then that we also begin to establish our beliefs, attitudes, and behaviors surrounding health through communication about health within the family (Geist-Martin, Ray, & Sharf, 2003; Pecchioni, Thompson, & Anderson, 2006; Segrin & Flora, 2006). In fact, everyday interactions and conversations in the family can impact how we make choices surrounding our health in addition to how we negotiate meanings of health and illness (Bruss et al., 2005; Tardy & Hale, 1998).
Just as the family serves as a central socializing unit in shaping members’ understanding of health, disruptions in health such as the diagnosis or maintenance of an illness shape members’ understanding of family. Because illness is inextricably linked to one’s body, it is often conceptualized as an individual experience. However, it is more accurately described as that which is physically experienced by one but socially and emotionally experienced by many (Jones, 2002). The experience of illness in the family, whether minor or life threatening, has the power to alter individual family members and their relationships to one another, as well as the family unit as a whole (Kawanishi, 2006). When a family member is ill, other members may undergo small and large-scale changes such as performing new tasks, handling new responsibilities, or taking on new roles. Because of this, illness in the family often requires family members to renegotiate their own roles and responsibilities, the roles and responsibilities of their family members, and their changing relationships to one another in the face of these renegotiations (Miller-Day, 2011). If the illness is chronic, these new tasks, roles, and responsibilities may become permanent, thereby altering the family and its members forever (Miller-Day, 2011).

Though numerous physical and mental illnesses have the potential to create drastic and profound changes to the family, of particular interest to this study is the experience of depression. Unlike physical illnesses that can be explicitly confirmed with medical tests, the symptoms and diagnosis of depression are often tied to social aspects moreso than biological ones. Instead of objective somatic tests, subjective self-reports often constitute the diagnosis of depression. Depression is most commonly diagnosed
using credentials set forth by the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Health Disorders (DSM)*. However, as our culture approximates thresholds at which individuals believe the durations and intensities of emotions are acceptable (Blazer, 2004), the boundaries of defining and diagnosing depression are often fuzzy (Horwitz & Wakefield, 2007). Therefore, correctly diagnosing and accepting a family member’s mental illness can be a difficult task (Tessler & Gamache, 2000).

Just as depression proves difficult for family members to understand, members may also struggle to understand the changes within their ill family member (Rose, Mallinson, & Walton-Moss, 2002). Unlike physical illnesses that affect one’s physical body, mental illnesses may present with not only somatic symptoms but also unseen psychological ones. As Kawanisha (2006) explains,

One of the most essential and difficult struggles in dealing with a loved one’s mental illness is that both their personality and behavior are invaded and plagued by the illness. The line between personhood and the disease is seldom clear. (p. 141).

With no definitive line between person and illness, depression requires a negotiation of both the illness and the individual. Truly, in the greying of the line between the illness and the self, the experience of depression stands as a rich site wherein to explore how individuals communicatively make sense of both the individual and the disease.

Because depression is in part socially constructed and experienced with the other through its relational manifestations, understanding the cultural discourses circulating in society surrounding depression can help researchers understand how individuals with a
depressed family member make sense of the illness (Horwitz, 2011; Jones, 2002; Solomon, 1998). As this study will explicate, a number of competing ideologies circulating in our culture at large exist in explaining depression. In examining if and how individuals call upon these variant discourses, we can better understand how cultural discourses of depression inform emerging adults’ discursive attempts at trying to make sense of their mothers’ depression. Understanding how members construct their understandings of depression is incredibly important in that family members’ understandings of the illness can affect whether and how they provide care, take on responsibilities, and even accept their family member as mentally ill (Jones, 2002; Solomon, 1998).

Despite evidence demonstrating the bidirectional relationship between understandings of health and understandings of the family, research in family communication focused on health has historically been a neglected area of communication inquiry (Cline, 2003). Thankfully, this intersection of health and family communication research has been marked by rapid growth in the last decade (Galvin & Braithwaite, 2014). The majority of this contemporary work explores communication patterns following the diagnosis of an illness. These studies predominantly examine how families disseminate information about a member’s illness (Zhang & Siminoff, 2007), how family members respond to hearing about a member’s illness (Hay et al., 2009), and how family members make decisions together regarding care (Clayton, Dudlye, & Musters, 2008). Each of these aforementioned bodies of research demonstrates the rich potential in examining communication at the intersection of health and family.
Nonetheless, each also continues an intellectual tradition in family communication that positions the family as a private and contained relational unit separate from the societal and cultural contexts surrounding it (Baxter, 2011).

The separation between family and the societal and cultural contexts within which the family is embedded is unfortunate in that communication about family is laden with beliefs, assumptions, and expectations carried from culture. Similarly, understandings of health and illness are also laden with ideas, assumptions, and expectations carried from and shaped by social factors and institutional practices that extend well beyond the relational borders of the family (Bottorff, Oliffe, & Kelly, 2012). Perhaps most importantly, cultural understandings of health and illness and cultural understandings of family often evolve concomitantly and can reinforce or challenge assumptions of the other (Dolgin, 2014). For example, advances in reproductive technologies in the medical field have allowed for opportunities in non-traditional families not previously available.

Conversely, the continued evolution of what constitutes a family has implications across a wide array of health contexts from the increased use of genetic testing and genome mapping in making health decisions to determining who is allowed to be a part of health decisions. Therefore, an examination of how individuals come to make sense of illness and their family member(s) as a result of that illness should include an examination of not only the immediate relational discourses circulating within the family but also the cultural discourses surrounding it. Truly, to better understand both how individuals understand illness and family, the inclusion of culture is not merely warranted, but necessary.
Recent work by family communication scholars does answer the call to understand family as it operates amongst and within societal and cultural contexts (Baxter, Suter, Seurer, & Thomas, 2014; Norwood, 2013; Suter, Seurer, Webb, Grewe, & Koenig Kellas, 2015). Much of this work examines how relational and cultural discourses shape individuals’ understandings of their family members such as Breshears and Braithwaite’s (2013) study on discourses surrounding the experience of having a parent come out as gay or lesbian and Norwood’s (2010) examination of discourses surrounding family members’ understandings of having a transgender family member. Other scholars have examined how cultural discourses inform individuals’ understandings of their own familial identities. For example, Suter et al. explored how female co-mothers constructed understandings of their motherhood. Similarly, Baxter et al. examined how foster adoptive parents constructed understandings of the meaning of their family.

This small but growing body of work in family communication clearly demonstrates the pervasive power of cultural assumptions, ideas, and understandings in shaping how family members come to understand themselves, their family members, and their family unit as a whole as it sits in relation to culture. However, family communications scholars have yet to make similar intellectual steps towards the inclusion of culture when examining topics of health. As such, a rich but unexplored nexus wherein to explore the intersections of family, health, and culture is in communication surrounding family members’ health (Pecchioni, Cook Overton, & Thompson, 2014). While the examination of any number of health topics stands to provide important
knowledge to the field of family and health communication, this study focused specifically on that of maternal depression

With roughly 8.3% of the adult population meeting the criteria for major depression within the last 12 months and 19.2% meeting the criteria at some point in their lifetime (Bromet et al., 2011), the prevalence of depression in the United States and its multiple variants of meaning in U.S. culture warrant continued examinations of the illness and how individuals understand it. This study focuses explicitly on maternal depression for a number of reasons. First, a significant amount of women experience depression with depression’s lifetime prevalence rate at approximately 20% for women with a median age of onset of 32 years (Kessler et al., 1998; Kessler et al., 2005). Second, a significant amount of women experience depression and motherhood concomitantly. In fact, approximately 68% of women meeting criteria for mental disorders over the course of their lifetime report being mothers with an average of 2.3 children (Nicholson, 2010; Nicholson et al., 2002). Third, women show earlier ages of onset, report greater severity of symptoms, and are more likely to experience chronic depression in noting a greater number of depressive episodes post initial diagnosis (Essau, Lewinsohn, Seeley, & Sasagaway, 2010; Kornstein et al., 2000). Considering its severity and duration of symptoms, maternal depression stands as an illness likely to generate a noticeable impact on the family (Kessler & Bromet, 2013; Nicholson et al., 2002).

Much like depression, understandings of motherhood are also comprised of dynamic concepts continually shaped by the cultural and historical contexts within which
they are embedded (Arendell, 2000). In a comprehensive review of late 21st-century scholarship on motherhood, Arendell notes that the predominant cultural ideology circulating in North America is that of intensive mothering. First articulated by Hays (1996), intensive mothering defines motherhood as a parental role uniquely fitting to women in that they are inherently skilled as parents in comparison to male parents. In the discourse of intensive mothering a woman is completely centered on her children’s needs with a mother being expected to: “devote her entire physical, physiological, emotional, and intellectual being, 24/7, to her children” (Douglas & Michaels, 2005, p. 4). The expectation of such high emotional and intellectual involvement in children’s lives positions overall expectations for mothers as increasingly demanding. Despite its demanding expectations, the discourse of intensive mothering remains the dominant model of motherhood (Liss et al., 2013) and a number of scholars have begun to examine how mothers from traditionally marginalized communities articulate their motherhood as it relates to the demands of intensive mothering (Elliott, Powell, Brenton, 2015; Manoogian, Jurich, Sano, & Ko, 2015) as these cultural expectations essentially set the bar for what is considered good mothering.

Though not explicitly studied in the cultural context of motherhood, prior explorations of the experiences of family members of the mentally ill note an inherent difficulty in accepting and caring for an individual unable to fulfill their normative social roles (Stein & Wemmerus, 2001). As Becker (1997) points out, “People consciously wrestle with some cultural ethos that is at odds with their life situation. This is particularly true when life circumstances do not fit with cultural ideas about what
constitutes normalcy” (p. 15). With expectations of motherhood embedded in an ideology of intensive motherhood wherein women are expected to be all and do all, the experience of depression as a mother stands to create a situation in which a mother may be unable to meet the expectations of motherhood as articulated by the dominant discourse of intensive mothering. Considering that depression often presents with symptoms such as chronic fatigue and a loss of interest in daily activities that can inhibit one’s ability to perform daily tasks (Mayo Clinic, 2012), it stands to reason that mothers with depression may at some points be unable to perform intensive motherhood.

Current research examining discourses of motherhood and their relation to experiences of motherhood focuses predominantly on mothers’ perspectives (e.g., Elliot, Powell, & Brenton, 2015). This voice given to mothers in research on motherhood is certainly intuitive and provides valuable knowledge to its study. However, it is important to note that individuals do not begin to construct understandings of motherhood only when they themselves become mothers. Further, these meaning making processes are similarly not limited to women as men too construct understandings of motherhood. Therefore, understanding the cultural discourses of motherhood in addition to how individuals accept or reject them in creating an understanding of motherhood can productively shift away from focusing solely on mothers themselves and give voice to other family members. Because motherhood is a continually redefined process that individuals engage in through interaction (Marshall, 1991; Tardy, 2000), research including children’s perspectives on motherhood and depression stands to provide a
unique and necessary component to fully understanding the maternal depression experience.

While expanding research on children’s perspectives of motherhood stands to enrich current knowledge in family scholarship at large, this study focuses specifically on the experiences of emerging adult children (18-25 year olds) in that emerging adults are old enough to have arguably shifted into some of the tasks and roles of motherhood that their mothers were unable to engage in during their upbringing. The shift from a mother caring for her child to a child caring for his or her mother, a process commonly referred to as parentification (Minuchen et. al., 1967), represents a discord with cultural expectations and age-appropriate expectations of care within the family (Tessler & Gamache, 2000). Shifts in normative roles of parents and children represent parent-child role reversals and among emerging adults with mothers with depression cause disruptions that yield negative psychological consequences for emerging adults (Abraham & Stein, 2013).

In examining emerging adults’ narratives of maternal depression, the study illuminates how individuals communicatively make sense of the identity of their mother in addition to her depression. This exploration into emerging adults’ understandings of motherhood and depression provides a welcome first step into an area of family communication research and health communication research rife with potential in expanding our understandings of the experience of mental illness within the familial context. The inclusion of emerging adults’ perspectives stands to provide a more nuanced understanding of how depression plays out in familial contexts.
In positioning communication as core to establishing and maintaining changing identities (Braithwaite, Galvin, Chiles, & Lie, 2013), exploring how emerging adults communicatively make sense of the experience of a mother’s depression in the family can generate invaluable understanding into how individuals make sense of maternal depression and motherhood. Considering the centrality of communication to the experience of depression and relationships, the lack of research conducted in the field of communication studies represents a clear path for enriching knowledge about depression and personal relationships in addition to extending relational communication theories into health communication contexts.

In addressing the dearth in scholarship and moving research featuring the inclusion of culture forward, the study sought to understand how emerging adults (18-25 year olds) with a mother with depression discursively make sense of the identity of their mother in addition to the disease itself. To do so, this study explores the communicative meaning making processes that occur within emerging adults’ narratives of their experience of having a mother with depression. To explore contested ideologies of depression and motherhood in emerging adults’ narratives of maternal depression, relational dialectics theory (RDT) frames the study.

Based in part from theorist Mikhail Bakhtin’s (1981; 1984; 1986) work on dialogism, relational dialectics theory (RDT) examines how language use creates and defines our individual and relational identities (Baxter, 2011). The theory positions meaning making as a localized process occurring through a discursive struggle of discourses voiced within talk (Baxter & Braithwaite, 2010). These discourses, or
generally understood systems of meaning and points of view that comprise our social world (Bakhtin, 1984; Baxter), interpenetrate in variant, complex ways within talk. Meaning emerges as the dialogic production of this interpenetration and struggle of discourses voiced within talk (Baxter, 2011).

In its explicit focus on discourses, RDT provides a utile lens through which to identify what cultural discourses individuals call upon when constructing meaning in their talk. Further, in highlighting the necessity to attend to the struggle of discourses in talk when multiple cultural discourses are identified, RDT enables researchers to understand how cultural discourses may be privileged, marginalized, or combined to create meaning. In doing so, the theory creates unique insight into not only critical understandings of family and health in demonstrating power dynamics between cultural discourses but also preemptive insight into the potential emergences of new cultural understandings.

Using RDT as the theoretical framework, the goal of this study is two-fold. First, the study aims to identify what cultural discourses surround emerging adults’ communication about maternal depression and motherhood. Specifically, the study seeks to uncover what discourses of maternal depression and motherhood animate emerging adults’ stories about having a mother with depression. Second, the study seeks to understand how the identified discourses create meanings of maternal depression and motherhood for emerging adults. Because the discourses surrounding depression and motherhood are complex and shifting, emerging adults’ stories of their mother’s
depression represent ideal texts in which to understand the construction of meaning via talk (Baxter, 2011).
CHAPTER TWO

REVIEW OF LITERATURE

In structuring a context for the investigation, this chapter will explore current articulations of the understandings of depression in addition to understandings and expectations of motherhood. The review begins with the historical account of the various understandings of depression leading into an exposition of how the disease is currently understood in U.S. culture within both professional and lay contexts. Literature on maternal depression will also be reviewed to explore how it sits in relation to these articulated U.S. discourses of depression. Next, U.S. understandings and expectations of motherhood will be reviewed. Following these reviews, the chapter will examine how mental illness in the family has been studied and in particular what current research can tell us about maternal depression, emerging adults, their experiences with depression in the family, and their utility in expanding research on understanding experiences of mental illness in the family. Finally, an explication of and theoretical justification for relational dialectics theory (RDT) will be provided.

Depression

Depression is a commonly occurring and often chronic disorder currently accounting for approximately 4.3% of the global burden (i.e., mortality and disability) of disease (World Health Organization, 2013). In what is regarded as the most comprehensive cross-national survey of major depression ever undertaken (Kessler &
Bromet, 2013), Usten et al. (2004) lists depression as the largest contributor to non-fatal illness burden worldwide across both developing and developed countries.

In the United States, depression is most commonly diagnosed through the use of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Health Disorders (DSM)*. The DSM-V (American Psychiatric Association, 2013) marks major depression as the inability to commit to day-to-day routines for at least two weeks and a concomitant report of four or more depressive symptoms (e.g., loss of interest, fatigue, rapid weight loss, or rapid weight gain).

While women and men both experience depression, the lifetime risk of a woman developing depression is significantly higher than that of men. In fact, both existent and current examinations of its epidemiology approximate a risk rate for women as twice that of men (Kessler & Bromet, 2013). Depression is also thought to be more persistent in women as they typically report a greater number of depressive episodes throughout both adolescence and adulthood (Essau, Lewinsohn, Seeley, & Sasagaway, 2010; WHO, 2011). While a number of proposed explanations explaining this discrepancy point to biological and/or sociocultural factors, it is of particular importance to this dissertation to also note the unique tie of depression to motherhood. Though most often studied in the context of new motherhood (i.e., postpartum depression), approximately one in five mothers report the experience of depression at some point in their lives (Nicholson et al., 2002).

Many individuals diagnosed with depression – regardless of gender – report embodied causes of the illness. In fact, almost three fourths of all primary care patients that are eventually diagnosed with depression initially present with physical complaints
(Blair, Robinson, Katon, & Kroenke, 2003). But, depression is not an illness understood solely through the body. In fact, a growing segment of contemporary research on depression notes the importance that individuals place not only on physical symptoms but also on social and cultural ones in understanding their illness (Galasinski, 2008). Beyond their bodies, individuals note their social and cultural positions (e.g., class, sexual identity, race) and relational difficulties (e.g., divorce, familial issues) in understanding their illness. These participants demonstrate a complex contradiction that sits at the crux of both intellectual and lay attempts to understanding depression. Does depression come from within the body or from the outside environment surrounding it? Would an answer to such an exploration help explain the gender disparity in rates of depression among men and women? Truly, depression and more specifically its causes are marked by a plethora of understandings each backed by impressive bodies of demonstrative research (Horwitz & Wakefield, 2007).

**Tracing Terminology: A Brief History of Depression**

Before discussing current cultural understandings of depression, it is important to briefly examine depression’s conceptual evolution from the earliest identifications of melancholy and madness to depression’s present-day position as a recognized and treatable mental illness. In doing so, one can better understand how depression as a disease has, from its beginning, been explored and understood through a variety of etiological narratives. As Hirschbein (2009) eloquently points out:

> Depression, like other diseases, has been constructed by social, professional, cultural, and gender forces around it. While the construction of disease in general has been a fruitful topic for many historians, psychiatric illnesses are particularly interesting to study because so much of what we think of as mental illness has
changed over time within transformation in American society and the medical specialty of psychiatry. The history of depression illustrates important shifts in physician practice and theory, professional issues within medicine, cultural factors regarding mental health and illness, and the gender basis of mental health. (p. 6)

Considering the multitude of influences at play in constructing depression, it should come as no surprise that even our present-day understandings of depression remain in-flux. Before exploring the complexity of depression as culturally understood today, briefly noting its historical shifts across time will ideally demonstrate the polyphony of forces and circumstances that have arguably led up to our multifaceted understandings of it in contemporary society.

From the earliest known writings on depression in the 5th century through the 18th century, what we now refer to as depression was discussed primarily as melancholy (Horwitz & Wakefield, 2007). In these writings, melancholy typically indicated an experience of extensive and persistent feelings of fear and/or sadness without an identifiable cause (Horwitz & Wakefield, 2007; Radden, 2000). During this time, two primary understandings of the etiology of melancholy emerged. One theory focused on melancholy as an illness originating within the body, while the other focused on melancholy as an illness coming into the body from outside forces (generally supernatural or spiritual in being). These two discourses would continue to shift back and forth in their dominance of acceptance across time (Radden, 2000).

Surprisingly, the earliest widely accepted theory of melancholy was one focused on the illness as medical in nature. Put forth by the Greeks, melancholy was understood as an illness explained by the humoral theory in which the four humors of the human body were thought to be imbalanced (Radden, 2000). During the Middle Ages, the other
primary understanding of melancholy’s cause, the cosmological-supernatural explanation, took precedence (Radden, 2000). This more theological view explained illness as resulting from sin or from a test sent by God and was arguably privileged due to the historical context of the time as Christian Churches were at the pinnacle of their power (Conrad & Schneider, 2010). Between the 16th and 18th centuries, in concurrence with the larger movement of the Renaissance, the medical model of melancholy once again regained its foothold as the dominant understanding and physicians began to play a larger role in the care of those suffering from the illness (Conrad & Schneider, 2010). Through the 19th and 20th centuries the medical model continued its reign (Conrad & Schneider, 2010).

In the early 1900s, an important rupture within the medical model of melancholy occurred. On one side, Emil Kraepelin and his colleagues focused on identifying the embodied signs of depression in order to develop clear scientific theories of mental illness. On the other side, Sigmund Freud and his colleagues focused on the development of psychoanalytics, which focused less on the physical body and more on the mind (Conrad & Schneider, 2010). The Freudian ideas of understanding and treating mental illness with psychotherapy continued to gain credence until the mid 1950s when the medical model of illness again became centered with the ushering in of psychotropic medication (Conrad & Schneider, 2010).

It is in the late 1950s and 1960s that the actual term “depression” began to emerge in psychiatric literature. Again drawing on the dichotomous facets of its etiology, depression was diagnosed as either exogenous or endogenous. Exogenous depression was understood as that which was generated by environmental matters. Endogenous
depression was understood as resulting from internal or biological causes (Schwartz & Schwartz, 1993). These terms were both later replaced in the late 1970s and singularly relabeled as “major depression,” thereby excluding the causational components of diagnosis in determining whether the illness was onset by internal or external factors. In 1980, major depression was formally included in the *DSM-III*, a term which remains today (Blazer, 2006).

Despite its relatively stable diagnostic definition in psychiatric literature from the 1980s to today, it is important to note that the cultural understanding of depression continues to evolve. This evolution is noted as one that is dependent in large part upon culture (Gotlib & Hammen, 2002). Unlike physical illnesses that can be diagnosed and defined through physical symptoms, depression is a mental disorder with an understanding intimately tied to the social aspects of the culture within which an individual is embedded. As Horwitz (2002) points out:

> Standards of appropriateness are not universal properties of the human species but culturally specific norms that regulate roles and situations. Social expectations of appropriate behavior must always play a part in determining whether behaviors indicate psychological dysfunctions, expectable reactions to social circumstances, or social deviance . . . Because judgments of appropriateness, rationality, proportionality, and the like are intrinsically connected to culturally defined normative systems, valid definitions of mental disorder always involve the use of social values. (p. 25)

Cultural variations exist in our parameters of appropriateness in expressing any emotion. Each culture unknowingly approximates what intensity and duration of these emotions is acceptable. A move beyond these parameters may be considered a move to depression (Blazer, 2005; Horwitz & Wakefield, 2007).
Considering depression’s dynamic history, it should come as no surprise that present-day research examines the illness with biological, psychological, and environmental lenses. Contemporary scholarship is marked by an equally diverse expanse of theories utilizing such frameworks in an attempt to better illuminate the mechanisms underlying its causes. Though a detailed account of such theories is beyond the scope of this chapter (for full review see Beck & Alford, 2009), the overarching assumptions guiding each are couched within two major camps of understanding: 1) the biomedical model of depression, and 2) the psychosocial model of depression. As such, the next section will articulate the central premises guiding both approaches and examine their pervasiveness in both professional and lay understandings of depression.

**The Biomedical Model of Depression**

Despite the rift in psychiatry in the 1950s caused by the movement of many to Freud and psychoanalytic ideas, a number of factors in the late 20th century seemingly bridged the division under a united acceptance of the biomedical model of depression. Among these factors likely includes the inclusion of major depression in the *DSM-III* and the rapid advancements in biochemical and genetic technology catalyzing an explosion of pharmaceutical research. In fact, the biomedical model and its assumptions of depression have largely dominated the last thirty years of depression scholarship (Blazer, 2005; Deacon, 2013).

Today, explanations of depression in professional contexts predominantly point to biological mechanisms as paramount to the etiology of depression (Hirschbein, 2009). The biomedical model of depression explicitly contextualizes depression as a biological
disorder or disease. This model stems from the larger discourse of the biomedical model of disease in general which is defined by Engel (1977) as that which:

[a]ssumes diseases to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological and behavioral dimension of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioral aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes. (p. 13)

In moving this biomedical model framework onto mental illness, the biomedical model of depression rests on the following tenets as outlined by Deacon (2013): “(a): mental disorders are caused by biological abnormalities principally located in the brain, (b) there is no meaningful distinction between mental diseases and physical disease, and (c) biological treatment is emphasized” (p. 847). In sum, depression is linked largely to biochemical and neurological conditions (Adame & Knudson, 2007; Blazer, 2005), stems from genetic or neurobiological issues (Ainsworth, 2000; Schwartz & Schwartz, 1993), and is understood, diagnosed, and treated best by modern medicine (Miller, 2010).

The biomedical model has become so prominent in recent years that the first decade of the 21st century has been referred to by some scholars as the “Decade of the Brain” (Miller, 2010). In fact, some scholars argue that its pervasiveness may be affecting funding by privileging projects that seek to understand depression through biomedical research and biomedical education, thereby pushing psychosocial theories and treatments to the margins of current inquiry in the field (Deacon, 2013; Pilecki, Clegg, & McKay, 2011). In addition to its wide acceptance in academic work focusing on depression, the biomedical model is also the primary explanation endorsed by a number of mental health-focused organizations including the National Institute of Mental Health,
the National Institute on Drug Abuse, the National Institute on Alcohol and Alcoholism, and The National Alliance on Mental Illness (Deacon, 2013). Despite its privileging in current research and among those organizations most closely tied to public education, it is important to note that there is another major narrative of depression which continues to be voiced both in professional and lay understandings of depression, the psychosocial model.

**The Psychosocial Model of Depression**

Broadly, psychosocial theories of depression rest on the assumption that the causes of depression stem not from biological discrepancies but rather a number of internal cognitive factors and/or external environmental factors (Ainsworth, 2000). Although the symptoms of depression may be exhibited somatically, the psychosocial model of depression does not equate mental illness with physical illness. As such, depression is viewed as an illness to be treated through various behavioral methods as opposed to explicit medical ones.

The earliest psychosocial theories likely trace back to Freud and his psychoanalytic theory, which defines depression as an inability to effectively deal with strong emotions such as sadness and anger. Individuals suffering from depression turn emotions inwards towards the self instead of processing and releasing them (Ainsworth, 2000). More contemporary psychosocial theories, commonly referred to as the cognitive behavioral theories, rest largely on the assumption that the way in which individuals process information mediates emotions and thoughts that may predispose individuals to depression. For example, Beck’s (1967) theory of depression posits that individuals with depression cognitively process information differently and arrive at different cognitive
products than non-depressed individuals (Beck & Haigh, 2014). In other words, not only do depressed individuals see the world more negatively, they also privilege negative incoming information while silencing incoming positive information (Abramson et al., 2002).

More recently, social and cultural factors have begun to be examined as potential factors in depression’s development. In considering the higher prevalence rates of depression among certain populations such as women, minorities, and those of lower socio economic status, it is hard to ignore the logic behind moving the research focus beyond that examining only genetic or even cognitive frameworks into research examining the relationship between these populations and their higher incidence of depression (Horwitz, 2011).

Building off of this logic, social theories of depression have gained strong support in their examination of depression. These theories posit depression as a reaction to various micro-level and macro-level stressors and pressures (Harper, 2009). On the micro level, a fairly large body of work exists in examining depression and one’s interpersonal context (for review see Joiner, 2002). The interpersonal context of depression takes into account the potential of negative personal and familial relationships in generating negative mental health outcomes as well as considering how having depression may affect one’s ability to foster healthy interpersonal relationships (Ainsworth, 2000). Further, micro-level stressors such as divorce, illness, and poor work environment may create a social environment of high distress leading to depression (Horwitz, 2002). On a macro-level, these stressors may result from a number of marginalized social positions such as one’s race, class, or gender (Harper, 2009), which
could explain why members of minority groups are more likely to emphasize the source of depression as stemming from social and environmental causes compared to their white counterparts (Karasz, 2005).

**Lay Understandings of Depression**

Overall, the psychosocial model of depression currently sits as the prevailing understanding of depression among the general public (Schomerus, Matschinger, & Angermeyer, 2006). Despite the dominance of the biomedical model of depression in scholarly literature and national mental health organizations, researchers investigating lay beliefs about the causes of depression have made note of the consistent discrepancy between lay conceptions of depression and professional ones with lay individuals predominantly noting psychosocial causes as paramount to developing depression (Laubner, Falcato, Nordt, & Rossler, 2003). In a recent analysis of all public attitude surveys of mental illness conducted up to March of 2011, Schomerus et al. (2012) found psychosocial understandings of depression as the most noted cause of depression across studies of lay understandings.

While the psychosocial understanding of depression remains dominant among the general public, when examining the public perception studies across time, Schomerus et al. (2012) found a steady increase in the percentage of individuals voicing the biomedical model of depression. Scholars note that this general shift in public opinion towards the biomedical model of understanding could be due to the fact that mental health literacy comes largely from public health campaigns created by public institutions in addition to direct to consumer advertising from pharmaceutical companies which both privilege the
biomedical understanding of depression (Deacon, 2013; France, Lysaker, & Robinson, 2007).

**The Biopsychosocial Understanding of Depression**

As psychosocial and biomedical understandings of depression continue to jockey for acceptance across both professional and personal contexts, it is important to note that an additional body of research is beginning to highlight a third etiological narrative of depression’s cause in which biological symptoms are tied in with life experiences. For example, in feminist psychology research on postpartum depression, scholars note the importance of work seeking a both/and perspective that allows for both biological and sociocultural arguments to be given credence in investigating postpartum depression (Dubriway, 2010). In other words, while women may have certain genetic, biochemical, or hormonal deficits or changes predisposing them to depression, social and environmental factors may ultimately determine if and how that depression manifests. In providing this inclusion, this growing body of work seeks to include both psychosocial and biological factors (Guimon, 2004; Kangas, 2001; Pescosolido et al., 2010). This more complex, multi-faceted model is slowly gaining credence in both the professional and lay realm and is referred to as the biopsychosocial model.

The biopsychosocial takes a systems approach to the study of depression and attempts to provide a more integrative and transdisciplinary lens to the etiology of depression. In the biopsychosocial model of depression, both inhibiting factors (e.g., genetic predisposition, neurological deficits) and activating factors (e.g., stress, loss) play into the development of depression wherein inhibiting factors alone do not guarantee but rather predispose one to the onset of depression (Garcia-Toro & Aguirre, 2007;
Wasserman, 2006). In other words, individuals may have certain genetics or biochemical deficits that predispose them to a potential for depression, but social and environmental factors may ultimately be what either allows that potential to manifest or remain dormant.

Regardless of which approach to understanding the etiology of depression proves most efficacious, it is clear that cultural understandings of depression both in scientific literature and among the general public remain complex and dynamic in nature. In moving our framework of understanding the etiology of depression into the more specific role-based context of motherhood, we can now explore how extant research on maternal depression situates itself in relations of these understandings.

**Women and Depression**

In reviewing extant literature on maternal depression, it is important to first make note of the gender disparity between men and women in the epidemiology of depression. While both men and women experience an increasing rate of depression starting in early adolescence, the rate for young women at the time doubles (Kessler et al., 2005b). Similar to our understandings of the causes of depression, the disparity between women and men’s rates of depression is attributed to both biological and psychosocial factors (Palazidou, 2000). First, some theories posit that biological differences in sex hormones cause increased vulnerability to depressive symptoms in women (Flynn, 2010). Following a biomedical model, these theories highlight several potential hormone fluctuations as the cause of depression’s onset. For example, women’s gonadal hormones are known to fluctuate during premenstrual, perinatal, and menopausal periods that often coincide with spikes in rates of depression among women (Flynn, 2010; Kohen, 2000; Stoppard, 2000).
Again, while biomedical theories may shed light on understanding depression among women, others continue to push for an acknowledgment of wider social attributes. As Becker, Levin, & Hanson (2010) point out, “Despite increased attention and promising advances in the science and practice of women’s mental health, disparities based on gender, race, ethnicity, and socioeconomic status persist, and women continue to have higher risk than men for mental disorders” (p.6). Despite these factors’ potentials in the etiology of women’s depression, research continually focuses on women’s bodies, thereby making it difficult for women to make sense of their depression with any framework besides the medicalized perspective (Stoppard, 2000). In focusing solely on a biomedical model, scholars argue that women are essentially pathologized resulting in the complete blocking out of any potential social effect and centering solely on women’s bodies (Lafrance, 2009).

**Maternal Depression**

Depression has the potential to manifest in women at any point during their experience as mothers. However, the vast majority of research exploring maternal depression focuses almost exclusively on postpartum depression (Flynn, 2010). This narrow scope examining the nexus of motherhood and depression may be a move by scholars to avoid reducing the identity of a woman with depressions to that of strictly a mother. For example, some scholars note that the focus on postpartum depression within maternal depression research is likely due to its explicit connection to children in that it has a known impact on pregnancy, fetal, and infant outcomes (Flynn, 2010). With postpartum depression representing the majority of current work on maternal depression, postpartum depression research will serve as the central focus in examining how extant
Postpartum depression affects approximately 8-11 percent of women during pregnancy and 6-13% postpartum though some studies demonstrate postpartum rates as high as 15% (Pearlstein et al., 2009). While mood disturbances following the birth of a child are noted by some of the earliest physicians, public accounts of postpartum depression did not emerge in popular culture until the 1950s, with a clear description of the disease officially listed in the *DSM-IV* in 1994 (Miller, 2002). Unlike the more commonly experienced and less severe postpartum blues which occur at a much higher prevalence (50%) and within a few days of the birth of the child, the onset of postpartum depression occurs within a few weeks to as long as six months beyond the birth of the child (Miller, 2002; Patel et al., 2012). The experience of postpartum depression is typically marked by symptoms of appetite loss, anxiety, fear of harming the baby, feelings of shame, guilt or inadequacy, and insomnia (Miller, 2002).

In situating maternal depression research in relation to previously identified cultural understandings of depression, we can see a very clear reflection with the overarching corpus of research divided into two camps. One situates postpartum depression as stemming from individual characteristics that predispose women to depression after childbirth (biomedical model) while the other situates postpartum depression as a reaction to external stressors occurring prior to and after the birth of a child (psychosocial model). Put simply, the biomedical model positions postpartum depression as a pathological response to motherhood, while the psychosocial model
positions it as a normal, albeit difficult, one (Nicolson, 1998; Schwartz & Schwartz, 1993).

From a biomedical standpoint, most research operates on the belief that postpartum depression results from hormone fluctuations experienced between pregnancy and post-birth (Pearlstein et al., 2009). Among these examinations of hormones are two primary hypotheses (Miller, 2002). First, research demonstrates that women experience a significant drop in both estrogen and progesterone after giving birth and note that higher differentials between pre- and post-levels correlate to greater propensities of experiencing postpartum depression (Harris, Lovett, & Newcombe, 1994). A second hypothesis posits that postpartum depression may stem from low levels of oxytocin, which are typically released during mother-infant bonding (Miller, 2002). Despite these correlations, there is still currently no direct evidence linking a hormonal imbalance explicitly to postpartum depression (Miller, 2002).

Much like the disparities between the biomedical and psychosocial views of depression at large, postpartum depression as viewed through the psychosocial lens places women and their depression within broader cultural and social positions. In the psychosocial model, postpartum depression is not a biological response to motherhood as much as a standard sociological response to the inherent difficulties women face while experiencing the various physical, social, and emotional changes to their identity as they transition to motherhood. The psychosocial model of postpartum depression highlights a number of relational and social factors such as stressful life events, marital conflict, low partner support, low-income status, and poor social support in outlining risk (Pearlstein, 2009). As Mauthner (1999) further explains:
[f]eminist social scientists argue that a medical disease model, in which postpartum depression is seen as individual pathology, is inappropriate because it obscures the socio-political nature and context of women’s distress . . . They link depression to women’s inferior status in society, and to structural conditions and constraints including the medicalization of childbirth, poor provision of state-funded childcare, current labor market structures and policies, inadequate parental leave options, the loss of occupational status and identity, isolation, and gendered divisions of household identity. (p. 145)

While these scholars do not refute that the etiology of postpartum depression may be connected to a woman’s physical body, their primary concern rests with the potential of the medical model to silence these larger cultural conditions. In response, an emergent body of scholarship examining postpartum depression through the lenses of feminist, psychological, and sociological scholarship seems to offer evidence that it may indeed be an experience deeply connected to social and cultural factors (Abrams & Curran, 2009; Vik & Haftin, 2012). For example, in their investigation of postpartum depression among low-income mothers, Abrams and Curran (2009) found that postpartum depression symptoms were linked not to biological causes but rather to the hardships of raising children in the context of poverty. In addition, Everingham, Heading, and Connor (2006) found that while fathers framed postnatal depression experiences through the biological lens, mothers understood their experience through a frame of identity loss. Indeed, the loss of identity is a consistent finding in qualitative examinations of postpartum experiences (Abrams & Curran, 2011; Vik & Haftin, 2012). On a wider cultural scale, Miller (2002) notes the distinct differences in prevalence rates among cultures with those placing high value on social support for new mothers reporting lower overall rates of depression.
Notwithstanding the recent increase in scholarship examining the contextual factors that may be at play in predisposing women to postpartum depression, the biomedical model of depression remains the dominant discourse among academic, professional, and lay understandings (Mauthner, 1999; Nicolson, 1998). Despite this dominance, contemporary treatment recommendations tend to operate under a biopsychosocial model in encouraging combined treatments of antidepressants, psychotherapy, and support (Leahy-Warren & McCarthy, 2007). This multidimensional approach to treating postpartum depression is largely due to the spectrum of severity and individual women’s preferences with their treatment (Leahy-Warren & McCarthy, 2007).

Despite qualitative studies demonstrating the use of psychosocial frames by participants in understanding their illness, the paucity of such studies in comparison to those examining depression through a biomedical model has arguably allowed for the continued privileging of the biomedical model as the central etiological theory of depression among mothers. Similarly, despite the fact that depression can occur across a mother’s lifespan, the vast majority of extant research on maternal depression focuses almost exclusively on new mothers with postpartum depression (Flynn, 2010). Further, among literature that does widen its scope to include examinations of maternal depression beyond the perinatal stage, the focus remains primarily on familial outcomes such as how maternal depression affects women’s parenting styles (for full review see Lovejoy et al., 2000) and children’s psychopathology (for full review see Goodman et al., 2011 and Mendes et al., 2012).

Overall, maternal depression is a highly prevalent mental illness affecting a significant portion of mothers. Understandings of maternal depression are determined
through multiple variants of potential causation based on biological, psychological, and social factors. These postulates can be couched within two wider camps of understanding. The biomedical model, which assumes that depression is a result of biomedical abnormalities within the brain, and the psychosocial model, which assumes that depression is a result of internal cognitive factors and/or external sociocultural factors.

While a significant body of research exists in examining depression within the context of motherhood utilizing both biomedical and psychosocial approaches to understanding, the majority of extant maternal depression research focuses explicitly on postpartum depression and favors those studies conducted with a biomedical lens. As such, additional research in the field of maternal depression is warranted in examining the experience of maternal depression beyond the postpartum period. As Nicholson (2010) points out, “The opportunities provided by parenting and a woman’s experiences as a mother cannot be untangled from her mental health, her functioning in other significant life roles, and the supports and challenges conveyed by her family, community, and societal contexts” (p. 368). Being a mother is a highly salient and meaningful life role for many women, and it is a role that extends well beyond a child’s infancy. Therefore, maternal depression research should similarly extend beyond the postpartum period to more fully understand maternal depression.

In moving maternal depression research beyond the postpartum timeframe, this research also adds to the literature in its methodological and theoretical shift away from the predominantly post-positivistic body of extant literature into an interpretive/dialogic framework. With little to no clear or consistent biological evidence of depression, the
illness remains one that is largely constructed through communication and lived experience. Therefore, it is unfortunate that the majority of extant literature on maternal depression has utilized objective approaches to researching what is arguably a highly subjective experience. Further, an inclusion of the lived experience of children as they understand maternal depression represents an understudied area rife with potential. The experiences of both motherhood and depression are ones that take place relationally, and therefore should be examined as such. Additionally, this work seeks to expand the amount of research exploring how individuals make sense of the illness rather than placing a lens, biomedical or psychosocial, on their experiences for them.

**Motherhood**

In addition to the multiple discourses framing contemporary understandings of depression, cultural discourses of motherhood also frame understandings of the meanings and expectations of motherhood. In order to explore emerging adults’ discursive constructions of motherhood and maternal depression, it is important to understand how emerging adults call upon both discourses of depression and discourses of motherhood.

Motherhood, and more specifically standards of motherhood, is a familial role derived from and fashioned by culture and society (Hequembourg, 2013; Thurer, 1994). Notions of how to both attain the title of “mother” and maintain a status of “good mother” in any society are dynamic concepts continually shaped by the cultural and historical contexts within which they are situated (Arendell, 2000). As such, motherhood cannot be separated from these wider contexts or examined in isolation (Collins, 1994). As Thurer (1994) states:
Each society has its own mythology, complete with rituals, beliefs, expectations, norms, and symbols . . . The way to mother is not writ in the stars, the primordial soup, the collective unconscious, nor in our genes . . . Our particular idea of what constitutes a good mother is only that, an idea, not an eternal verity. The good mother is reinvented as each age or society defines her anew, in its own terms, according to its own mythology. (p. xv)

While each society constructs its views of mothering, some views become more dominant than others. These dominant ideologies become the lenses through which experiences of motherhood the role of motherhood itself is understood (Glenn, 1994). As this section will explicate, a number of ideologies of motherhood serve as powerful and pervasive benchmarks upon which experiences of motherhood, understandings of motherhood, and mothers themselves are often created and judged.

It is important to preface the explication of cultural ideologies of motherhood by noting that most, if not all, dominant ideologies of motherhood in the U.S. center predominantly around idealized models of motherhood originating primarily from white, middle-class, heterosexual women and do not necessary capture the experiences of women outside of these privileged positions (Glenn, 1994; Park, 2013; Springgay & Freedman, 2012). While these ideologies of motherhood may not capture the experiences of women sitting outside of these privileged positions represented by cultural ideologies of motherhood, understanding and studying these hegemonic discourses of motherhood is important as all women must sit in relation to them and emerging adults may understand the role of motherhood through their lenses (Arendell, 2000; Glenn, 1994; Taylor, 2011).

Though definitions and expectations of motherhood have continually evolved throughout history, most scholars point to the inception of current discourses of motherhood germinating during the industrial revolution and early 19th-century rise of the
middle class (Baber & Allen, 1992; Koniak-Griffin, Logsdon, Hines-Martin, & Turner, 2006). During this time, as women and men began to operate in distinctively different domains and children became a central focus of family, a woman’s role as mother and caretaker became her primary identity (Arendell, 2000; Baber & Allen, 1992).

Scholars first began interrogating understandings and representations of motherhood in the late 20th and early 21st century (Arendell, 2000; Bell, 2004). Branching out from traditional explorations centered on how different types of mothering related to child outcomes, scholars during this time began to recognize the importance of understanding motherhood through women’s lived experiences (Arendell, 2000). With the ushering in of post-feminism in the 1980s came an awareness of rising cultural expectations for women in their roles as mothers. This led to a rapidly expanding branch of inquiry from the 1990s to our present day exploring the sociocultural discourses of motherhood and the consequences of these discourses on individual’s understandings of motherhood and on the lived experiences of women (Arendell, 2000).

Historically, the dominant ideology of motherhood in the United States was comprised of two discourses: biological determinism and gender essentialism (Gailey, 2000). Biological determinism positions women as inevitable mothers because of their bodies. In fact, women and mothers are conflated as an undifferentiated identity (Glenn, 1994). In the discourse of biological determinism, women are fated to become mothers because of their bodies’ capacities to give birth and care for children through bodily processes (e.g., pregnancy, childbirth, and breast feeding) (Gailey, 2000). As such, women are seemingly predestined to become mothers with giving birth and raising children the fulfillment of their ultimate purpose in life as women.
Moving slightly away from the body and into socially constructed roles, gender essentialism places women and men as inherently different in their parental instincts and abilities. Women are viewed as inherently maternal, possessing an instinctive ability to nurture and care for children. These instincts are therein believed to create a special bond between mother and child that only a mother can form (Gailey, 2000). A mother thus becomes an irreplaceable figure for children. Though discussions on “parenting” may lexically signify a state occupied by both men and women, the maternal body remains the body that is presumed to conduct most parenting behaviors. As such, most “parenting” advice is directed towards women and features feminized suggestions towards activities such as nurturing and sensitivity (Gillies, 2007; Park, 2013). As Johnston & Swanson (2006) point out, the fact that ideologies and constructions of motherhood and the “good mother” even exist rather than constructions of parents and “good parenting” clearly demonstrates the continued perpetuation of gender roles and expectations placed solely on mothers. In other words, mothers at a cultural level are the primary family members expected to fulfill the primary role as caretaker and source of connection for children (Walters & Harrison, 2014).

Taken together, the discourse of biological determinism and gender essentialism create the ideology that “real” motherhood is based on genetic connection, that childbearing and child rearing are a women’s natural role, and that those roles cannot be filled by others (Gailey, 2000). In placing the mother as one who comes to mothering through biological processes and instinctual connection, “real” motherhood becomes a unique experience. More recently articulated by Park (2013), this discourse of
“Monomaternialism,” notes that the role of mother can only be truly occupied by one woman and continues to inform an essentialist view of motherhood (Suter et. al., 2015).

The belief that motherhood is tied to both the sex and gender of women is present in a number of contemporary discourses of motherhood. DiQuinzio’s (1999) articulation of the “essential motherhood,” ideology describes motherhood as a “[f]unction of women’s essentially female nature, women’s biological reproductive capacities and/or human evolutionary development” (p. xiii). Because women inherently possess these uniquely female skills, a woman’s natural state is therefore a state of mothering and to not fulfill the role would have a negative effect on a woman’s emotional well being (DiQuinzio, 1999; Hequembourg, 2007). More recently, Douglas and Michaels (2004) coined the term “New momism” and defined motherhood as a role woman must fulfill to be complete.

Though establishing the identity of mother is defined in each of the aforementioned discourses as attained through biological processes, others cultural understandings of motherhood approach the concept through the lens of social construction (Berger & Luckman, 1966). As Collett (2005) explains, “[a] woman may become a mother by giving birth, but she truly takes on a mother identity by playing a socially defined, publicly visible role” (p. 328). This move into articulating motherhood as a role shifts the focus away from women’s bodies and towards women’s actions. One of the first scholars to move understandings of motherhood from an institution to an experience, Ruddick (1989) defines motherhood as a practice rather than an identity. In a woman’s willingness to engage in practices of motherhood, her role as mother moves from an inherent and biologically established identity to one continually earned and
performed (Ruddick, 1989). In articulating motherhood as something one does rather than something one is, Ruddick (1989) paved the way for understandings of motherhood as a performance rather than a state of being.

It is also important to note that the idea of motherhood as performance rather than a biological tie has not eliminated the power of the discourse of biological essentialism entirely. As Park (2013) notes, “Adoptive mothers know that their status as mothers depends on mastery of the social script for good mothering . . . biological mothers who embody the norms regulating their status as mothers---unless and/or until such time as they inadvertently deviate from that script” (p. 69). While adoptive mothers must perform mothering to even earn the title of motherhood, biological mothers are seemingly granted motherhood status initially and must only perform motherhood in order to keep that status. While opening up motherhood as a performed role did not eliminate the discourse of biological essentialism, it opened up avenues of research that allowed for the examination of performances of motherhood as they sat in relation to institutional and cultural definitions and expectations of motherhood (O’Reilly, 2010).

Interestingly, in Ruddick’s (1989) framing of motherhood as something women did, the role of motherhood became an action understood through discourses of labor wherein children became social capital that mothers invested in (Ennis, 2015). As such, motherhood became an identity whose worth could be measured by examining the amount of time, money, and effort that women put into their mothering. The labor as love model of motherhood now framed mothering as a job wherein children’s outcomes were dependent upon the amount of labor that women put into their jobs as mothers. Today, mothers are judged both by how much mothering work they put into their
children and on how their children turn out (Horwitz & Long, 2006). As a result, some scholars believe that intensive mothering beliefs are at their strongest (McHenry & Schultz, 2015).

The shift in understanding motherhood as a labor-intensive process ushered in what is currently considered the predominant discourse of motherhood in contemporary U.S. culture, the discourse of intensive motherhood (Arendell, 2000; Bell, 2004; Damaske, 2013; Hays, 1996; Johnston & Swanson, 2006). First articulated by Hays, intensive mothering stands as the current normative standard of the good mother. This model of intensive motherhood is defined as that which positions raising children as wholly centered on children’s needs with a mother’s needs taking a back seat to her child’s physical, emotional, intellectual, and social development (Vincent, 2010).

In some ways, intensive mothering is very similar to earlier articulations of motherhood in that it positions raising children as an explicitly maternal task and children as vulnerable, innocent beings who need constant guidance. However, intensive mothering takes expectations of motherhood a step above early articulations by also requiring mothers to actively seek out external guidance on their mothering practices. Mothers must not merely mother their children, but mother them with expertise. This mothering requires methods that are “informed by experts, labor-intensive, and costly” (Hays, 1996, p. 21).

While today’s understandings of motherhood are labeled with a myriad of names such as the “soccer mom” represented by a mini-van driving, snack carrying, child focused woman (Douglas & Michaels, 2004), each is built largely off the foundational conceptions of the good mother as outlined by Hays (1996). Intensive motherhood
clearly informs these new conceptualizations and prevails in labeling a mother’s expectations as to “devote her entire physical, psychological, emotional, and intellectual being, 24/7, to her children” (Douglas & Michaels, 2004; p. 4). Further, despite an ever-increasing percentage of women entering the workforce, this intensive view of mothering continues to prevail as the dominant discourse of motherhood requiring women who take on the role of outside work to continue to focus the core of their energy on their children. For this reason, many scholars point to the power of intensive mothering as damaging to women not for instilling in them a desire to care for their children but for instilling feelings of guilt and shame in being unable to meet the standards set forth by intensive mothering (Vincent, 2010).

Because women transitioning to motherhood regularly report a loss of their former identity (Oakley, 2005; Vik & Hafstein, 2012) and an uptake of “mother” as their new primary identity (Ardenell, 2000), the importance of not only being successful through intensive mothering but also being perceived as successful can quickly become a central identity issue for women (Collett, 2005). Indeed, because these discourses are so ingrained, women who fail to live up to the expectations or experiences of the idealized view of motherhood may enter into a cycle of self-blame or worse, fail to report their experiences, thereby disempowering them and allowing for the predominant story of motherhood to remain.

Despite the unrealistic expectations that the discourse of intensive motherhood places on women, it is clear that it remains the measuring stick upon which all mothers are evaluated. Further, for women outside of the white, middle-class heterosexual mothering experience, intensive mothering becomes not merely a benchmark for good
mothering but a forced expectation in order to prove themselves as mothers (Romagnoli & Wall, 2012). Sadly, intensive mothering has served to bifurcate the diverse and complex experiences of mothering into camps of “good” and “bad,” therein objectifying and regulating those who cannot meet intensive mothering expectations (Springgay & Freedman, 2012). In fact, by framing the story of motherhood with the lens of intensive mothering, women who fail to live up its standards are often labeled as deviant such as teen mothers who are assumed to lack financial means and/or skills to mother well (Wilson & Huntington, 2005) or commuter wives who are assumed to lack the time required to mother children well (Bergen, Kriby, & McBride, 2007). For women of low socio-economic status, the discourse of intensive mothering can be particularly marginalizing in that they must often choose between working to financial support their children therein losing time at home with their children or stay at home with their children therein failing to meet the expectation of providing the child with financial security (Medina & Magnuson, 2009). Similarly, because intensive mothering calls on mothers to seek out expert advice on raising children, some mothers feel stigmatized in their inability to follow this expert advice such as those mothers who must formula feed rather than breastfeed their children (Afflerback, Carter, Koontz Anthony, Grauerholz, 2013). Perhaps most disheartening, because intensive mothering positions child outcomes as dependent upon a woman’s ability as a mother, Lalvani (2011) found that mothers of children with Down Syndrome felt marginalized as mothers and called for shifts in understandings of “good mothering” toward contextual lenses rather than through the wider discourse of intensive mothering.
Although research exploring the effects of intensive mothering ideology on women’s experiences of mothering continues to grow, the majority of extant scholarship describes the experiences of mothering as predominantly positive (Brown, 2010). The romanticizing of motherhood as one traditionally concomitant with happiness is arguably why negatively valenced experiences of motherhood remained relatively absent from research prior to the 1990s (Ross, 1995). Perhaps more importantly, this romanticized view of mothers and their effort in mothering as labors of love has inhibited examinations into issues of power as it pertains to motherhood (Glenn, 1994). Indeed, because motherhood is positioned primarily as a positive experience, mothers may not only have a hard time communicating their negative experiences to others but also making sense of their negative experiences within themselves. As Nelson (2009) points out, “In her omnipresence, ‘mother’ becomes the taken-for-granted, and the real, live women who occupy the role of “mother” are left to negotiate, by themselves and with each other, the tensions between the ideals and realities of motherhood” (p. 12).

The experience of depression and motherhood as it occurs within a culture privileging the discourse of intensive mothering adds an additional layer of difficulty on women in that they likely find themselves unable to meet the requirements of what culture deems a good mother. It should come as no surprise then that across qualitative studies capturing women’s experiences with postpartum depression there exists a consistent incongruity between women’s expectations of motherhood and the reality of their motherhood (Beck, 2002). The resultant danger of the discourse of intensive mothering is its ability to both shame women for having negative feelings during their
transition to motherhood along with diminishing their agency in discussing their feelings with others for fear of condemnation from outsiders (Beck, 2002).

With the experience of depression sitting in direct opposition to the expectations laid out by the discourse of intensive motherhood, mothers with depression represent a particularly poignant population in examining how individuals constitutively negotiate incongruences between cultural expectations and lived realities. As such, an examination into how these mothers are understood is warranted. Further, as work exploring motherhood in relation to cultural ideologies of motherhood continue to grow, the inclusion of those mothered, rather than solely those mothering, represents an unexplored but potentially rich avenue of research.

Motherhood is an identity relationally experienced between mother and child. Indeed, motherhood is a continually redefined process women engage in through interactions with others (Tardy, 2000; Marshall, 1991) and understood through experiences with others (Heisler & Ellis, 2008). As Pederson (2012) points out, “Meanings that are created, shared, and negotiated in the family are embedded in larger sets of social meaning, ideologies shaped by discourse,” (p. 232). Emerging adults then likely come to understand motherhood both through their micro level interactions with their mother in addition to these understandings as they sit in relation to understandings of motherhood circulating in the culture at large. Children, as much as mothers, are paramount in shaping identities of motherhood. Therefore, research including the children’s perspectives on the incongruence between depression and intensive motherhood stands to provide a unique and necessary component to fully understanding the maternal depression experience.
Depression and Mental Illness Within the Family

Despite a noticeable lack of family members’ voices and experiences in research on mental illness at large (Rose, Mallinson, & Walton-Moss, 2002), research on familial characteristics has been prominently featured in research on mental illness’ causes and effects. It is important to note that these bodies of work do not focus explicitly on depression but rather encompass a range of diagnoses such as schizophrenia, bipolar, and major depression. Broadly, research on mental illness in the family covers four major areas of exploration: (1) effects of family characteristics and dynamics on the development and/or progression of mental illness among its members (e.g., Parra et al., 2011), (2) effects of one’s mental illness on his or her family members (e.g., Goodman et al., 2011), (3) stigma and perceived burdens of mental illness for well family members (e.g., Magana, Garcia, Hernandez, & Cortez, 2007), and (4) qualitative accounts of well family member’s experiences of having a depressed family member (e.g., Badger, 1996).

Of the four aforementioned approaches to studying mental illness within the family, the largest body of existent work explores how family characteristics and dynamics affect the development and/or progression of mental illness (e.g., Mannion & Meisel, 1998). Historically, the assumption that family environments contribute to mental illness runs throughout numerous psychological and psychiatric models of causation. In fact, some scholars argue that the assumption of family as a cause of mental illness may have led to the late 19th- and early 20th-century movement towards the institutionalization of the mentally ill (Jones, 2002).
Today, as understandings of the causation of mental illness are now assumed as multidimensional and not solely caused by one’s home environment, care of the mentally ill has shifted back to family members. In contemporary research, studies of familial characteristics as potential cause take two primary approaches. First, a substantial and growing body of work examines the biological transmission of mental illness within the family through biological marker studies and genetic transmission and expression research (Depression in families, 2011; Jones, 2006). Researchers taking this biological approach examine the heritability and co-morbidity of mental illness through transmission via the parent-child dyad and twin studies (Gibb et al., 2009; Middledorp, Cath, VanDyck & Boomsma, 2005). Second, research examines the psychological and social components of family in determining potential risk factors associated with the development of mental illness (Depression in families, 2011; Sheeber, Hopes & Davis, 2001). Researchers taking this approach examine specific facets of family life such as parenting styles (Hamon & Schrodt, 2012) and marital quality (Whisman, 2001) to assess their potential effects in predisposing or deterring the development of a mental illness in its members in addition to its effect on the progression of illness.

It is important to note that an additional and growing body of contemporary research recognizes the characteristics of the family as an avenue of help rather than hindrance for members with a mental illness (Solomon, 1998). The bulk of this work focuses on the positive effects of social support and social ties provided by families (Thoits, 2011). Similarly, a growing body of work focuses on familial education and intervention programs in seeking to understand how best to utilize the family in
preventing and/or reducing mental illness. For example, Shimazu et al. (2011) found that families who had undergone psychoeducation were effective in helping the prevention of relapse for their mentally ill family members. Further, research demonstrates the success of family-focused intervention approaches for families specifically affected by maternal depression in improving quality of family interactions and individual well being (Foster, O’Brien, & Korhonen, 2012; Valdez et al., 2011).

Ironically, research examining the family’s effect on the development and/or maintenance of maternal depression often focuses on a time during which women are either first entering into or expanding their role of motherhood by focusing almost exclusively on postpartum depression. Similar to the overarching body of work on family characteristics, maternal depression is examined both through a biological lens in examining a family history of depression from women’s family or origins in addition to explorations of family characteristics. For example, some studies demonstrate that familial characteristics such as a lack of social support from one’s spouse, conflict with spouses, number of children currently in the home, and previous deaths of children in the family can all contribute to a woman’s likelihood of experiencing maternal depression (Noble, 2005).

Along with examining the positive and negative effects of familial traits on a member’s mental illness, another body of work examines the effect of a member’s mental illness on the family (Goodman et al., 2011). Studies in this vein explore a diverse range of relational outcomes such as examining the effects of parental depression on parenting behaviors (Spector, 2006; Wilson & Durbin, 2010), children’s psychopathology (for full
review see Goodman et al., 2011) and child development (for full review see Downy & Coyne, 1990). Work also examines the potential for comorbidity of depression between parents and children (for full review see Beardslee, Gladstone, & Connor, 2011) and amongst siblings (Middeldorp, Van Dyke, & Boomsma, 2005).

In examining maternal depression and its effects on families, work focuses primarily on effects of maternal depression on children (Lampard, Franckle, & Davison, 2014). It is generally agreed upon across disciplines that maternal depression affects a myriad of child development outcomes both at the time of a mother’s depression and well beyond the time of her recovery (Manning & Gregoir, 2008). Overall, maternal depression is associated with negative or reduced maternal parenting behaviors (Lovejoy, Graczyk, O’Hare, & Neuman, 2000) and a number of negative physiological, psychological, and physical health outcomes for children (for full reviews see Burke, 2003; Lampard, Franckle, & Davison, 2014; Letourneau, Tramonte, & Williams, 2013).

Considering the extensive work on the experience of stigma for mentally ill individuals (for full review see Brohan, Slade, Clement, & Thornicroft, 2010), it is not surprising that the third major body of work examining families and mental illness revolves around the experience of stigma and family burden for family members. Family members are often subjected to ‘courtesy stigma’ (Goffman, 1963), or stigma resulting from a personal association with a stigmatized individual. Members consistently report the experience of stigma in interactions from outsiders both towards their family member with mental illness and towards themselves and their family as a whole. In their review of mental illness stigma on family members, Corrigan and Miller (2004) note that parents are often blamed for mental illness in their children and siblings and spouses are often
blamed for not ensuring strict adherence to recovery plans for their mentally ill family members. They also note children’s fear of being contaminated by their mentally ill father or mother (Corrigan & Miller, 2004). Similarly, Fjone, Ytterhus, & Almvik (2009) found that children with parents suffering from mental illness actively struggled with trying to make themselves appear normal in their everyday life and especially among their peers in order to avoid stigma associated with their parents’ illness. Individuals recognize the stigma placed on family members while also internalizing a stigma of their own, creating feelings of guilt and self-blame and leading to negative personal outcomes (Markowitz, 1998; Wahl & Harman, 1989).

The smallest body of extant work examining mental illness in the family examines the lived experiences of mental illness in the family. For example, McCann, Lubman, and Clark (2012) explored how emerging adults came to terms with their own depression and utilized their families as support networks during their mental illness. Ahlstrom, Skarsatar, and Danielson (2010) investigated how parents with depression viewed its effect on their family lives by noting a back and forth struggle between suffering and dignity. They believed their family suffered because of their depression and reported feeling a need to continually work to reclaim their dignity as parents and as a family that they perceived depression had taken from them.

Research including individual perspectives beyond those of mentally ill (i.e., experiences of well family members) is also scant. Jones (2002) speculates that the shortage in research on experiences of well members in comparison to those diagnosed is due to pre-existent ideological biases that frame families as objective systems rather than
a group of individuals subjectively experiencing a member’s illness. As such, most research focusing on the lived experience of depression within the family privileges that of the diagnosed individual (Jones, 2002). Research that does include the perspectives of other family members includes a fairly diverse range of familial viewpoints such as the experiences of parents who have children with mental illness and the experience of well siblings (Ahlstrom, Skarsatar and Danielson, 2009; Kawanishi, 2006). Perhaps the most consistent result across studies is that of the burden families must endure because of a parent’s illness (Awad & Voruganti, 2008; Jones, 2002; Karp, 2002). Broadly, family burden includes burdens of care (e.g., providing assistance with daily living), burdens of control (e.g., handling troublesome behaviors), and burdens of finance (e.g., covering the cost of treatments and/or loss of wages due to caregiving) (Tessler & Gamache, 2000).

Finally, and of importance to this study, is the experience of children when a parent has a mental illness. Despite the noticeable impact of a parent’s mental illness on a child as demonstrated by a large body of post-positivist work, children’s voices remained virtually nonexistent in literature on mental illness in the family until the early 2000s. Gladstone, Boydell, and McKeever (2006) note that this dearth in research could be due to a number of reasons such as the assumption that individuals with mental illness do not have children or the lack of interaction between organizations that treat mental illness in adults and those that work with children. Unfortunately, most of the early work that does examine children of parents with mental illness cast children as either “at risk” or “resilient” (Gladstone, Boydell, & McKeever, 2006; Gladstone, Boydell, Seeman, & McKeever, 2011). In other words, one body of extant research primarily seeks to
understand the potential negative outcomes of having a parent with mental illness and the other attempts to identify what resilience factors might inhibit those negative outcomes and allow children to thrive despite their parents. While these bodies of work are invaluable to understanding mental illness in the family, they essentially position children as containers that are either adapting or not adapting to a member’s mental illness (Gladstone, Boydell, & McKeever, 2006). By including children’s perspectives on research, we are only now beginning to conceptualize children as active participants in their experiences rather than passive receptacles (Gladstone, Boydell, & McKeever, 2006).

Across qualitative studies of children’s experiences of parental mental illness, a number of themes emerge. First, children often note a lack of understanding about their parents’ illnesses (Garley, Gallup, Johnston, & Pipitone, 2003; Meadus & Johnson, 2000; Trondsen, 2012). This lack of understanding is attributed to a lack of information communicated to them about their parent’s illness (Meadus & Johnson, 2000) and a perceived lack of openness by parents when discussing their mental health (Trondsen, 2012). Children also note feelings of stress and fear at the unpredictability of daily life (Ahlstrom et al., 2009). In addition to the stress of the unpredictability of their home life, children note the stress of worrying about their ill parent (Stallard et al., 2004), especially when away from the home such as during school hours (Cree, 2003).

Arguably the most pervasive finding across studies of children’s experiences with parental mental illness was the burden of care placed on children. Similar to Awad and Voruganti’s (2008) and Jones’ (2002) findings of the burdens of care, control, and
finance on the family at large, children often report experiencing emotion burden (e.g.,
handling stress), instrumental burden (e.g., doing chores or helping with childcare), and
support burden (e.g., comforting a parent) (Champion et al., 2009). Further, though
children themselves are not necessarily expected to bear the weight of the financial
burden of a parent not working due to mental illness, Polkki, Evast, & Huupponen (2005)
point out that because the well parent must often make up for financial loss by working
more, additional instrumental burdens are placed on children such as doing household
chores and taking care of younger siblings in the absence of both parents due to mental
illness and increased time their well parent spends working. Even though children are
rarely recognized for the work they do in caring for their parents when examining family
care (Gladstone, Boydell, & McKeever, 2006), they are arguably one of if not the most
important caregivers in the family when a parent suffers from a mental illness.

In describing and understanding the caregiving that children must often provide
for parents with mental illness, a number of researchers have noted experiences of
parentification (Champion et al., 2009; Van Parys & Rober, 2014). First introduced as
the “parental child” in the 1960s by Minuchin et al. (1967), parentification refers to the
process wherein children are expected by parental figures to fill in the role of parent.
Often understood as a role reversal for children and parents, the parentification process
involves children both taking up the tasks normally carried out by the parent in addition
to providing support to the parents themselves (Earley & Cushway, 2012).

Though a number of familial situations may cause the parentification of children,
mental illness in particular requires that children provide support explicitly for their
parents emotional well being in comforting their parents (Van Parys & Rober, 2014) in addition to overseeing basic safety and household needs (Aldridge, 2006). While taking on parental roles and tasks does allow children to feel included in their parents’ rehabilitation (Aldridge & Becker, 2003), it is important to note that it is also associated with increased anxiety-depression symptoms and social competence (Champion et al., 2009). Children stepping into these parental roles can sometimes begin to accept the role as part of their identity wherein they have trouble relinquishing the role of parent even when their parents are well enough to reclaim the role (Rose & Cohen, 2010). As these children emerge into adulthood, the experience of parentification continues to affect their adult relationships with parentification linked to co-dependent relationships and narcissism in adults (for review see Earley & Cushway, 2002).

Similar to research on mental illness in the family at large, existent research on parentification for children with mentally ill parents is focused primarily on the outcomes of parentification (Abraham & Stein, 2010). What is lacking in current work is an examination of how children actively make sense of their role as a parent and more importantly the role of their parent in light of the role-reversal. Prior explorations of family members of mentally ill note an inherent difficulty in accepting and caring for an individual unable to fulfill their normative social roles or expectations (Stein & Wemmerus, 2001). For example, the shift from a mother caring for her children to a child caring for his or her mother represents a discord with cultural expectations and age-appropriate expectations of care within the family (Tessler & Gamache, 2000). These shifts in normative roles of parent and child represent parent-child role reversals, and among emerging adults with mothers with depression, cause disruptions that yield
negative psychological consequences (Abraham & Stein, 2013). In fact, emerging adults
with mothers with affective disorders report significantly lower levels of affection and
future care giving intent and significantly higher levels of felt obligation towards mothers
(Abraham & Stein, 2012).

Several conclusions can be drawn from existing scholarship on mental illness
within the family. First, research examining familial causes and effects demonstrate a
bilateral relationship between mental illness and family characteristics (Jones, 2006). In
other words, mental illness tends to operate in a vicious cycle wherein mental illness
symptoms can lead to lower family functioning and lower family functioning can lead to
the development or sustainment of mental illness. Second, the diagnosis and
maintenance of mental illness in a family member is a major stressor for families
(Whitton, 2011). In particular, children’s experience with role reversal is noted as a
major aspect of parental depression experience. This parentification has both immediate
and long-term effects on children and similar to depression, requires children to
renegotiate understandings of their role in the family in addition to the roles that their
family members play. Perhaps more importantly, many studies note the struggle children
endure in both understanding their parent’s mental illness in addition to understanding
their role as a parent because of it (Knutsson-Medin, Edlund & Ramklint, 2007).

Third, though recent work has begun to incorporate family perspectives in
exploring mental illness within the family, these perspectives continue to receive
significantly less attention than work exploring the perspectives of those with mental
illness (Depression in families, 2011; Whitton, 2011). Though research centering on
family members’ experiences is relatively sparse, results of such studies consistently note
the struggle of family members in understanding the causes of mental illness and accepting the changes within their ill family member (Rose, Mallinson, & Walton-Moss, 2002). As Kawanisha (2006) explains, “One of the most essential and difficult struggles in dealing with a loved one’s mental illness is that both their personality and behavior are invaded and plagued by the illness. The line between personhood and the disease is seldom clear,” (p. 141). This struggle in understanding and making sense of a parent’s depression was found across studies capturing the experiences of children with a parent with mental illness (Gladstone, Boydell, & McKeever, 2011).

Finally, of extant work examining the experience of family members and in particular children’s experiences of parental mental illness, the vast majority did not utilize a specific theory or theoretical framework which Gladstone, Boydell, and McKeever (2011) note as particularly problematic in that it prevents researchers from understanding how assumptions of mental illness may affect understandings of the experience. Further, although the impressive body of work focusing on family communication processes and their relationship to mental illness utilizes many of the methods and conceptual constructs of communication studies field, the vast majority of this work has been conducted outside of the field (Segrin, 2012). Beyond Duggan and Le Poire (2006), who used inconsistent nurturing as control theory to examine how individuals utilized different communication strategies in an attempt to curb their
romantic partner’s depression, virtually no current research applies communication theory in conducting research on mental illness and the family.

**Emerging Adults**

While a number of familial relationships stand as potentially rich sights of exploration in maternal depression research, this study explores the experiences of maternal depression through the voices of emerging adults. Defined as the period from late teens through mid 20s (18-25), emerging adulthood represents a new stage in traditional life course conceptualizations and is situated between adolescence and young adulthood (Arnett, 2006). First articulated by Arnett (2000), emerging adulthood is a new period of development for individuals in their late teens to early twenties caused by several demographic shifts such as the later age of marriage, having children, and increased time spent in college, Arnett argued that individuals were no longer reaching full adult status at the same time as their grandparents or even parents. Early emerging adult research notes five key features of emerging adulthood: (1) The age of identity exploration, (2) the age of instability, (3) the self-focused age, (4) the age of feeling in-between, and (5) the age of possibility (Arnett, 2000; 2007). Like the majority of extant work on motherhood, it is important to note that the development of and explorations of emerging adulthood theory has been based primarily on experiences of white, middle-class individuals (Arnett, 2006).

Similar to research on children, several studies have examined the experience of parental depression for emerging adults (Abraham & Stein, 2013; Kaimal & Beardslee, 2010). While some of this work demonstrates very similar experiences to that conducted
with children and young adults such as the experience of role reversal between parents and emerging adults (Abraham & Stein, 2013) and difficulty with psychosocial and psychological adjustments as a result of having a parent with mental illness (Abraham & Stein, 2013; Abraham & Stein, 2010), Kaimal and Beardslee found that emerging adults understandings and perspectives of the experience changed across time. The researchers found that individuals living at home viewed the experience as predominantly negative in that it had an adverse affect on their life. However, some participants noted a shift in their perspective from self-oriented (e.g., highlighting negative effects on their lives) to other oriented (e.g., understanding the situation and their parent) when they left their home to attend college (Kaimal & Beardslee, 2010). Though some participants did maintain their perspectives, the presence of shifting perspectives during the time period of emerging adulthood provides evidence of the importance of including their perspectives in understanding the experience of being a child of a depressed parent and whether and how that experiences carries on into adulthood (Kaimal & Beardslee, 2010).

The experiences of emerging adults are particularly important to examine for several reasons. First, the period of emerging adulthood represents at time when individuals begin to build an independence and identity separate from their family of origin. As such, emerging adults must restructure relationships with their family or origin (Tanner, 2006). In the case of relationships between emerging adults and their parents, this typically involves moving from a hierarchical to symmetrical relationship (Arnett, 2006). While this may look somewhat different for children who have experienced maternal depression in noting parentification and role reversal literature, it
stands to reason that emerging adults must still renegotiate their relationship with parents and also likely develop unique insight into past experiences as they develop their own sense of identity and come to a more equal positioning with their parents. Further, though younger children are often left out of explanations of what is going on with their parents during the diagnosis and maintenance of depression (Kaimal & Beardslee, 2010), emerging adults may be viewed more as friends and confidantes (Bynner, 2005) and are therefore more likely to be privy to their mother’s depression. Emerging adulthood is also a time when communication between emerging adults and parents has the capacity to evolve from patterns established during adolescence (Aquilino, 2006). Emerging adults are more likely to be active participants in the communicative sense-making processes family members must undertake in coming to terms with their mother’s depression.

Second, in addition to being an active participant in communicative sense-making within their family, emerging adults are also more capable of narrating that sense-making to outsiders (McAdams & Olson, 2010). Prior work utilizing retrospective accounts of experiences of mental illness demonstrate their unique potential in both enriching current studies of the experience of having a parent with mental illness in addition to providing unique insight into the evolving sense making that adults utilize when recalling and making sense of their childhood and adolescent experiences as adults (Van Parys, Smith, & Rober, 2014). Emerging adulthood is the first time when individuals can formulate a “new and ideally integrative understanding of one’s life story” (McAdams & Olson, 2010, p. 32). This integrative understanding allows emerging adults to articulate life experiences and identity commitments to others. Therefore, emerging adults can
articulate their prior experiences with their mothers in addition to narratively explaining their own unique communicative constructions of motherhood and maternal depression.

Third, emerging adults and mothers sit at a unique nexus of relational connection and autonomy (Arnett, 2007). Even though most emerging adults have left their families of origin because the majority have not yet formed their own families or have only recently established their own families, the bonds to family of origin and more specifically parents remain relatively strong (Arnett, 2007; Kenny & Rice, 1995; Labouvie-Vief, 2006). As such, emerging adults are connected enough to have a salient relationship with their mother and their experiences but autonomous enough to offer their own unique communicative perspectives.

Fourth, considering that major depression is already known to emerge during the years coinciding with emerging adults (Arnett, 2007; Schulenberg & Zarrett, 2006), understanding how emerging adults communicatively make sense of depression is of value not only in the relational context of how emerging adults understand motherhood but also in understanding how emerging adults understand depression at a time when the illness has a potential to manifest in their own lives.

Finally, research examining emerging adults’ relationships with family members with mental illness is scarce. The small corpus of current research exploring perspectives of emerging adults with mothers with depression examines effects of maternal depression on relational components between emerging adults and their mothers such as perceived role reversal, affection, obligation, reciprocity, and care giving intent (Abraham & Stein, 2010, 2011, 2013). What is noticeably absent in each of the studies is an examination of
how these emerging adults made sense of the experience of having a mother with depression. More importantly, no studies were found across disciplines in examining how emerging adults communicatively come to make sense of and negotiate understandings of maternal depression and motherhood.

As demonstrated prior, numerous cultural discourses currently animate the meaning of depression such as the biomedical model of mental illness and the psychosocial model of mental illness. While we understand which discourses are currently privileged and which are marginalized, what is not known is how individuals draw upon those discourses in rendering their understandings of depression intelligible. Overall, most extant literature conceptualizes women and their families as contained entities within which experiences of depression play out. To date, there is no clear understanding of whether and how both cultural discourses at large and relational understandings within the family concomitantly construct individuals’ understandings of depression.

Further, understanding how emerging adults either align with or resist the culturally privileged discourse of intensive mothering when making sense of their mother’s depression is an equally understudied and valuable undertaking. As Becker (1997) points out, “People consciously wrestle with some cultural ethos that is at odds with their life situation. This is particularly true when life circumstances do not fit with cultural ideas about what constitutes normalcy” (p. 15). Considering the discourse of intensive mothering is the dominant discourse of motherhood in contemporary society, it is clear that emerging adults must make sense of a mother who is potentially unable to
represent the discourse of intensive mothering while suffering the symptoms of depression. In order to continue to understand how best to develop these family-focused approaches, we must continue to enhance our understanding of how families define, understand, and handle mental illness (Jones, Beach & Jackson, 2004).

The diagnosis of maternal depression stands as an important turning point for both women and their families. Relational dialectics theory (Baxter, 2011) provides a useful heuristic to unravel how emerging adults communicatively make sense of the constructs of depression and motherhood. Prior scholars have noted the utility in using RDT to provide insight into what discourses animate the sense-making processes during turning points (Parcell, 2013) and of understanding motherhood (Suter et al., 2015). Using RDT, researchers can fruitfully unpack how emerging adults communicatively construct understandings of maternal depression and motherhood. Because the discourses surrounding depression and motherhood are complex and arguably in clear contestation with each other, emerging adults’ stories of their mother’s depression represent ideal texts in which to understand the construction of meaning via talk (Baxter, 2011).

**Relational Dialectics Theory**

Like any good theory, RDT’s history is marked by a continual evolution of its ideas across decades of intellectual theorizing and application. Originally developed by Baxter and Mongtomery (1996), initial steps in RDT’s development centered on communication as a dialectic process based heavily on traditional Hegelian ideas of dialectics and change. Yet, Baxter’s exposure to and wider incorporation of the insights of Bakhtin in the late 1980s shifted her view into a more dialogic approach to studying relationships by approaching the study of communication with a more constitutive lens.
and incorporating several core concepts of Bakhtin (Baxter, 2004a). In continuing her pursuit of Bakhtin, Baxter articulated a second-generation description of RDT in 2011, noting the primary difference between the first and second as essentially shifting the figure-ground from examining contradiction to examining dialogue in all of its forms (i.e., examining the centripetal-centrifugal and transformative components of language).

Baxter explains:

First-generation relational dialectics (Baxter & Montgomery, 1996) positioned the concept of contradiction at the centerpiece of the theory, with other dialogic elements occupying a more muted background. In contrast, second-generation relational dialectics positions the several meanings of “dialogue” with more or less equal footing--dialogue as centripetal-centrifugal flux, dialogue as utterance, dialogue as aesthetic moment, dialogue as a critical sensibility. (p. 188)

In placing contradiction as paramount to RDT-informed work, the majority of scholarship utilizing the first-generation articulation identified several core tensions in the relational experience (e.g., connection versus autonomy). However, the majority of this work failed to examine how those tensions were at play with one another in relational talk. As such, the work lacked the critical lens that second-generation RDT provides by encouraging scholarship that not only identified the circulating contradictions but also exploring the power relationships between them in addition to their potential for the creation of new meaning. In providing a richer unpacking of the dialogic concepts of the utterance chain, the interpenetration of discourses, and the unpacking of power in discourses (Baxter, 2011). Therefore, an examination of each of these concepts will ideally give us a clear understanding of RDT and its application.

In understanding dialogue as a centripetal-centrifugal flux, RDT seeks to understand what discourses exist in individual’s everyday talk and how those discourses
interpenetrate in the production of meaning making within relationships (Baxter, 2011). In this way, talk, and specifically the discourses housed within it, become the central vehicle through which meaning is made and through which individuals and personal relationships are examined (Baxter, 2011).

To examine the construction of meaning within talk through the variant interpenetrations of discourse, RDT utilizes a slightly altered conceptualization of Bakhtin’s (1981b) centripetal and centrifugal flux in examining how discourses contain discursive power in the social world. For Baxter (2011), a centripetal discourse represents a view positioned as “[n]ormative, typical, and natural, and thus it functions as a baseline against which all else is somehow positioned as a deviation” (p. 123). Conversely, centrifugal discourses sit outside of the centripetal’s privileged position and represent the unnatural or deviant views (Baxter, 2011). Baxter notes that because centripetal discourses are centered and legitimated, they carry with them more discursive power than centrifugal discourses. Discursive power then is expressed and identified as those discourses with the capability to define or legitimate a social reality (Baxter, 2011; Bakhtin, 1981b).

In idealized dialogue, multiple discourses are voiced with equivalent discursive power (Baxter, 2011). Though, this is rarely the case. In some instances of talk, individuals may voice only the centripetal or normalized viewpoint, thereby completely silencing the centrifugal. Bakhtin (1986) referred to such instances as monologue. Conversely, when both centripetal and centrifugal discourses are given voice in individuals’ talk, it is said to be dialogic, or double-voiced. In other words, whereas monologue only allows for the voice of one discourse, dialogue allows for two or more
through the direct or indirect voicing of alternative discourses (Bakhtin, 1981b; Baxter, 2011). Through the discursive struggle of these multiple discourses in dialogic talk, we see the production of meaning (Baxter, 2011).

In keeping with Bakhtin’s belief in the unfinalizability of language and the social actor, RDT sets itself apart from other theories of dialectics by positioning this centripetal-centrifugal struggle as paramount and unending. Both within and across time, the centripetal-centrifugal struggle within dialogue is not something to overcome but rather an existent and continual flux wherein any given utterance can result in a change of the positioning of discourses (Baxter, 2004b). For example, the commonly identified relational struggle of certainty-uncertainty in prior RDT-informed work is not one to ultimately overcome but rather a component of the relationship that is continually managed.

In their first iteration of RDT, Baxter and Montgomery (1996) refer to this dialogic process of meaning construction occurring through the interplay of discourses as communication praxis. Because these processes are given additional voicing in the latest articulation, a brief examination is warranted. First, Baxter and Montgomery note that interplay of discourses is possible not only within a single utterance but also across time between utterances. When multiple discourses co-occur within a single utterance at a single moment in time, it is said to demonstrate synchronic interplay. Conversely, when a single discourse is present at one time while another is voiced at another, the utterances are said to demonstrate diachronic interplay. Without longitudinal data, diachronic interplay is largely missed in that it presents as monologue when examined at only one point in time (Baxter, 2011).
Baxter (2004b) notes that there are brief moments of completion when this seemingly incessant centripetal-centrifugal flux finds wholeness. Baxter (2007a) conceptualizes these moments of completion using the Bakhtinian notion of the aesthetic moments or: “any occasion in which the flux of centripetal-centrifugal interplay is momentarily constructed as a seamless whole” (p. 13). Baxter notes aesthetic moments arising in her research on a number of personal relationships (e.g., friendships, romantic relationships, family relationships) and in a number of ways (e.g., seamless conversation, relational wholeness). Though these fleeting aesthetic moments can manifest in any relational context and/or environment, Baxter (2007a, 2011) notes ritual events as particularly rich in potential for understanding aesthetic moments within personal relationships. For example, in their work on marriage renewal ceremonies, Baxter & Braithwaite, (2002) note the celebration of a renewal as a way for couples to momentarily suspend the common tensionality of the public and private components of their relationship. At a vow renewal ceremony, the private relationship is celebrated in a public way, which temporarily weds (for lack of a better term) the two discourses together rather than situating them as a facet of the relationship in constant flux in giving both the discourse of public (via the public ceremony) and the discourse of private (via the celebration of the dyad) equal footing within one event.

The centripetal-centrifugal flux of dialogue, along with its potential to consummate into an aesthetic moment of wholeness, takes place on the discursive playing field of the utterance chain. Using RDT, the utterance is not conceptualized as a representation of inner thoughts of a speaker but rather as a verbal site of meaning making where a multitude of discourses intersect (Baxter, 2011). RDT shifts utterances
away from psychological concepts and moves them towards “verbal crossroads of contested meanings” (Baxter, 2010b). In other words, utterances are examined not for their connections to any one individual’s thoughts but rather as part of a larger set of utterances already spoken and anticipated in response.

In their first articulation of RDT, Baxter and Montgomery (1996) flesh out Bakhtin’s (1986) notion of the utterance into four primary petals: the distal not-yet-spoken, the distal already-spoken, the proximal not-yet-spoken, and the proximal already-spoken. The distal already-spoken and the distal not-yet spoken pertain to wider sociocultural discourses. Conversely, the proximal not-yet-spoken and proximal already-spoken focus on the micro-culture of discourses or those situated within the immediate communicative environment of relational partners (Baxter, 2010b).

Building off of the idea that culture is constructed from intersections of multiple perspectives (Swidler, 2001), the distal already-spokens on the utterance chain represent those utterances already voiced by individuals outside of a relationship and/or by the culture at large (Baxter, 2011). For example, the idea of a “traditional family” is one rarely voiced by an immediate other in conversation but nonetheless is highly salient in our understanding of family arguably because of its repeated voicings in culture at large.

In anticipating the potential evaluation of outside individuals and/or the wider audience, the distal not-yet-spoken represents the anticipated response of the general other or superaddressee. Baxter (2010b) notes that in relational studies, discursive struggles often emerge at the distal not-yet-spoken when individuals must make sense of the conventional aspects of their relationship as they butt up against what is normal, expected, or even ideal as presented by society.
As opposed to the distal petals on the utterance chain that represent wider sociocultural discourses, the proximal petals of the utterance chain represent the more immediate meanings and anticipations embedded within a distinct and immediate relational history (Baxter, 2010b). Indeed, just as individuals come to understand themselves and their relationships through culture at large, each utterance also has the potential to either reproduce or change an immediate relational identity (Baxter, 2010b). The proximal already-spoken represents the unique site of the utterance chain wherein a couple’s relational past collides with its meaning in the immediate present (Baxter, 2011). Conversely, the proximal not-yet-spoken represents the immediate anticipated response of the other and is a useful site through which to understand relational difference (Baxter, 2011).

At its core, RDT examines language in-use through both exploring its position on the utterance chain and understanding how the discourses comprising each utterance interpenetrate in the production of meaning (Baxter, 2011). RDT provides a utile conceptualization to understanding the constitutive nature of meaning creation in individual and relation identities within personal relationships (Baxter, 2011; Baxter & Montgomery, 1996). Specifically, RDT frames meaning making as an emergent process resulting from a discursive struggle of competing discourses voiced within individual talk (Baxter & Braithwaite, 2008; Baxter, 2011). Therefore, RDT provides a unique contribution to studying communication constitutively in that it articulates a mechanism through which to study the meaning making process as it plays out in human communication (Baxter, 2010a).
Justification for RDT

As contemporary scholars call for a move of Bakhtin’s dialogism into the social sciences (Wall, 1998) and specifically the fields of gender studies (Francis, 2012), social work (Irving & Young, 2002), and psychology (Clegg & Salgado, 2011; Cresswell, 2011; Salgado & Clegg, 2011), RDT provides communication scholars with an excellent theory through which to use concepts of Bakhtin’s dialogism in furthering our understandings of interpersonal, relational, and family communication. Moving forward with such a theory, however, requires a reconceptualization of several facets the discipline has historically held dear.

In her recent articulation of RDT, Baxter (2011) provides five primary “seeings” (p. 7) afforded by the theory in generating new knowledge on even seemingly well-researched phenomena in the field of interpersonal communication. These re-workings highlight tacit assumptions in traditional interpersonal communication scholarship and demonstrate the rich potential of RDT in challenging them in charting new understanding in the field. The false binary of public/private, the bias against uncertainty, the illusion of the monadic individual actor, the inattention to power, and the illusion of relationships as containers each represent different re-framings through which future research might productively utilize RDT scholarship in shedding new and nuanced light on phenomenon (Baxter, 2010). As such, an unpacking of each re-framing will demonstrate the potential of RDT-informed research in moving scholarship on maternal depression and depression within the family context forward.

While each of the five assumptions highlighted by Baxter (2011) represent common assumptions that permeate the majority of extant research in interpersonal
communication, the false binary of the public/private is perhaps the most pervasive in that it “undergirds our very conception of interpersonal communication” (p. 8). Historically, studies of interpersonal communication do not include the public sphere and studies of communication in the public sphere do not consider interpersonal components. However, as Shotter & Bilig (1998) point out, even among dialogic research this false binary is unfortunate in that scholarship “[t]ends to focus on how particular utterances are occasioned by the immediate dialogical context, and to ignore the more long-term ideological influences at work in a speaker’s society at large” (p. 19). Indeed, as Baxter (2011) points out, sociocultural life is created and constituted in the relational and relationships are rife with ideology from the wider sociocultural environment within which they occur.

Similar to interpersonal communication research, the false binary of the public/private underpins the vast majority of extant research on maternal depression and depression within the family. When examined in the context of the family, most maternal depression research focuses on parenting behaviors of mothers and their children’s outcomes (Field, 2010). Similarly, studies of maternal depression focusing on the culture at large consistently fail to incorporate any aspect of familial relationships. Through the use of RDT, which allows for an interpenetration of public and private in the utterance chain, we can expand our understanding of how emerging adults make sense of maternal depression and motherhood within their family based both on their immediate relationships and on cultural discourses of depression and motherhood circulating around them.
Baxter’s (2011) second assumption, the bias against uncertainty, positions several concepts traditionally viewed negatively in human communication as not only positive, but absolutely necessary for individual and relational growth. RDT positions uncertainty as valuable in that discursive certainty runs the risk of becoming calcified while discursive uncertainty allows for dialogic creativity (Baxter, 2011). Additionally, importantly concepts of uncertainty and openness rest on the assumption of a preformed individual who reveals oneself through openness. RDT rejects this notion of the preformed self, instead framing identity as something constantly under construction (Baxter, 2011). As such, uncertainty can never be reduced in that individuals are consistently in a state of becoming. In moving away from the privileging of certainty and the assumption of a preformed individual, RDT-informed work can bring significant insight to the study of maternal depression and motherhood. In particular, understanding motherhood as an identity in flux rather than preformed is a unique and useful conceptualization as emerging adults come to understand their mother before, during, and in some cases after having depression.

Baxter’s (2011) third re-working iterates the need of relational scholarship to move away from its focus on monadic and contained individuals towards a focus on the social in-between. In viewing individuals as contained beings, communication is conceptualized as a conduit through which internalized goals, ideas, needs, etc. translate from one being to the other. Conversely, RDT moves the analytic unit of study into communication. In doing so, relational identities and understandings come not from individual psyches but from the interplay of competing discourses voiced within utterances (Baxter, 2011).
The focus on a communicative construction of understanding allows RDT to provide rich insight into understandings of maternal depression and the role of motherhood in the family. First, the study of illness in the family is often focused either on how a member’s illness affects familial processes or how familial processes affect a member’s illness. Very little research exists in understanding how a family actually makes sense of a member’s illness. Further, little research exists in understanding how individuals make sense of their depression in the context of their families. Using RDT provides the potential for understanding how families together construct understandings of depression and in the case of maternal depression, motherhood.

The inattention to power comprises Baxter’s (2011) fourth suggested reworking for interpersonal scholarship. With critical work comprising a significantly smaller portion of research within the field of interpersonal communication than both post-positve and interpretive work, a turn towards critical studies represents unique potential not only for maternal depression research but also for family and health communication at large. As noted prior, RDT positions power as located not within people, but discourses. An examination of power within discourses using RDT therefore generates an ability to identify and critique those discourses currently occupying centripetal positions in culture.

Considering the increase in acceptance of the biomedical model despite a lack of explicit evidence, it is clear that the biomedical model of depression represents the centripetal view of depression. However, frustration with the biomedical model even within the field of its creation may signal that depression research is at the cusp of a potential fracture in understanding. RDT represents a way to identify the powerful
discourses currently circulating in everyday talk pertaining to depression and how those centripetal discourses may constrain or silence a woman’s experience with depression. Further, RDT gives us a way to also identify what potential centrifugal discourses are circulating along with how those discourses interpenetrate or work to dethrone the centripetal understandings of maternal depression as they sit now in culture at large. Similarly, the discourse of intensive motherhood currently represents a centripetal understanding of expectations of motherhood (Hays, 1996). RDT can provide researchers with a way of understanding the discursive struggles emerging adults face in understanding their mother in a society that privileges intensive mothering. Indeed, RDT provides a useful framework through which to justify critical work interrelating the larger cultural ideas of depression and motherhood in addition to giving us a useful heuristic in unraveling the complex nexus between the two.

Baxter’s (2011) fifth and final reworking involves dismantling the illusion of relationships as containers. Similar to her argument of dissolving the public/private boundary, Baxter argues that we must move beyond understanding relationships as contained entities that together interact with their environment and instead view them as dynamic and ever changing understandings that are constantly being constructed through communication. Relationships themselves are meanings (Baxter, 2011).

In enhancing our understanding of maternal depression, scholarship must make a similar move away from examining women and their illness as contained beings and towards understanding women and their depression as continually constructed and constituted through their communication with self and other. Similarly, as families come to understand depression and motherhood, the study of communication using RDT will
enable us to unlock how meaning about depression, and motherhood are generated in the in-between.

Baxter’s (2011) five re-workings of interpersonal communication along with her recent articulation of RDT provide communication scholars with an incredibly powerful heuristic device through which to understand how meaning unfolds in relationships. The theory holds rich potential in enhancing our knowledge in a myriad of interpersonal, relational, and family communication contexts.

**Research Questions**

From the review of literature on depression, maternal depression, and motherhood, it is clear that a number of discourses circulate in our culture at large in understanding depression and motherhood. In voicing their experiences with mothers with depression, emerging adults are voicing an experience that likely draws on numerous discourses of depression and motherhood. By examining the discursive struggle within their stories, the study sought to understand what discourses shape experiences of maternal depression along with how those discourses shape the meaning of depression and motherhood. Therefore, the first research question posed is:

RQ1: What are the discourses that animate the meaning of motherhood and depression in emerging adult talk on maternal depression?

In following the theoretical commitment of Baxter’s (2011) newest iteration of RDT, the analysis of emerging adults’ stories must move beyond simply identifying the discourses and include an examination of whether and how those discourses occur concomitantly in talk to construct meaning. In carrying out this additional analytic step, RDT gives scholars a way to identify if and how emerging adults draw upon one or a number of
discourses of depression to construct understandings of the illness and motherhood. As such, the second research question asks:

RQ2: How does the interplay of competing discourses surrounding emerging adult experiences of having a mother with depression construct meaning of depression and motherhood?
CHAPTER THREE

METHODOLOGY

In seeking to investigate the discursive meaning making processes voiced in emerging adult narratives surrounding motherhood and depression, qualitative methods and more specifically in-depth interviewing was chosen as the method of collection. Further, in recognizing that cultural discourses of motherhood and depression may carry different amounts of cultural legitimization and therein occupy centripetal (privileged) or centrifugal (marginalized) positions in defining motherhood and depression, the study took a critical approach to data analysis. Specifically, Baxter’s (2011) methodological companion to RDT, contrapuntal analysis, was chosen as the data analysis procedure in order to uncover and unpack the role of discursive power in meaning making.

Since the study sought to investigate what cultural discourses participants voiced in discursively making sense of depression and motherhood, the study focused on the distal-already-spoken site of the utterance chain. As noted in Chapter Two, the distal-already-spoken site of the utterance chain pertains to those discourses already circulating in mainstream U.S. society. These cultural discourses are commonly understood and often shared by cultural members through their continually voicing (Baxter, 2011).

Because of the focus on the distal-already-spoken, data for the current study was collected through one-on-one interviews. Baxter (2011) notes that when individuals participate in interviews with a researcher previously unknown to them, they are actively
engaging in border work as they attempt to render their private experiences intelligible to the “public” audience of the interviewer. Participants engaging in this border work view the researcher as a generalized other and tend to draw upon distal already-spoken discourses in order to make their experience intelligible (Baxter, 2011). Because one of the primary goals of the study was to identify circulating discourses of depression and motherhood, interviews served as a utile collection technique in gathering rich data focused on the distal already-spoken site of the utterance chain.

**Participant Eligibility**

Participants eligible for this study met several primary criteria. First, participants were defined as individuals between the ages of 18 and 25 in concurrence with the age limits set by Arnett (2000) in defining the emerging adult age range. Emerging adults were chosen as the participants of this study because of their ability to articulate their experiences and narrate their complex sense making processes in rich detail. Based on emerging adult literature (Arnett, 2000), narration is a cognitive skill developed during the years coinciding with emerging adulthood (McAdams & Olson, 2010). Specifically, emerging adults were assumed to still be young enough to recall their experiences of maternal depression in rich detail as many were presumably within a five-year time frame of living away from home for the first time but old enough to narrate their sense making processes surrounding those experiences. For the second primary criterion, participants had to self-report having a mother with current or former clinically diagnosed major depression.

Although there are a number of specific variants of mental illness resting under the umbrella term of depression such as postpartum depression, seasonal affective
disorder, and psychosis (NIMH, 2014), this study specified clinically diagnosed major depression for several reasons. First, because contrapuntal analysis requires a central, semantic object around which to direct data analysis, it was assumed that selecting one specific type of depression would allow for a clearer and stronger analysis. Similarly, it was assumed that the requirement for a clinical diagnosis would allow for a clearer and stronger analysis in ensuring that participants’ mothers were experiencing the same type of mental illness. Second, it was assumed that a clinical diagnosis would enhance the likelihood that mothers had engaged in some form of treatment. Because the treatment of depression ties directly into understandings of depression, I hoped that requiring a clinical diagnosis would allow for conversations surrounding treatments and enhance the depth of my analysis when examining how participants discursively made sense of the illness. Third, major depression is currently one of the most common mental disorders in the United States with almost seven percent of the adult population experiencing depression in a given year (NIMH, 2014). As a prevalent mental illness, I hoped that specifying major depression would aid in securing a sufficient amount of qualified participants. Further, one of my objectives within the study was to translate findings into useful resources for families currently experiencing mental illness. With this in mind, I hoped that selecting a prevalent mental illness would create an opportunity for the study findings to benefit a large number of families. In addition to the prevalence of major depression, it is important in light of the purpose of this study to also note that major depression is not inherently tied to circumstances such as postpartum depression (i.e., tied to childbirth) or seasonal affected disorder (i.e., tied to the onset of fall and winter). As
such, it represented a type of mental illness that required participants to discursively construct understandings of its meaning without these clear and well-established causes.

Although participants needed to self-report having a mother with current or former clinically diagnosed major depression, mothers did not need to be in current treatment or currently be experiencing symptoms of major depression at the time of the interview. Participants also needed to report being in contact with their mother during the time of her diagnosis and/or management of depression but did not need to report being in current contact with their mothers at the time of the interview. To verify the diagnosis of depression, participants needed to report an explicit confirmation either from their mothers or from family members. In other words, individuals who noted that they believed their mother was suffering from major depression but had not confirmed the diagnosis were not accepted for participation.

**Participant Recruitment**

After receiving IRB approval, participants were recruited using several strategies. This study required multiple means of recruitment due to the likelihood that appropriate participants would be difficult to reach. Further, prior work utilizing relational dialectics theory with hard to reach populations (e.g., family members of transgender individuals and children of gay and lesbian parents) successfully utilized as few as twenty to as many as thirty-seven participants (Breshears, 2010; Norwood, 2010) so thirty participants was theorized as an initial goal for a successful contrapuntal analysis. I made this decision with the understanding that theoretical saturation for both the identification of discourses and exploration of discursive interplay identification would be needed during data
analysis before it could be accurately determined if a sufficient amount of data had been collected.

Participant recruitment was carried out in two primary phases. The first phase of participant recruitment began in mid-July of 2014 after receiving approval from the University of Denver’s Institutional Review Board in June of 2014. Phase two of recruitment began in September of 2014. Phase one of recruitment continued concurrently with phase two until an adequate number of participants had been procured for the study by October of 2014.

Recruitment phase one involved recruitment within the local community and online via snowball sampling. First, I located a number of local mental health alliance organizations specializing in family therapy interventions, family outreach, and family education for families dealing with a member’s mental illness. The Depression/bipolar Recovery Group of Midtown Denver hosts both public forums and private support groups for individuals and family members of individuals suffering from bipolar and/or major depression. The Denver Alliance for the Mentally Ill offers support and education for families of people with mental illness and family-to-family education classes designed with support from the National Alliance for the Mentally Ill. The classes are led by family members and designed for family members of people with mental illness. The Arapahoe/Douglas and Jefferson County Alliances for the Mentally Ill offers bi-weekly education and support groups for family members of people with mental illness. Finally, I also contacted Denver’s Al-Anon network, which supports the family and friends of alcoholics. Although this group is not specifically targeted towards individuals with mental illness, research on both alcoholism and depression note the high rates of
comorbidity between the two illnesses and as such the network was deemed a potential cite for productive recruitment (Pandey et al., 2014).

Initial contact was made with each organization to inquire if information about the study might be disseminated to the families the organizations served. After researching each organization and locating the gatekeeper (i.e., the preferred point of contact for each organization that grants access to the population each serves), I made initial contact with each of the organizations’ preferred individuals via email. Each email included information about my study including a summary of the purpose, requirements, procedure, and researcher contact information (see Appendix C). Through these initial contacts, I was directed towards one specific individual working with the Denver Alliance for the Mentally Ill who oversaw a number of the group leaders working across a number of organizations. After speaking with the individual, we decided together that the best method of reaching family members would be for individual group leaders of each organization to distribute my information to their communities. The information provided to potential participants through these group leaders included the study announcement and my contact information in order to allow interested participants to contact me directly (see Appendix D).

In addition to community outreach, I utilized a variant of snowball sampling by posting information about my study online via the popular social networking site Facebook. Purposive sampling methods like snowball sampling traditionally involve prior participants contacting other individuals they know who might qualify for a study (Merrigan & Huston, 2009). However, considering the potentially sensitive nature of the topic, I requested that individuals willing to share my information share with their entire
social networks rather than share with single individuals they thought might qualify for the study in order to protect the anonymity of participants.

The use of snowball sampling via Facebook in particular as a virtual snowball sampling (i.e., sampling online) was included because it has been found to be as effective—and in some cases more effective—than traditional snowball sampling (Balter & Brunet, 2012). Perhaps more importantly, Balter and Brunet (2012) argue that Facebook is more effective than traditional snowball sampling in that potential participants have immediate access to information about the researcher and/or are given information about the study by an individual they trust. Considering the sensitive nature of the study, Facebook stood as a utile way to recruit participants in that they had access to information about me and/or were able to learn about the study from a trusted individual. In recruiting via Facebook, I was able to disseminate information about my study on my personal profile page. In addition, members of my social network shared my study announcement with their own social networks on their personal pages.

In phase two of recruitment, participants were recruited from the University of Denver via classroom sampling. This classroom recruitment began in undergraduate communication courses at the start of the Fall 2014 quarter. I requested and was granted access to all nineteen sections of undergraduate communication courses. In addition to reaching out to students in communication courses, I also spoke with the Department of Psychology and the Department of Sociology and was able to recruit in each department’s introductory, large-lecture courses.

In each of the twenty-one classroom recruitments, I spoke to the students briefly (4-5 minutes) about my research and the importance of the particular study (see
Appendix H). I also shared information about the qualifications for participation, information about reimbursement for participation, and the potential for extra credit or course credit in the classroom. In addition, each student received a physical copy of the study announcement containing information about the study, information about reimbursement for participation, and my contact information (see Appendix E). Also, information for the study was posted to the Communication Studies department website (see Appendix E). The website includes a specific page for study announcements and allowed for individuals not present in classroom presentations to access information about the study. Finally, information for the study was distributed to the University of Denver’s Health and Counseling Center who agreed to briefly place the study announcement in the waiting room of the Health and Counseling Center clinic (see Appendix E).

Individuals who were interested in the study contacted me via telephone or email to indicate their willingness to participate. Each participant was contacted within 24-hours of his or her initial email or telephone contact with me after procuring email contact information from participants who had indicated their interest to me via phone. In the follow-up email, I reiterated the requirements of the study and attached the informed consent document (see Appendix G). As part of this iteration, I made sure to note that participants needed to report having a mother with clinically diagnosed major depression. Although they did not need to provide proof of this diagnosis, I specifically noted in the email and informed consent that a clinical diagnosis was required. I noted in the email that the participant should read through the informed consent to ensure that they did not have any additional questions about the study and requested they indicate to me a
good time to conduct the interview if they still believed they met the requirements for the study and wanted to participate (see Appendix F).

Most interviews were conducted within one week of initial contact, though some occurred as long as two weeks after initial contact due to scheduling conflicts. Interviews were scheduled at the participant’s convenience both in terms of day, time, and location of interview. All interviews were conducted in person and ranged in length from 38 to 96 minutes with an average length of 51 minutes. The majority of the interviews were conducted on the University of Denver campus though a handful did occur at various coffee shops throughout the Denver Metro area. Interviews conducted on campus were conducted at a location of the participant’s choosing. The majority of participants requested to be interviewed in the campus library. I reserved private conferences rooms the day prior to ensure that the interviews could be conducted in a confidential setting. Three participants requested to be interviewed in the Communication Studies department. These interviews were conducted after traditional office hours (i.e., after 5:00 p.m.) and were conducted in the Communication Studies department’s private conference room. Finally, three participants requested to be interviewed outside on campus. Participants wishing to be interviewed outside were allowed to select an outdoor location of their choice where they felt comfortable. Before beginning each interview conducted in a public setting such as coffee shops and outdoors on campus, I made sure that each participant was aware of the risks to confidentiality and inquired as to what he or she felt comfortable with me disclosing should an individual known to the participant approach us during the interview.
Participants in the study were reimbursed for their study participation in two ways. First, participants indicated to me during their interview if they wanted me to contact any of their instructors for extra credit or required research participation credit. If students provided information about instructors, the instructors were emailed within one week of the interview and informed of the day and time of the student’s participation in my project. All participants were also offered a $30 Amazon gift card for their participation in the project. I initially planned to conduct thirty interviews and, accordingly, procured thirty gift cards prior to participant recruitment so as to reimburse each interviewee. However, six participants declined compensation for participating in the interview. Therefore, I continued recruiting until I was unable to offer financial compensation to participants. In total, I recruited and conducted interviews with 36 participants between August and October of 2014. Of the 36 participants, seven were recruited via the dissemination of information from the network sampling within the Denver metro community and online via Facebook and 29 participants were recruited via classroom recruitments at the University of Denver.

**Participant Information**

Although each of the 36 participants was currently living in Colorado at the time of the interview, participants included individuals from across the United States, two residents from Canada, and one from Norway. Participants from the United States reported living in 16 states at the time of their experiences with maternal depression. The majority of participants identified as female ($n = 30$) with men making up a sixth of the participant population ($n = 6$). Participant ages spanned the emerging adulthood range from 18 to 25 ($M = 20.8; SD = 2.5$) and identified predominantly as White ($n = 30$) with
Iranian \((n = 1)\), Latina \((n = 1)\), Mixed-race \((n = 1)\), Native American \((n = 1)\), Filipino \((n = 1)\), and Vietnamese \((n = 1)\) populations also represented.

**Data Collection**

Prior to conducting interviews with participants, I conducted two pilot interviews to ensure the quality of the protocol. The interviews were conducted with two individuals known to me who reported having a mother with depression but who were no longer within the age range for emerging adulthood \((18-25\text{ years})\). I conducted both pilot interviews shortly after receiving IRB approval to the study in late June and immediately prior to beginning my official participant recruitment. Both individuals participating in the pilot interviews were in their late-20s and reported having a mother with major depression for the majority of their childhoods.

Conducting the pilot interviews allowed for two primary insights prior to beginning my official data collection. First, the interviews allowed for a more accurate gauge of the length of time it might take an individual to move through the interview protocol to ensure I was providing accurate information on my recruitment materials. Second, the pilot interview participants were able to offer valuable feedback on the organization and wording of questions. With the help of the pilot interview participants, the organization of the protocol questions was reorganized to better match the natural flow of narratives. The first protocol had participants move through their entire experience chronologically wherein participants described their understandings of both depression and motherhood when their mother was first diagnosed with depression. The reorganized protocol had participants move through their experiences topically with questions pertaining to motherhood followed by questions pertaining to depression. This
topical reorganization of interview questions helped the protocol became more coherent and better matched the natural progression of participant experiences as they discursively moved through their stories. After the slight reorganization of the interview questions, I again interviewed one of the participants to ensure that the ordering of questions improved the protocol.

Prior to each participant interview, each of the participants completed a short demographic survey asking for participant age, ethnicity, and home state. Participants were free to leave any section of the survey blank. Before beginning the official interview, I reviewed several points from the informed consent that the participants previously received via email when agreeing to participate in the study. First, I informed each of my participants that the interviews would be recorded and explained how the taped information would be kept confidential. Because I was not transcribing the recorded interviews, I explained to my participants how their information would be shared with the transcriptionist and how the transcriptionist would keep the information confidential in addition to how some material in the transcript would change to further protect anonymity (e.g., family members’ names would be changed). Finally, I briefly discussed what my dissertation was and described how the information they provided might be used later (e.g., presented at conferences).

Although some of the information discussed during this time was redundant from the informed consent, I took the time to do so to ensure that my participants had a clear understanding of both how the information they provided would be protected in addition to how it might be used in the future. Considering both the sensitivity of the research topic and the age range of participants, I believe this short conversation gave participants
confidence in the confidentiality of the project in addition to providing them insight into the overall research process. After describing the aforementioned aspects of the research process, I provided a brief summary of my own professional interests in the study including the overall goals of the study such as creating better resources from families affected by mental health problems.

After describing my professional goals for the study, I finished my pre-interview conversation by detailing my own personal experiences with depression within my family. In sharing these personal and professional stories, I believe I helped build a sense of rapport with my participants through clearly explicating the purpose of the project and self-disclosing my own personal interests (Lindlof & Taylor, 2011). In addition, by initially telling my story (see Appendix A), I believe I gave participants time to ease into the interviewing space while I discussed my perspective. After discussing my positionality to the project, I allowed the participants to ask any additional questions of me, including any questions about the interview before beginning.

After receiving verbal consent form each participant, I began each interview with a grand scale question asking participants to tell me the overarching story of their mothers’ depression (i.e., participants described the overarching story of the timeline of their mother’s depression). Lindlof & Taylor (2011) note that grand scale questions are productive, nondirective questions that allow participants to freely describe their experiences in a scope that they feel comfortable with work well as a starting point in interviews. Norwood (2011) notes the importance of beginning narrative interviews in this way in order to allow participants to frame their experiences in a story format. Doing so also allows the researcher to better understand which aspects of the overall experience
the participants feel are salient to their experience while maintaining uniformity with semi-structured questions. Additionally, the question allowed participants to select which aspects of their experience they were willing to share considering the potentially sensitive nature of the topic.

Following this overarching narrative, I asked the participants several follow-up questions such as: “Is this something still affecting your family today or is it more of an episode in the past?” In some instances I asked for clarification or elaboration on certain points in participants’ stories. These follow-up and clarifying questions allowed me to gain richer insight into participants’ families and helped me direct questions later in the interview such as asking questions about communication among siblings if I found out the participant had a sibling or asking about grandparents’ reactions if the participant mentioned grandparents in the initial narrative.

The remainder of the interview utilized a semi-structured interview protocol. The protocol was flexible in that questions were adjusted, or reordered during the interview in order to accommodate or to sensitively handle what was happening in interviews (Rubin & Rubin, 2012). The ability to maintain flexibility with the protocol was of the utmost importance considering a number of participants noted that they had not discussed the experience of having a mother with depression in-depth prior to the interview. A number of participants did experience strong emotions during the interview, perhaps because they had not previously disclosed such information to others. During these emotional moments, I refrained from asking them for attributions for their emotions in an attempt to respect their privacy, and I would also pause the interview process accordingly. During these pauses, I spent time talking with the participant to make sure that he or she felt
comfortable continuing and to ensure that the participant knew that he or she could stop their participation at any time. In addition, I asked the participants who did wish to continue if there were any topics they would prefer to move away from for the rest of the interview. For example, one participant asked to stop recording for a moment to emotionally collect herself during which time we agreed that we would skip a few of the questions pertaining to motherhood and instead move towards questions focused more on her understandings of depression.

Generally, interview questions asked participants to relay their experiences of having a mother with depression including how they understand both depression and motherhood. Example questions included: “Has your understanding of the role of mother changed at all over the course of your mother’s depression? Prior to your mother’s diagnosis what were your understandings of depression? How do you think you might explain it now?” Participants were also asked to reflect on how both their mother and their collective family unit communicated about depression. Example questions included: “How would you describe your family’s communication overall about your mother’s depression? Did you ever talk to individuals outside of your family about your mother’s depression?” In addition, participants were asked to reflect on the negative and positive aspects of the experiences of having a mother with depression including what advice they might give to individuals and families who are facing a similar situation. Example questions included: “Do you think your family did anything particularly well or particularly not well in regards to your mother’s mental illness? What advice might you give to other people in your situation?” Finally, participants were asked to reflect on my interview protocol and think if there were any questions that I did not ask that might be
important to ask in order to fully capture their experiences with maternal depression. Overall, the majority of participants noted that they believed the protocol had covered the breadth of their experiences with maternal depression. Upon concluding the interview, participants were thanked for their time and presented with the $30 Amazon gift card. Participants were also provided with information about the health and counseling center on the university’s campus in addition to counseling options in the metro area (see Appendix H).

Upon completion of each interview, audio files of each interview were sent to a professional transcriptionist. Once I received the full transcripts of the interviews, I engaged in an audibility check (Lincoln & Guba, 1965) by reading through each in full while listening to the original interview in order to ensure accuracy of the transcripts and to verify that all identifying information had been removed or changed. In addition, I made sure to note instances of laughter, joking, and sarcastic tones and added my own notes taken during the interview to the transcripts in order to provide as much context as possible when analyzing the data. Once I completed the audibility check for each interview, I contacted the transcriptionist and instructed her to delete the audio file and her copy of the corresponding interview transcript.

**Data Analysis: Contrapuntal Analysis**

Data for the study was analyzed using contrapuntal analysis as explicated by Baxter (2011). Because RDT conceptualizes discourses as power-laden and often in competition with one another, Baxter proposes this unique type of discourse analysis as it is specifically designed to attend to the identification and exploration of discursive power. Though Baxter concedes that other discourse analysis techniques may be
employed successfully in RDT research, she notes that contrapuntal analysis is more favorable in that it is designed specifically for RDT and as such can serve as a methodological tool through which the theory and method can establish themselves and grow.

Guiding a contrapuntal analysis is the broad analytic question “What are the competing discourses in the text and how is meaning constructed through their interplay?” (Baxter, 2011, p. 152). To answer this question, contrapuntal analysis requires a three-step process: selecting a text (in this case interview transcripts), identifying discourses, and identifying the interplay of competing discourses (Baxter, 2011). After selecting a text, a researcher selects the central topic(s) of interest, or semantic object(s), within the data set. In this case, I entered into data analysis with two predetermined semantic objects in mind: motherhood and depression. I read through my texts with the questions of: “What are the competing discourses surrounding motherhood and depression in the text and how is meaning constructed through their interplay?”

Because the study sought to understand discursive constructions of both motherhood and depression, a contrapuntal analysis was conducted in full for each semantic object. In other words, I first went through the entire process of identifying discourses and identifying the interplay of discourses solely with an eye towards understanding the discursive construction of motherhood. Then, I went through the process of identifying discourses and identifying the interplay of discourses with the goal of understanding the discursive construction of depression. Conducting a full analysis for each semantic object separately allowed me to immerse myself in the data with an eye
towards each specific concept in greater detail rather than attempting to identify all of the discourses surrounding both motherhood and depression within a single analysis.

During contrapunctal analysis of the semantic object of depression, I noted two major struggles surrounding the discursive construction of depression. The first struggle surrounded the existence of depression (i.e., whether depression was a legitimate illness or an emotional state). The second struggle surrounded the etiology of depression (i.e., the causes of depression). Although both struggles cohered around the semantic object of depression, I decided to break them down into two separate contrapunctal analyses for two reasons. First, the struggle surrounding the etiology of depression did not fit into the struggle surrounding the existence of depression in that all discourses surrounding the etiology of depression operated on the assumption of depression’s existence. In other words, the struggle of the etiology of depression involved various discourses pertaining to where depression originates from but each of these variant discourses operated on the presumption that depression was in fact a legitimate illness. As such, it did not fit squarely within the struggle surrounding the existence of depression. Second, the struggles surrounding the existence of depression and the etiology of depression both presented rich and complex instances of polemic and transformative interplay.

In sum, I decided that breaking the semantic object of depression into two analyses would both provide rich insight into the complex discursive meaning making processes in constructing understandings of depression that one analysis alone would not capture. In total, I conducted three full contrapunctal analyses. Rather than describe the process of each of the three analyses in full, below I describe the general methodological
process I engaged in as it occurred during contrapuntal analysis one which explored the discursive construction of motherhood.

**Identifying discourses.** To fully attend to the identification of discourses, Baxter (2011) suggests garnering knowledge about potential interpersonal and sociocultural discourses surrounding the semantic object prior to conducting the analysis. In this case, I spent time exploring cultural understandings of motherhood in contemporary U.S. society. To engage in this work, I examined contemporary scholarship on motherhood across several disciplines (e.g., sociology, media studies, feminist studies) in addition to examining work on motherhood published in more publicly accessible spheres (e.g., newspapers, magazines, popular books). In addition, I explored a number of motherhood blogs and message boards in order to examine how mothers themselves were describing their experiences.

Priming myself with this information served not as a deductive coding tool during my analyses but rather as a sensitizing tool for me in inductively interpreting my data (Baxter, 2011). In other words, I did not enter into my data analyses seeking out the specific discourses of motherhood as explicated in Chapter Two. Rather, I became versed on contemporary discourses of motherhood in order to understand the current landscape of motherhood within the culture at large as a way to prepare myself to identify discourses within my data. After receiving the interview transcriptions, I moved into the identification of discourses by conducting a thematic analysis utilizing Braun and Clark’s (2006) six step guidelines for thematic analysis: (1) becoming familiar with the data set, (2) generating initial coding categories, (3) generating themes (discourses), (4) reviewing
themes (discourses), (5) defining and naming themes (discourses), and (6) locating exemplars (Baxter, 2011; Braun & Clark, 2006).

In order to become familiar with the data set, I spent significant time both listening to my interviews and reading through the interview transcripts. After listening to each interview at least once, I read through my transcripts in full twice to garner a general feel for the data set. It was during my initial listening and readings of the interviews that I made the decision to break my analysis down into three separate analyses. I read through the data set in its entirety a total of three times before beginning my first analysis.

When generating initial coding categories and developing themes for a contrapuntal analysis, Baxter (2011) notes that one should first develop a clear semantic object in order to code utterances that cohere around it. In this case, the semantic object for the first analysis was motherhood and utterances that spoke to the larger analytic question “What is motherhood?” were coded. Baxter (2011) also suggests engaging in the process of unfolding as part of a thematic analysis (Bakhtin, 1984). Unique to contrapuntal analysis, unfolding involves conceptualizing data as part of a larger utterance chain built upon utterances of the past and constructed with anticipation towards utterances of the future. To engage in the process of unfolding, Baxter poses two primary questions: “What prior utterances might this utterance be a response to?” and “What subsequent responses are invited by this utterance?” (p. 161). Using these guiding questions, I was able to garner a richer understanding of current understandings and expectations of motherhood. For example, when describing some of her mother’s actions as unfavorable, one participant prefaced the statement by saying: “Probably sounds
terrible the way I’m talking about her.” Although the participant did not directly voice the idea that a child should not speak negatively about his or her mother, the participant’s voicing of the idea that speaking about a mother’s mistakes inappropriate gives a latent nod to expectations of motherhood and children in contemporary culture.

With my semantic objects selected, my familiarity with data established, and my eye trained towards Baxter’s (2011) analysis suggestions, I began to read through the data set and generated my initial coding categories. Once initial coding categories were established, I moved into the third step of my thematic analysis and examined whether and how those categories cohered into larger themes, or discourses. After generating my discourses, I reviewed each to ensure that they were capturing my data set and were mutually exclusive. With each discourse explicited in full and deemed sufficient in capturing the data set, I defined and named each theme in accordance with Braun and Clarke’s (2006) fifth step of thematic analysis.

For the first analysis, two primary discourses of motherhood emerged: 1) the discourse of ideal motherhood, and 2) the discourse of real motherhood. For the second analysis, two primary discourses of depression (reality) emerged: 1) the discourse of depression as sadness, and 2) the discourse of depression as illness. For analysis three, two primary discourses of depression (etiology) emerged: 1) The biomedical discourse of depression, and 2) the psychosocial discourse of depression. After reviewing and naming the themes (discourses), I generated a robust analytic memo clearly naming the overall and defining each discourse. The memo contained a detailed breakdown of each discourse and the subsequent tenets comprising each. In addition, each memo contained
a detailed list of exemplars in accordance with the final step of Braun and Clarke’s (2006) thematic analysis procedure.

**Identifying the interplay of competing discourses.** Once discourses were identified, I analyzed whether and how the discourses were competing in the text. Baxter (2011) identifies two primary ways discourses intersect in a dialogically expansive text: *diachronic separation* and *synchronic interplay*. In *diachronic separation*, centripetal and centrifugal discourses (i.e., privileged or culturally centered discourses) occur across time or communicative topic. Baxter notes two types of diachronic separation: *spiraling inversion* and *segmentation*. When one discourse is centered at one point in time but marginalized at another point in time, the data represents *spiraling inversion*. When one discourse is centered during a certain communicative context and marginalized in another, the data represents *segmentation*. Because both spiraling inversion and segmentation occur across time and context, it is often difficult to identify instances of both types of interplay in data that is collected as one point in time. Specifically, these instances may appear to be monologic (i.e., only one discourse is given voice) in a given data set as a participant voices only one discourse in that given point in time. However, Baxter notes that identifying instances of spiraling inversion and segmentation is possible in narratives of retrospective accounts as participants vocalize discourses that they voiced at an earlier point in time or within a different context in comparison to the discourse that they voice now.

In order to identify instances of diachronic separation, I read through the data set with a specific eye towards identifying instances of participant talk wherein participants either described their understandings of motherhood and depression retrospectively (i.e.,
described how their understandings evolved from their childhood to now) or described
their understandings as they occurred across various contexts (i.e., participants
descriptions of how they communicate about depression at school versus at home).

After analyzing the data with an eye towards diachronic separation, I moved into
the identification of *synchronous interplay*, or the interplay marked by multiple discourses
co-occurring at a singular point in time (Baxter, 2011). Baxter further breaks down
instances of synchronous interplay into four primary types of struggles: *antagonistic-
nonantagonistic, direct-indirect, serious-playful, and polemic-transformative*. Of central
importance to this study were the antagonistic-nonantagonistic struggle, the serious-
playful struggle, and the polemic-transformative struggle. As such, each will be
reviewed briefly as it pertained to the data set.

In *antagonistic struggles*, semantic positions are taken up by two separate
individuals and the struggle for meaning is located between the two individuals’ voicing
of different positions. For example, one individual may call upon the discourse A of
motherhood and another individual may call upon discourse B of motherhood when
discussing motherhood. Conversely, *non-antagonistic* struggles occur when multiple
discourses are voiced within one individual’s utterance (Baxter, 2011). So, an individual
may call up both discourses of motherhood in his or her utterance. Because participants
were speaking with a researcher and not with other members of their families, the
majority of the data included *non-antagonistic* struggles. However, because participants
recalled actual conversations with individuals, reported *antagonistic* struggles also
emerged in the data. In other words, instances of antagonistic struggles emerged when
participants recalled conversations wherein they provided both their statements and the other individual’s statements.

When examining the interpenetration of discourses in both antagonistic and non-antagonistic struggles, Baxter (2011) notes three types of discourse markers researchers should attune to in locating discourses in contention: negating, countering, and entertaining. Each type of interplay represents a unique discursive process wherein individuals place discourses in contention with one another to various degrees. Baxter notes that in many instances certain lexical markers can serve as cues to a reader in identifying each. As each type of interplay was present in all three of my contrapuntal analyses and serves as a central component of my results, each will be explained in full.

Baxter (2011) defines negating as a discursive process in which an individual voices a certain discourse for the sole purpose of refuting it or clearly supplanting it with another discourse. For example, a participant might say, “Some people think that depression is caused by social difficulties, but our family knows that it is genetic.” In this case, the individual highlights the psychosocial discourse of depression for the specific purpose of rejecting it with the biomedical discourses. Baxter notes that negating is often most evident in true antagonistic struggles wherein two individuals align with and voice differing discourses. In the case of the current data set, negating was located primarily in instances of reported speech wherein participants called up a discourse as voiced by another individual and then refuted it either their own reported speech in the recalled interaction or in the present.

Like negating, countering involves the voicing of a certain discourse for the purpose of refuting it. However, instead of directly refuting a discourse, an individual
will usurp an expected discourse with an alternate one. In doing so, countering allows for the displaced discourse to maintain some legitimacy while simultaneously pushing it to the margins as it grants legitimacy to a different discourse. For example, an individual might say, “I can understand why some people think my mom’s depression is caused by social difficulties considering what has happened to our family, but ultimately I think what is really going on is genetics.” The statement allows for the psychosocial discourses to hold some credence but ultimately lands on the side of the biomedical discourse. In identifying instances of countering, Baxter (2011) notes that a number of lexical cues (e.g., although, however, but, yet, just, surprisingly) can help cue a reader as they signal a shift in meaning.

Unlike negating and countering wherein one discourse essentially finds centripetal positioning and other discourses are pushed to the margins either directly through negating or with granted legitimacy through countering, *entertaining* fails to position any discourse as more powerful than another. In instances of entertaining, a clear explication of several discourses are given voice by the narrator but the narrator is unable to position either as centripetal. So, an individual might say: “Some people think that depression is caused by social factors and some think it is caused by genetics. I guess I am not sure what the cause is.” In this case, the utterance voices both discourses as legitimate and notes an inability to determine which is more correct constructing the meaning of depression. Like countering, Baxter (2011) again notes that a number of lexical cues (e.g., maybe, might, could, it’s possible) can cue a reader into recognizing the potential for instances of entertaining.
In identifying these instances of antagonistic and non-antagonistic struggles, I paid special attention to utterances where participants recalled past conversations with individuals pertaining to motherhood. To identify instances of countering, negating, and entertaining, I read through the data multiple times with a general eye towards identifying instances of each and with a specific eye towards the discursive markers via the noted lexical cues as explicated by Baxter (2011).

The third dimension of synchronic interplay important to the study is the serious-playful struggle (Baxter, 2011). Of the four dimensions of interplay, the serious-playful struggle is the most attuned to the tone of an utterance. Baxter calls upon Bakhtin’s (1981d) notions of the rogue, the fool, and the clown in describing how an individual can playfully reject an utterance. Of interest to this study was the discursive move of the rogue. The rogue is classified as an individual who takes a discourse, attributes it to a certain group, and then mocks the group (therein giving an indirect rejection of the discourse attributed to the group). For example, an individual might say, “Scientists say that depression is caused by chemicals. Scientists also used to say that lobotomies were viable treatments for depression.” In this way, the individual rejects the credibility of the scientists and therein rejects the credibility of the discourse purported by the scientists.

Although I had not originally anticipated the presence of the serious-playful struggle in the data, I noted during my interviews that my participants often made jokes and took on a sarcastic tone when narrating some aspects of their experiences. As such, I made a point when listening to interviews with my transcripts to mark down times when the tone of my participants turned sarcastic in order to help attune me to the potential of the serious-playful struggle.
A fourth and equally central discursive struggle for the study was the polemic-transformative struggle. Occurring when discourses move from their zero-sum jockeying and into a transformed discourse, these transformative struggles can occur via two discursive processes. First, an individual may voice two discourses and give them equal credence in a way that allows for the creation of a new meaning. This hybrid gives a new meaning to the discourse while still allowing for each discourse to maintain their original properties. For example, an individual might say that depression is caused by both biomedical and psychosocial reasons, thereby creating the hybrid meaning currently known as the biopsychosocial cause of depression. Each potential cause is given equal weight, and though a new discourse (biopsychosocial) is formed, the components of the biomedical and psychosocial discourses can still be identified within the biopsychosocial discourse. In addition to hybrids, sometimes the move from a discursive back and forth struggle to a transformative struggle involves a “profound realignment of discourses in which new meanings are created,” (Baxter, 2011, p. 138). These aesthetic moments create an entirely new meaning and are often accompanied by an affective sense of momentary wholeness.

Unlike instances of negating, countering, and entertaining, there are no true lexical cues to serve as markers for instances of hybrids or aesthetic moments. As such, the identification of hybrids and aesthetic moments requires a clear and detailed understanding of both the overall data set and the discourse of the semantic object. As such, I made a point to attempt to identify instances of hybrid and aesthetic moments after I had generated a strong analytic memo and identified instances of each of the other types of struggles. In attempting to identify aesthetic moments and their accompanying
affective components, I merged any noted emotional moments from my initial interview notes and from my notes taken when listening to the interviews into my data set.

**Verification Procedures**

Following the precedent of prior studies employing contrapuntal analysis (e.g., Braithwaite, 2010; Norwood & Baxter, 2012; Norwood, 2011; Suter, Baxter, Seurer, & Thomas, 2014), this study utilized five verification procedures to demonstrate rigor: referential adequacy, audit trail, member checks, and data exemplars. First, the study utilized referential adequacy both during the initial thematic analysis and the subsequent interplay analysis. Utilized successfully by a number of research projects using contrapuntal analysis (Baxter et al., 2012; Suter et al., 2014), referential adequacy in a contrapuntal analysis involves analyzing half of a data set in order to develop initial themes, overall discourses, and interplay identification and then using this initial analysis as a benchmark for the analysis of the second half of the data in order to determine if the initial analysis holds (Lincoln & Guba, 1985). As such, the first half of the data was analyzed to generate initial themes and discourses. Then, using the initial analysis as a comparison point, the second half of the data was analyzed in order to ensure that themes and discourses identified in the first half of the data were equally as represented in the second half of the data. In addition, this step ensured that the themes and discourses identified in the first half of the data fully encapsulated the entire data set. Along with using referential adequacy to verify the thematic analysis, it was also utilized in verifying the interplay analysis. Again, the first half of the data was analyzed to generate an initial interplay analysis. Using the first interplay analysis as a benchmark, the second half of the data was analyzed to determine if the initial analysis held (Lincoln & Guba, 1985).
Second, I also kept an audit trail throughout my analyses. An audit trail typically requires each member of a research team or sole researcher to keep organized and detailed records of each step of the research process (Lincoln & Guba, 1985). Though an audit trail can be noted by a number of documentations (Lincoln & Guba, 1985), Baxter, Suter, Thomas, and Seurer (2013) explicitly note their audit trail as accomplished through chronologically organized analytic memos made by each team member during each step of the contrapuntal analysis project (e.g., initial coding categories, finalized discourses, and interplay analyses). Following these footsteps, I created a number of analytic memos throughout the data process pertaining to my initial coding categories, my finalized discourses, my initial interplay analysis, and my final interplay analysis. By maintaining an audit trail, I had a detailed account of each step of the contrapuntal analysis, and this enabled my ability to give consistent attention to detail throughout my analysis and offered rich and nuanced details with my results.

The third verification procedure utilized was member checking. Lincoln & Guba, (1985) Note member checks as a crucial technique in establishing credibility by checking interpretations and conclusions with participants from a study. Member checks were particularly important for the study as Baxter (2011) calls for researchers conducting contrapuntal analyses to ensure that discourses are ringing true to participant experience (Driskil, Meyer, & Mirivel, 2013). During the course of my interviews, three participants noted interest in hearing about my results. Upon completion of my analyses, I contacted these participants and requested that they examine my results with an eye towards ensuring that it rang true to their experiences. Because I conducted three separate analyses, each of the three participants received two of the three results chapters. In
assigning certain chapters instead of presenting the results in full, each chapter was
reviewed by at least two participants and the amount of material I asked my participants
to read was reduced. I emailed each participant two full results chapters including both
the initial discourse explication and interplay analysis and noted that participants were
welcome to provide written feedback via email, discuss the results with me on the phone,
or meet in person. One participant provided written feedback and two called to discuss
their feedback with me. Overall, the participants noted that the results and, in particular,
the discourses explicated rang true to their understandings of motherhood and depression.
In discussing the chapter on the etiology of depression, the two participants who had
received the chapter noted the interplay analysis as resonating with their experiences in
grappling with the understanding of where their mother’s depression originated. Overall,
the participants provided positive feedback for all three results chapters.

Finally, the study verified its results through the use of extensive data exemplars
throughout both the thematic and interplay analyses (Lincoln & Guba, 1965). Baxter et
al. (2013), Norwood (2012), and Suter et al., (2014) note the importance careful
identification of exemplars in order to ensure that their exemplars both rang true to the
larger narratives from which they were embedded and adequately reflected the themes,
discourses, and interplay present in the data set. In addition, the provision of multiple
exemplars demonstrates the consistency and salience of the themes and interplay
represented in the text. In the current study, data exemplars provided evidence of both
singular instances of interplay wherein certain types of interplay only occurred once or
twice within the data in addition to providing multiple examples of the more prevalent
instances of discursive interplay that were pervasive across the data set
CHAPTER FOUR
RESULTS PART ONE
DISCURSIVE CONSTRUCTIONS OF MOTHERHOOD

As the study sought to understand how emerging adults discursively construct understandings of motherhood and depression in the context of having a mother with depression, results of the three contrapuntal analyses were broken into two chapters with Chapter Four exploring meanings surrounding the semantic object of motherhood and Chapter Five exploring meanings surrounding the semantic object of depression.

Despite this conceptual separation for the purpose of exploring these discursive constructions, participants did not narrate their experiences surrounding motherhood and depression in isolation. Rather, their stories moved amidst and amongst them as they described their experiences growing up with a mother with depression. Around a third of participants reported that they could not remember a specific age at which they knew about their mother’s depression but noted that it had been a lifelong experience for them. In other words, these individuals could not recall a time growing up during which their mother did not suffer from depression. Among those remaining, participants described being as young as five to as old as seventeen when they realized their mother had depression.

A central experience to the participants was the renegotiation of the meaning of motherhood. For some participants, this renegotiation occurred as a direct result of a
mother’s diagnosis. In other words, participants described how their mothers changed after the diagnosis of depression and the subsequent renegotiations of their understandings because of these shifts. For others, this renegotiation of motherhood was attributed to growing older and more mature. Most pointed to late high school and early college as the time frame when they began to understand motherhood in different or new ways. Participants often expressed guilt, and in some cases embarrassment, for coming to these new understandings later in their relationships with their mothers. In other words, participants often voiced regret in taking so long to reach their current understanding of motherhood and wished they had been able to understand the role of motherhood as they currently described as children.

In line with prior work exploring experiences of children with parents with mental illness (e.g., Van Parys, Smith, & Rober, 2014), one of the most common themes that ran throughout the data was that of parentification (Minuchin et al., 1967), or the identification of having to step into the role of motherhood and/or experiencing a hierarchy shift in the mother/child relationships. These stories of parentification were voiced by a number of participants and served as a utile lens through which to understand discursive constructions of motherhood. Participants often articulated their need to “step into the role” of motherhood both in instrumental and emotional ways. As this chapter will subsequently demonstrate, noting this step into the role of mother provided a useful discursive cue in locating how emerging adults discursively construct understandings of motherhood.

Just as participants described their understandings of motherhood evolving and shifting across time in their retrospective accounts, their utterances in the present also
demonstrated a continued discursive struggle to construct understandings of motherhood. In other words, though participants may not have realized it in the interview, their utterances demonstrated a continued discursive struggle in constructing meanings of motherhood. These struggles occurred primarily on the distal-already-spoken site of the utterance chain with participants calling upon a number of competing pre-existent cultural discourses when constructing meanings of motherhood. However, participants also called upon proximal discourses of motherhood wherein discourses of relational past elided and interpenetrated with these wider cultural discourses of depression.

In answering RQ1, the first section of the following chapter will review each discourse of motherhood by providing an overview of each discourse via an in-depth presentation of the DIM and DRM’s oppositional tenets. After reviewing the discourses, the chapter will then explore research question two by examining the ways in which the DIM and the DRM discursively construct the meaning of motherhood through their interplay in participant utterances.

**Discursive Struggle One: The Meaning of Motherhood**

The first primary struggle centered on the meaning making of motherhood. Results of the contrapuntal analysis revealed two primary discourses of motherhood: the discourse of ideal motherhood and the discourse of real motherhood. These discourses of motherhood are each comprised of two primary, oppositional tenets. The discourse of ideal motherhood (hereafter the DIM) is articulated through two tenets: (1) mothers as cultural script, and (2) mothers provide full care and support. Troubling the DIM is the discourse of real motherhood (hereafter the DRM). The DRM is articulated through two
primary countering tenets that sit in response to the tenets of the DIM: (1) mothers as individuals, (2) mothers provide what they can.

Both the *discourse of ideal motherhood* and the *discourse of real motherhood* follow the intellectual shift first articulated by Ruddick (1989), which conceptualizes motherhood as defined not solely upon biological connection but rather via a performance of motherhood. In other words, giving birth and mothering are marked as distinctly different phenomena with mothering understood as a role and/or set of actions rather than a title given to women with genetic ties to their children. Similarly, participant talk surrounding motherhood was not articulated as a genetic or biological connection to a child. In fact, only one participant in a single utterance noted the experience of giving birth to a child as connected to motherhood.

**Discourse of Ideal Mother (DIM)**

As each tenet of both the DIM and the DRM will demonstrate, virtually all articulations and discursive constructions of motherhood voiced by participants fell into a more socially constructed (Berger & Luckman, 1966) framework of motherhood reliant upon historical circumstances and specific social contexts (Glenn, 1994). Specifically, the DIM called upon specific scripts of motherhood circulating within the U.S. culture at large and the current dominant ideology of motherhood, *the discourse of intensive mothering*. The DIM positions motherhood as a set of culturally specific scripts (e.g., moms bake cookies) in addition to a role requiring a individual to provide full daily care (e.g., taking children to school) and emotional support (e.g., being emotionally present in children’s lives) for children.
In articulating motherhood as a set of culturally specific scripts, the DIM draws upon what Baxter (2011) labeled a “discursive template” (p. 59). A discursive template refers to those relationship-specific discourses that circulate in U.S. culture at large and provide a commonly understood background of distal already-spokens for definitions and expectations of certain relationships such as friends with benefits or the “real family” (Baxter, 2011, p. 59). For example, when an individual labels a relationship as “friends with benefits” he or she calls upon current cultural understanding of the term, which presently refer to self-proclaimed friends who engage in sexual activities with one another but do not consider themselves romantically linked or sexually monogamous (Hughes, Morrison, & Asada, 2005). Discursive templates, then, operate on an assumption of shared understanding both from the proximal and distal anticipated other. As Baxter (2011) points out, discursive templates become particularly relevant when individuals construct understandings of relationships that may deviate from the templates such as when stepfamilies construct understandings of family next to a discursive template of the “real family” which positions family as biologically and legally related.

Voicing the DIM, participant descriptions of motherhood draw on this discursive template by articulating culturally specific and stereotypic characteristics of motherhood in constructing their understandings. Participant utterances describe their mothers as doing “mom stuff” (16: 1301) and “mom things” (34: 496). Without the need to unpack and/or elaborate further, these participant utterances operated on the assumption of a

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1 All participant quotes are referenced by interview number and line number. As such, 16:34 refers to interview number sixteen, line number 34.
shared understanding of what those activities and descriptions of motherhood might entail.

In positioning motherhood as a role that involves providing full care and support, the DIM also re-inscribes components of the previously articulated *discourse of intensive motherhood* (Hays, 1996). In describing mothers as those expected to provide full care and emotional support for children, the DIM echoes the discourse of intensive motherhood by positioning mothers as those who are wholly and selflessly devoted to all of their children’s needs. Mothers not only provide the daily care required (e.g., “picking you up from every sports practice” 12: 170-171) but also their full emotional support for to their children (e.g., “supporting 110 percent in everything” 18: 379). In echoing the discourse of intensive mothering, utterances including the DIM even included descriptions of superheroes (e.g., “She was superwoman. She did it all, like my mom does everything,” 16:568-569) in describing a mother’s ability to do it all for children.

**Discourse of Real Mother**

In contrast with the DIM, the DRM moves the understanding of motherhood down from wider cultural scripts and cultural discourses of motherhood into one centered on individuality and reality. By positioning individuality as paramount to motherhood, the DRM marks motherhood as a role occupied by a unique, multi-dimensional individual with an identity and life experience stretching beyond that of mother. In the DRM, mothers are explicitly noted to be people (e.g., “I felt like she was her own person” 11: 395) rather than the more traditional cultural script provided by the DIM. Similarly, the DRM resists the expectations presented in the DIM of the responsibility of providing total support and instead privileges support as a mutual interdependence between mother
and child. Overall, the DRM dismisses the expectations set forth by culture as narrated in the DIM and instead foregrounds expectations of motherhood contextually. In other words, motherhood is described as an individual experience of a woman who is operating within her own unique relational means (e.g., “So I only expect what I think she’s capable of giving” 28: 295).

With both discourses reviewed in full, we can now turn our attention towards the individual, oppositional tenets comprising each. To demonstrate the oppositional nature of the tenets, the first tenet of the DIM will be presented in full followed by the first tenet of the DRM. Similarly, the second tenet of the DIM will be presented in full followed by the second tenet of the DRM.

Mothers as One(Multi)-Dimensional

**Mother as cultural script (DIM).** The DIM defines motherhood as a common familial role mothers engage in by adhering to the wider, cultural script of motherhood. This script of motherhood involves performing a number of activities and behaviors (e.g., cooking, providing rides, shopping) framed as traditional and normal in contemporary culture. Like the discourse of intensive mothering, this cultural script of motherhood is largely constructed from and framed by experiences of heteronormative, White, and middle-to-upper-class women in addition to representations of motherhood in a traditionally White mainstream culture (Douglas & Michaels, 2004; Ennis, 2015). Either because of the compositional diversity within the current sample of participants or because of the lack of diverse scripts of motherhood in popular culture, participant narratives voicing the DIM painted a predominantly one-dimensional and universal
picture of motherhood constructed within these frameworks of privileged cultural identities.

Evidence of the DIM as a pre-existent and widely assumed cultural understanding of motherhood was evident in some participant utterances in their use of nondescript language. For example, some participants used ambiguous lexical choices when describing motherhood (e.g., “stereotypical, gender bias mom” 23: 119). Considering the fact that participants were asked to describe their mothers and their understanding of motherhood to a generalized other (i.e., the researcher), their use of such ambiguous terms demonstrates the assumed cultural salience of the motherhood script in their lack of a more detailed picture of their own mother.

Beyond articulating activities of motherhood based on this assumption of shared understanding, participant utterances also spoke to the inherent difficulty of developing an understanding of motherhood when it fell outside of that specific understanding of motherhood. In some cases, participants even pointed directly to this culturally specific definition of motherhood such as the participant who described her mother as “deviant from the dominant narrative of what a mom does,” (36: 315-317). In using words like “things” and “stuff” and in explicitly noting that there is a dominant narrative of motherhood, participant utterances provide clear evidence of the existence of an unspoken but pervasive cultural script of motherhood. Pam describes the difficulty of understanding motherhood after growing up in a home with a mother with depression whose actions did not match those communicated to her by culture. Pam spent the

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2 In accordance with IRB, all names and locations have been changed to protect the anonymity of participants.
majority of her childhood unaware of her mother’s depression. However, after her
brother was diagnosed with depression while Pam was in middle school, her family
began to open up about mental illness and she realized that her mother also had
depression. She describes trying to make sense of her mother as a young child before
understanding that her mother was suffering from a mental illness:

I watched movies and TV shows, and genders are portrayed very . . . I always
thought, she wasn’t always the conventional mom . . . I think I was just very, I
was just kind of let down. I felt bad for myself a lot. I thought, why isn’t my
mom here? And why didn’t my mom make cookies today? Like, what the heck?
(20: 380-412)

Pam’s statement gives a nod to the assumed cultural script of motherhood both
indirectly and directly. Noting that her mother was not always the “conventional mom,”
Pam’s statement pulls on a definition of motherhood as witnessed in popular culture and
specifically motherhood as portrayed on movies and television. Later in her statement, a
more direct component of the cultural script is voiced when Pam questions: “Why didn’t
my mom make cookies today?” In pointing to this specific activity of motherhood, Pam
calls upon the DIM by framing a mother as one who adheres to a traditional cultural
script of motherhood.

Beyond voicing the DIM’s tenet of motherhood as cultural scripts by directly
referencing popular culture mediums (e.g., TV and moves), participants also voiced the
DIM when describing activities that their mothers engaged in before they experienced
depression. The majority of participants discussing motherhood in this way were able to
point to a specific event that caused their mothers’ depression and as such constructed
understandings of motherhood by both noting who their mother was before depression versus who she was after. For Jacob, this switch came on Christmas Day when his mother found out his father was having an affair. Jacob describes Christmas Day as a major turning point for his entire family in that his parents immediately filed for divorce, he and his sister became estranged from his father, and his mother was diagnosed with depression. For Jacob, the day caused his family to change from what he described as very traditional to very non-traditional. He describes this shift specifically in his mother:

She was pretty much the typical, like, soccer mom. Picking you up from every single sports practice . . . But yeah, she was very traditional in terms of—I mean she cooked a lot before that. And she completely stopped cooking at all. (12: 170-183)

Here, the term “soccer mom,” and its subsequent description of a mother picking kids up from soccer games and cooking highlights the DIM in positioning motherhood as role adhering closely to the cultural script of motherhood. In particular, the use of the term “typical” provides strong evidence of the DIM’s privileged position in culture by framing activities such as picking kids up from soccer and cooking as prototypical activities of a mother.

In another example, Kelly describes her mother, a stay at home mom throughout Kelly and her brother’s childhood, before she began to suffer from depression. Although Kelly notes that her family has a long history of mental illness, she believes that her mother did not suffer from depression until Kelly was around eleven at which time her mother began to suffer from additional health issues, lost her father, and moved Kelly’s family across the country. Kelly describes her mother prior to this turbulent time:
You know through my elementary school, she drove people to field trips and things like that. We baked Christmas cookies together. So that is, I would say that falls into stereotypical mom territory. And it’s actually funny; from those years I kind of remember a certain judgment about working moms. That she would probably deny. (4: 242-247)

Similar to Jacob, Kelly’s statement voices the DIM in noting that “stereotypical” mom activities include baking cookies, driving children on field trip, and in this case, staying at home. Further, Kelly’s statement’s voices the DIM (and perhaps gives a nod to its second tenet of mothers providing care) in noting a judgment towards working mothers.

While many participants voiced the DIM by directly describing their mother’s behaviors as they fell in congruence with cultural scripts of motherhood, others defined motherhood voicing the DIM by noting a lack of these exemplary activities and behaviors in their lives. For some participants, this lack was noted as occurring after the diagnosis and experience of depression. In other words, participants described motherhood as a set of culturally specific activities that their mothers disengaged from because of their depression. For other participants, having a mother with depression was a lifelong experience and there was no shift in behavior. For example, Kim describes her frustration with her mother when comparing her mother to her friends’ mothers during childhood:

I like saw all the other moms, like my other friends’ moms were all, like were doing mom stuff like taking their daughters out shopping, buying prom dresses. It was my dad that was, ended up helping me find my prom dress, like getting my
makeup done and stuff like that, you know, like for prom. And so like, I, she never, like went into that role, and so that was like another differences. Where she never, like, wanted the mom role or anything like that. (16: 129-137)

Kim’s statement provides a strong example of the DIM’s definition of motherhood as a cultural script in noting that she witnessed her friends’ mothers doing “mom stuff.” In addition, Kim articulates her mother’s inability to engage in such activities as her mother not wanting the “mom role.” Kim’s talk centers the DIM by noting that her mother sat outside of the role of motherhood because of her failure to engage in these activities with Kim. Similar to Kim, Hannah also describes a specific time when her mother failed to engage in motherhood the way that her friends’ mothers did, thereby resulting in frustration for Hannah:

I remember, like this is really stupid, but I remember like—like when you have your lunch box at school, all the kids are like: “Oh I have this cool stuff!” And during the elementary school period, my lunches would always suck because my mom just did it. She wasn’t doing mom things. (6: 201-206)

Hannah’s statement centers the DIM by remarking that a mother should not only pack a lunch for her child, but also pack an exciting one. Adhering to the DIM, the inability of Hannah’s mother to provide such a lunch led to Hannah describing this time as a time when her mother “wasn’t doing mom things.” As such, the DIM is highlighted as an assumed slate of activities that a mother engages in at an extensive level.

In the first tenet of the DIM, motherhood is tied into the cultural script or template of motherhood. Participants voicing the DIM spoke explicitly to culture by noting culture itself in providing those scripts and by describing activities that stereotypical
mothers engaged in (or fail to engage in) such as baking cookies, giving rides, packing lunches, and taking their daughters shopping. In opposition to this view of motherhood is the first tenet of the DRM, which dismisses the DIM and positions mothers as unique individuals rather than cultural stereotypes.

**Mothers as individuals (DRM).** The first tenet of the DRM resists the DIM and its one-dimensional view of motherhood as a commonly understood and enacted role. Instead of defining motherhood as a singular role that women take up and engage in via culturally specific activities and behaviors, the DRM defines motherhood as one of a number of roles women may perform in conjunction with others. In doing so, participant talk voicing the DRM frames mothers as women who hold experiences and identities beyond that of solely a mother. To accomplish this, participant talk centering the DRM focuses on descriptions of a mother’s individuality and experiences beyond the cultural script of motherhood rather than illustrating the role through the voicing of more generalized activities or expectations like those voiced in the DIM.

The DRM was most often voiced in participant utterances surrounding stories of the realization that their mothers experienced life events and relationships before and beyond becoming a mother. The majority of these realizations involved participants describing their understanding of motherhood as becoming more complex during and after the experience of their mother’s depression. For example, Lisa describes her experience of realizing that her mother’s depression might have been caused by events that happened prior to her mother’s marriage to her father and giving birth to her. Lisa notes that as a very young child she remembered her mother as being very caring and traditional (e.g., “I thought she was the good traditional mother who is constantly there
117. After divorcing Lisa’s father, Lisa’s mother was diagnosed with depression and began to abuse alcohol. Lisa was nine when her older sister informed her that her mother had depression. Lisa describes how this disclosure from her sister impacted her conceptualization of her mother:

Those thoughts were like: “Oh. She’s never told me anything about her childhood. That’s weird. [Laughing] I wonder if there was anything bad.” And then I thought about it more and like she really hasn’t told me anything. I know nothing about her life. And then I have no pictures of her. I have no pictures of my grandmother, my grandfather. I’ve never met them. And then I was like: “Oh my god, like I don’t know anything about my mom’s life. I’ve only thought about her as like a mother and not as a person.” So now I was thinking about her as a person and I’m like: “I have no idea who she is. At all.” And so yeah. And so then I kept trying to ask her and I still don’t really know anything about her. So all the information I get is from snooping. Do a lot of snooping. From pictures and everything. I’m like putting my life together through pictures, and uh, and my dad. Because they were obviously together through college and everything so he was able to tell me some stuff that was pretty major that I just didn’t know about . . . Really thinking about her as an actual person, ends up she’s had a lot of shit that she went through that she just doesn’t bring up. (15: 232-252)

Lisa voices the DRM in noting that her mother is a person with a past, with parents, and with struggles of her own that sit outside of her role as a mother. Moving beyond the DIM, Lisa’s story adds complexity to the identity of Lisa’s mother and centers the DRM in noting that Lisa is now thinking of her mother “as an actual person.”
Similar to Lisa, Tanya also discusses how she re-framed her understandings of her mother and her mother’s actions after her mother’s diagnosis of depression. Tanya’s mother was diagnosed with depression around the same time that Tanya left for college. As such, Tanya describes instances of coming home from college that require her to renegotiate her understanding of her mother because her mother’s actions now are different than she when Tanya was living at home (i.e., prior to her mother’s diagnosis). Tanya recalls certain times when she wished her mother would behave in a different way but then describes remembering that her mother is likely doing what she needs to do for herself as a person with depression in order to function in certain situations. In this reframing, Tanya notes that she has been able to overcome feeling self-conscious or stigmatized for having a mother who does not adhere to the DIM (thereby again providing evidence of the cultural salience of the DIM). As a result of this reframing, Tanya is now more open to talking with outsiders about her mother despite her mother’s inability to enact motherhood in a culturally scripted way. Here she describes her new view.

I feel like so often when people talk about this [motherhood] it’s like achievement based. This is what my parent does, their job, look at these cool things that they’ve done. But like it’s really helped me to really appreciate her personhood and who she is outside of the framework that I think traditionally most people think of. (33: 460-465)

Tanya’s statement centers the DRM in positioning motherhood as personhood. Tanya notes that she has moved her understanding of her mother and motherhood outside of the “framework” of traditional motherhood. She describes discussions about
motherhood with others as centered in the DIM in noting that individuals describe mothers by talking about what they do. Tanya’s statement then notes that she now pushes the meaning of motherhood “outside of the framework that I think traditionally most people think of,” giving a sideward glance to the cultural salience of the DIM in defining motherhood. In pushing outside of the framework, she articulates a new ability to view her mother as a person and therein highlights the DRM.

In the first tenet of the DRM, motherhood moves beyond a singular, traditional understanding as voiced in the distal-already-spoken of culture. Instead, motherhood is defined as a role occupied by a unique and individual person. Mothers are not merely reflections of wider cultural expectations, but unique individuals who have lives stretching prior to and beyond the role of motherhood, with individual wants and needs occurring alongside their role as mother. In this way, the DRM draws on utterances from the proximal, rather than distal, already-spokens in constructing understandings of motherhood. Though the idea that mothers are people is certainly one that exists in some capacity in the distal-already-spokens of culture at large, for participants in the current study, this knowledge came from conversations and understanding created within the contexts of relational utterances.

Just as the first tenet of the DRM shifts understandings of motherhood from cultural expectations to individual realities, the second tenet of the DRM resists expectations for mothers surrounding provisions of support as articulated by wider cultural expectations of the distal already spoken and instead centers the lived realities of the proximal-already-spoken. For the DIM, this cultural expectation for care positions mothers with providing for all of their child’s physical and emotional needs. While the
DRM certainly defines motherhood as a role of caregiving, the DRM’s troubles the expectations for care given by the DIM and instead places expectations as based upon personal ability. In other words, the DIM expects mothers to provide care only to the extent that they are able.

**Mothers Provide All(Some) Support**

**Mothers provide full care and emotional support (DIM).** Along with enacting the cultural script of motherhood, the discourse of ideal motherhood also defines mothers as individuals responsible for providing full care and emotional support for their children. Similar to the discourse of intensive mothering which describes good mothers as those willing to give their entire selves to providing full emotional, physical, and spiritual care to their children (Hays, 1996), the DIM defines motherhood as a role holding primary responsibility for a child’s physical and emotional well-being. Similar to participant utterances articulating the first tenet of the DIM, a number of participants voiced the DIM not when describing the experience of receiving full care and support from their mothers, but rather when describing the experience of a lack of providing care and support.

In some instances, this articulated lack of care was voiced in stories of parentification wherein participants described themselves as the main support giver in the family by caring for their mothers and in some cases their siblings. In the DIM, providing support is paramount to motherhood. As such, individuals discussed their experiences through a lens of parentification not only to describe the necessity to provide care and support but also to describe themselves as stepping into the actual role of parent. For example, Kim describes how she had to step into the role of mother for her own
mother during middle school and high school when her mother’s depression and subsequent abuse of pain killers made her unable to care for Kim. She explains:

I thought she was the weaker one and I needed to step up to the plate and be the mom, you know, of the house. So like I just really took on that role and I would take her and make sure she showered and make sure she took her medicine, make sure she wasn’t falling down you know and that sort of stuff. So, yeah I kind of just took on that role, thinking like maybe she wasn’t like, she wasn’t okay to be able to do this kind of stuff now . . . I mean I felt like I kind of needed to be the mother figure, so that was kind of like how it really changed a lot. Suddenly my mom was sick and weak and needed taking care of. So I needed to step up and be the mom now. (16: 179-188)

Kim’s statement voices the DIM in describing motherhood as a role wherein physical care is provided. Though Kim’s statement does not explicitly describe what a mother does, through her self-identification as the “mother figure” in the story wherein she provides support, Kim’s statement positions motherhood as a role that provides care and support. As such, she self-identifies as being the mother when recalling a time period when she was required to provide care and support to her own mother.

Similar to Kim, Krista articulates her understanding of motherhood using the DIM by describing what was lacking in her own experience with her mother. Krista mentioned throughout the interview that because of her mother’s depression and her older brother’s avoidance of the situation, Krista was often left to care for her mother in addition to her younger sister. She describes a particularly memorable time when her mother decided to step up and take care of her younger sister:
I remember too when my sister gave birth to my nephew. It was so funny. I remember her sitting in the room and she could have only one other person because the biological father was present for the birth. And so my sister could have only one other person in the room other than the father. And I remember me and my mom sitting next to each other like [stares], when we found this out. And kind of looking at each other and my sister and I both [shrugs] and then my mom like made a comment, like: “Oh where’s the stuff?” And she starts putting on the stuff. And me and my sister are both like looking at each other, like [surprised look]. It was assumed by both of us that I would be in the room with my sister and not my mom. And so when my mom started to like, it was weird because both my sister and I look at each other like [surprised look]. But I remember kind of like, okay. And I actually remember feeling at first, kind of a little bit angry at first. Like no, you don’t have this right, I’m sorry. Like I hate to say it, but you didn’t earn the right, like I did. So I’m going to be in the room with her. But then at the same time it was like, it almost felt like refreshing. Like a release because it was like, okay, do you want to step up and be the mom? Like, okay! Like I’ll take a backseat, like it’s been exhausting my whole life. Like parenting my sister and you. So like if you want to do it now, I will let you try. (5: 463-484)

In Krista’s story, we see that her mother’s willingness to go into the birth room with Krista’s sister (and arguably step into the role of taking care of Krista’s sister) resulted in Krista noting that perhaps her mother was ready to “step up and be the mom.” Krista describes frustration at first in noting that perhaps her mother did not deserve to go into the room as Krista, not her mother, had been providing the care and support to her
sister throughout both of their childhoods. Krista’s statement then frames the decision made by her mother as a relief as it perhaps means that Krista could step out of the role of mother. In positioning the decision to be in the birthing room with her daughter as one that allowed Krista to step out of the role of mother, Krista describes the decision to support as the decision to mother. As such, the voices the DIM in framing motherhood as providing support.

Along with describing motherhood through stepping into the role of mother, participant narratives also voiced the DIM in describing times when they perceived a lack of emotional support from their mothers. For example, Allison describes the lack of emotional support she received growing up with a single mother:

   For the longest time I just, I don’t want to say I disliked her but I guess I didn’t like the way she held things together. Because it was very, I could have like gone to any other place and got that same upbringing. Because she didn’t bring that emotional support. Yeah she made sure I had anything I needed, like food, all this stuff. But if I go to a hotel they have everything I need there too. So she could have been more emotionally there than she was . . . I don’t know. I just think that being a mom needs to be having that emotional support and that aspect of care and I guess security. Because we definitely felt physically secure but we never felt emotionally secure and that’s a huge deal. Because a legal guardian can give you physical security but a mother has that, I don't know. When I think of a mom I think of like someone cradling their baby. Showing them that all around support and security. (32: 351-365)
Allison’s talk centers the DIM in noting the importance of a mother providing emotional support. Like Kim, Allison’s articulation stems from a “lack of” rather than “experience of” the DIM’s tenet of motherhood as providing full care and support. Allison’s statement provides depth to the type of care and support that the DIM refers to in defining motherhood as all encompassing care and support. Moving beyond simply providing physical care, the DIM marks motherhood as a role providing security and emotional support. Krista also describes the importance of emotional support when describing motherhood. As noted above, Krista served as the primary caregiver for her sister and in some cases her mother throughout her childhood. When I ask Krista how she might articulate what a mother means to her now, she explains what she envisions her own mothering to be like when she has her own children someday:

I guess it just means being mentally and emotionally able to care for other people. To allow other people to lean on you and need you. And my, I just think that like my mom was so needy herself that there was no more space for me to need her. And that created a lot of like, just really messy, sticky situations our whole life. So when I think about being a mother myself, I want to be able, like my children can lean on me, like I’m strong for them. Like I will be there for them . . . I’ve realized that like, when I do get pregnant, I want to be able to give my children all of me. Like I want to be able to do that. And I’m not going to have kids until I feel like I’m ready to be that. And I think that’s because my mom was never able to really do that. And so that’s where it kind of comes from. (5: 547-570)

Krista’s understanding of the role of motherhood is articulated as one shaped by her need to step into the role of caregiver for her mother as a child. Like Tanya, Krista’s
talk highlights the DIM in noting the importance of providing support emotionally by saying that she wants her children to “lean on her,” when they need. Towards the end of her statement, Krista voices the DIM in noting that she wants to “be able to give my children all of me.” Similar to the discourse of intensive mothering which positions motherhood as a consummate role, Krista’s statement highlights the all-encompassing view of motherhood in being strong, present, and willing to devote her entire life to her children.

Similar to Krista, a number of participants voiced the DIM and its tenet of providing support in such an all-encompassing way. For example, Lisa articulates motherhood as fully supporting children not in the amount of support but in the consistency of it. She explains:

Motherhood. I love it. It’s uh, constant support, and uh you know, gentleness. This is very traditional, but this is how my mom is and she’s awesome. So gentleness, support, kindness, um, but smart and bold and brave and um. You know, they have their faults, but they’re always willing to go and catch yours instead of deal with theirs. (15: 782-787)

Like Krista, Lisa’s talk defines motherhood using the DIM in noting it as a role requiring constant, selfless support wherein a child’s needs are always placed above a mother. Lisa’s utterance also provides evidence for the cultural privileging of the DIM in noting that the viewpoint that mothers provide full and constant support is “very traditional.”

In sum, the second tenet of the DIM echoes the discourse of intensive mothering in positioning mothers as providing full care and emotional support. A mother must not
merely provide the physical components of motherhood as articulated in the first tenet of
the DIM, but also be fully present and able to provide emotional support and care. In
situations when a mother is unable to fulfill this role, the role is lexically stripped from
her in participants noting that they must step into the role of motherhood such as Kim
noting that she had to take on the mother role and care for her mother. In other cases,
participants note that their mothers step into the role of motherhood in their agreement to
provide care and support such as in Krista’s story of her mother going into the birthing
room with Krista’s sister. Moving into the DRM, the expectation for mothers as
individuals who provide support and care remains. However, the expected amount of
care and support shifts from a singular and all-encompassing cultural expectation of
mothers providing everything to an individualized understanding as each mother
providing what she is personally able.

Mothers provide what they can (DRM). The second tenet of the DRM
dismisses the DIM’s definition of motherhood as providing full care and support and
instead defines motherhood as providing the care and support that they can. In other
words, where the DIM defines motherhood as someone constantly and fully caring for all
aspects of a child’s physical and emotional care, the DRM defines motherhood as
someone willing to provide what one is able. In the DRM, the effort put into attempting
to provide support, rather than the constant attainment of fully providing it, is chief to
defining motherhood.

On the surface, the second tenet of the DRM looks similar to the second tenet of
the DIM in that participants voicing both the DIM and the DRM describe their mothers as
needing care. However, participants voicing the DIM positioned this need as one
requiring them to step into the role of motherhood. In other words, their mothers essentially lost the title of motherhood as participants described their need to step in and care for them. Conversely, participants voicing the DRM do not position caring for a mother as a parental move, nor do they position their mother’s identities as dependent upon caregiving. Instead, the DRM frames giving care as part of a natural relationship between child and mother, rather than a flip in roles between child and mother. In other words, providing support shifts from a top-down expectation of mother to child as voiced by the DIM to a reciprocal expectation of a mother/child relationship in the DRM. Therefore, the DIM and the DRM stand in stark contrast to one another in terms of how care is conceptualized.

To demonstrate, Carol describes her relationship with her mother and specifically how it changed as a result of her mother’s depression. As a child, Carol was confused by her mother’s behaviors until Carol’s older sister explained to her that their mother had depression. Carol described growing older and experiencing depression herself during her first year away at college as an important event in understanding her own mother and in developing her understanding of what motherhood is. She explains:

I don’t know if it was just because of myself going through that experience [depression] that mom and I instantly became closer. Like my mom’s my best friend now. Like I tell her everything. We’ll both be going through episodes and I’ll know what to look out for now and she knows what to look out for in me. So that’s really like it’s awesome. I love my relationship with her now . . . Yeah, motherhood is definitely—It’s more about kind of supporting each other instead
of just expecting her to take care of me. I’ve learned that we both need to be there for each other. It’s all about being together. (8: 161-175)

Instead of describing a role flip when discussing a need to support her mother, Carol’s statement highlights the DRM by positioning the provision of support as a mutual expectation for mothers and children to engage in concomitantly as opposed to a mother caring for a child.

Similar to Carol, Julie voices the DRM when describing her need to take on some of the tasks of motherhood without articulating a step into the role of motherhood. Though Julie describes her mother’s depression as being present for most of her life, she notes that some additional issues with autoimmune issues and thyroid issues also added into her mother’s inability to provide care for them during Julie’s childhood. Here she describes how her mother’s health affected her and her younger sister.

I think that made Katie and I be more independent too . . . I feel like it always ties back down to sleep. But it was like her sleep was just as valuable as ours. So we were getting up. We were making our breakfast. And other moms were doing that. And it was because we knew mom was busy and had other important things to do as well. And she would be late to things sometimes. And that didn’t really bother me. (34: 161-171)

Julie’s statement positions the activities she and her sister were doing as similar to what other mothers were doing. However, Julie’s statement does not position Julie or her sister as taking on the role of mother. Rather, Julie talk centers the DRM in noting her mother’s sleep was “just as valuable.” Julie’s mother does not lose her title of mother in her inability to provide the same care that other mothers were providing. The DRM
allows mothers to keep their titles despite not fully providing care and support such as when Julie describes making her own breakfast and not being bothered by her mother being late to things.

In addition to describing the importance of providing mutual support rather than expecting full support, some participant utterances also centered the DRM by noting that they themselves factored into the inability of a mother to provide full care and support. For example, Sarah implicates her own identity as a daughter when describing her mother:

I know I haven’t always been the easiest daughter. And I know that having depression makes it that much more difficult. But you know, my mom’s still my mom. She’s still going to try and support me in whatever way she can. You know, even though it sucks. Or it has sucked. (4: 612-616)

Sarah’s statement specifically calls out the DRM in describing motherhood as someone who gives what they can. Sarah first notes that she has not been an easy daughter and also notes that her mother’s depression likely also made mothering Sarah very difficult. In her statement “My mom is still my mom” Sarah’s talk highlights the DRM by explicitly stating that her mother has maintained her despite not providing full care and support. Sara’s statement justifies her mother’s role by calling on the DRM in noting her mother will try and support as she can.

In addition to discursively describing their mothers as mothers even in the absence of care, the DRM also unsettles the DIM’s expectations for care by respecting and celebrating mothers for doing what they can. Meredith, who has both a mother and a father with depression, described her need to take care of herself since her parents first
disclosed their depression to her when she was eight years old. While Meredith never discussed her childhood explicitly through the lens of parentification (i.e., she never describes herself as taking over the role of mother), she did discuss a number of instances wherein she took up some behaviors of her parents such as grounding herself: “I think the only time I was grounded, I grounded myself. Because I was like, I messed up. I am not going out for two weeks” (P24: 638-640). Although Meredith’s descriptions of such instances seem to describe someone parenting herself, when I ask Meredith how she understands motherhood, she responds:

Hmm, that’s a hard one. Role of motherhood. Because, you know, throughout all of this, I think my mom has demonstrated her role very well, just through her constant trying. Even though she has failed many times, she has tried many times and when I know if it came down to it, like if I stumble off a curb and broke my ankle, she’d be here on the next flight and be like: “Let me just like give you ice and here’s this.” Like I said, when someone she loves is doing bad, she just kicks into overdrive. She’s like, “I know my role right now.” And I think my mom—I just really love her to death. Like I love my mom to death. (24: 484-494)

Despite Meredith’s many stories of having to parent herself, when I asked her to describe how she understands motherhood, she voices the DRM as predominant to her understanding. In defining motherhood as doing what one can, the DRM allows for Meredith to articulate motherhood as a role that one tries their best at, and thereby allows Meredith to articulate her mother as demonstrating what motherhood is very well. Using the DRM, Meredith can celebrate her mother in noting her mother’s persistence in trying
to provide care and reliability when needed, rather than articulating it as falling short in her mother’s inability to parent full-time.

Just as the DIM’s final tenet calls upon its first tenet and promotes the expectation that mothers should be able to “do it all” by both performing cultural expectations of motherhood and offering care and support, the DRM’s final tenet takes into consideration its prior tenets of mothers as people and positions mothers as those who do the best that they can based on who they are and what is going on in their lives. In full, the DIM views motherhood as that which is performed in adherence to cultural expectations, requires the provision of support, and is most successful when individuals can fulfill all duties of motherhood as inscribed by these expectations. In positioning full care and support as a necessary component to motherhood, individuals voicing the DIM labeled themselves as mothers when describing situations in which they gave care to other family members.

Rebuffing the DIM, the DRM moves the understanding of motherhood down from cultural scripts and expectations, instead defining motherhood as a role occupied by an individual who is doing the best she can. The DRM rejects the DIM’s necessity to maintain the identity of motherhood based on achievements of care and instead defines motherhood as a role achieved and maintained through one’s willingness to provide support to the best of her ability. As such, individuals ascribing to the DRM do not describe themselves as stepping into the role of mother when voicing stories about providing care for family members or for themselves. Instead, individuals voicing the DRM allow their mothers to maintain their identity as mother even when she
demonstrates an inability to fully provide care and support. Effort, rather than attainment, creates meanings of motherhood in the DRM.

**Interplay of the DIM and the DRM**

In constructing meanings of motherhood, participant narratives yielded a number of types of discursive interplay both diachronically as participants articulated retrospective understanding of motherhood across time and synchronically within single utterances as participants voiced both the DIM and the DRM in constructing current meanings of motherhood. The diversity in types of interplay in addition to the amount present in the data provides strong evidence for a complex and continued discursive struggle in emerging adult talk when making sense of motherhood and depression.

In some utterances, discourses of motherhood shifted across time, with one discourse of motherhood privileged at one point in time and a different discourse privileged at a later point in time. This diachronic separation occurred primarily in participant utterances describing their understanding of motherhood retrospectively as it shifted from their initial understandings as aligned with the DIM to their understandings now as emerging adults in the DRM.

The majority of interplay captured in the data was synchronic in nature with participants voicing both the DIM and the DRM in single utterances during the interview. Additionally, there were two instances of discursive transformation in the form of hybrids wherein the discourses of DIM and DRM were able to suspend their discursive struggle and find equal footing in participant utterances. After discussing instances of diachronic separation, each form of synchronous interplay and how it emerged in the data will be explored followed by a discussion of instances of transformative dialogue.
**Diachronic Separation**

As noted prior, diachronic separation involves the shift in privileged and marginalized discourses across times (Baxter, 2011). Baxter (2011) highlights two primary types of diachronic separation: *spiraling inversion* and *segmentation*. In instances of spiraling inversion, shifts in privileged and marginalized discourses play out across time. In segmentation, shifts in the privileged and marginalized discourses occur across topical domains. The primary type of diachronic separation found in the data involved spiraling inversion wherein participant utterances described a shift from privileging the DIM earlier in their life to the DRM in their current understanding.

Megan, whose mother suffered from depression throughout Megan’s entire life, describes her shift in understanding of motherhood from adolescence to emerging adulthood:

Growing up I had all these expectations probably from media and friends, what a mother is supposed to be. So I expected things. I expected the home baked meals. I expected her talking to me about boy problems and talking to me about sex. I expected her doing things, taking notice of things. But I never took into account that when a person isn’t physically, mentally able to do that then they’re probably not going to. So as I got older and I’ve started learning more and understanding more and how like the idea of motherhood. Like there’s not going to be that one definition, I’ve stopped expecting the unexpectable with her. So I only expect what I think she’s capable of giving. I only expect what I think she should be like, like bare minimum. But then like I said before, when she would go out of that range I would act like: “what the hell?” Now I’m very appreciative. So she offered to fly up and see me. Which, whoa. So I’m like oh that would be
great. And still in the back of my mind I’m like it might not happen. She might not be able to but I’m hopeful and I’m grateful that she’s offering to do that. Even if it doesn’t happen, the fact that she’s thinking about that is enough. That’s kind of how I’ve renegotiated what she means to me. (28: 285-304)

Megan’s statement first highlights multiple components of the DIM. First, the DIM is voiced through the noted expectations of motherhood as articulated from media and notions of home cooked meals. Additionally, Megan’s statement then privileges the DIM by describing the expectation of having a mother who provided full support and guidance by discussing boys, talking about sex, and taking notice of her. Megan’s talk then shifts to her current understanding of motherhood which privileges the DRM in noting the importance of viewing her mother as a person who is dealing with other aspects of life beyond her mother/child relationship. Because of depression, Megan’s mother could not necessarily provide that level of motherhood that Megan voices with the DIM. Megan’s talk describes a move towards the DRM by noting that as she has gotten older she understands that there is more than one definition of motherhood. Finally, in voicing her acceptance of getting the bare minimum from her mother and being grateful for her mother attempting to be a part of Megan’s life, Megan’s talk fully centers the DRM as defining and valuing motherhood as someone doing what they can.

Similar to Megan’s statement, Pam also articulates motherhood as a change in understanding from a childhood privileging of the DIM to an adult privileging of the DRM. Pam’s articulates this discursive shift:

I definitely think I kind of kicked to the curb all of the things that when I was littler, being surrounded by moms that are always put together, and wearing
pastels, and cookies and staying home, because my family wasn’t like that. Now I just see her as a very, very good role model. A very, not as a role model for like how to be successful, but just how to live. She’s more of a person who she has taught me so much more about how to live and how to react and how to interact with people than how to be successful . . . So I think I have definitely seen her more as, it sounds so cheesy, but more as an inspiration of how to live and treat people than how to iron a shirt. (20: 465-480)

Recall from her earlier exemplar, Pam described feeling confusion during her childhood as to why her mother was unlike her friends’ mothers. Here, her talk first highlights the DIM in describing an understanding of motherhood as wearing pastels, making cookies, and staying at home. In describing her current understanding, Pam’s talk shifts from privileging the DIM to privileging the DRM in noting a clear negation of the DIM (e.g., “kicked to the curb”). Pam’s utterance privileges the DRM by positioning her mother as an individual rather than a culturally specific and perfect stereotype. In particular, noting that her mother is “more of a person,” positions Pam’s mother as a unique individual as opposed to the cultural script of a mother and celebrates that uniqueness as “inspirational” rather than as confusing.

**Synchronic Interplay**

Moving from an examination of diachronic processes wherein one discourse is voiced at one point in time and then another is voiced at a later point in time, synchronic interplay involves examining the creation of meaning via the voicing of multiple discourses at one given point in time. Along with examining the ways in which discourses compete within talk through the identification of instances of negating,
countering, and entertaining, Baxter (2011) also notes that synchronic interplay can be examined through four conceptual dimensions: antagonistic-nonantagonistic struggle; direct-indirect struggle; serious-playful struggle; and polemical-transformative struggle. As instances of antagonistic-nonantagonistic and serious-playful struggle were also identified in the data, they will be discussed as they occurred within instances of negating, countering, entertaining, and extracting.

**Negating.** Of the four types of interplay, negating was the most commonly occurring discursive marker identified in understanding the centripetal-centrifugal struggle between the DRM and the DIM. Negating is characterized by a direct rejection of a discourse. In some cases of negating, this rejection occurs via an antagonistic struggle during which two speakers privilege differing discourses. For example, speaker A may voice the DIM and speaker B may subsequently reject the DIM by voicing the DRM. In other cases, negating occurs in a non-antagonistic struggle characterized by a voicing of multiple discourses and rejection of a discourse within one individual’s statement. For example, speaker A may voice the DRM but then negate it by voicing the DIM in a single utterance. In these single utterances, negating occurs primarily through indirect or direct reported speech. Using indirect reported speech, a participant may call upon a widely circulating discourse with the purpose of refuting it or paraphrase the reported speech of an individual or group with the purpose of refuting it. Using direct reported speech, an individual will actually reproduce a specified individual’s statement and performance in order to subsequently reject the statement (Baxter, 2011). In the current data set, these instances of negating most commonly involved the DRM directly negating the DIM.
Renae provides an example or negating via voicing the direct reported speech of her sister in conversations about their mother. A mother of five, Renae’s mother was diagnosed with PTSD and depression shortly after her divorce from Renae’s father. Though Renae notes that her mother does not speak about her PTSD or her depression often, her mother tells Renae that it is attributed to her abusive relationships with Renae’s father who, following the divorce, became estranged from Renae’s family. Renae described her older sister as the primary caregiver for her and her younger siblings and noted her frustration with not having that same care from her mother. She describes having a conversation with her older sister about not asking their mother for as much help:

Well my sister would always tell me that you can be too dependent on your mom. And I’m like: “How can you tell me this? This is my mom? She’s my only caretaker, it’s not like I have a father.” So that was really hard. And in a way I think she messed it up and made me attached to her even more. Because it was like: “I’m going to have my mom whether you say I can or not.” So that was a big hurdle. (30: 355-361)

In this instance, Renae’s reported speech of her sister voices the DRM by noting that their mother cannot provide everything for them. Renae’s statement then negates the DRM with the DIM by noting that she would “have her mom” regardless of her sister’s advice, Renae talk centers the DIM by positioning motherhood as a relationship created and sustained by a mother taking care of a child.

Beyond negating through direct and indirect reported speech, another method of discursive negation as identified by Baxter (2011) is attending to the serious-playful
dimension of talk. In particular, Baxter (2011) described the serious-playful dimension of talk as focused on the tone of participant utterances and draws on what Bakhtin (1981d) originally labeled the *rogue*. The rogue describes a certain discourse and attributes it to a certain individual or group with the purpose of then mocking the group (Baxter, 2011). In mocking the group, the rogue thereby mocks and disqualifies the group. We can see this use of the rogue in Meredith’s description of her understanding of motherhood:

> So I think as a mother, she always fulfilled her duties. I mean, I could ask for an ideal mom who is up and active and like doing everything like making me a lunch and like being super mom. But like, that’s just not possible. I just, I don’t know if anyone actually has that, and if they do congratulations. I don’t know what that would be like, but I think every mom, if it’s not depression, if it’s not mental illness, has something that gets in the way of being a mother sometimes and she totally could have succumbed to it, but she didn’t. (24: 514-522)

Meredith’s talk first voices the DIM in mentioning that an ideal mother would be a “super mom” in her performance of motherhood by being active and making lunches. Her talk then directly negates the DIM by noting that motherhood as defined by the DIM is “just not possible.” Meredith’s talk draws on the discursive moves of the rogue when Meredith pulls in a sarcastic tone when noting that if anyone somehow does have a mother that embodies the DIM, “congratulations.” In using sarcasm in such a way, Meredith’s talk positions the DIM as foolish in its unrealistic and unattainable expectations, thereby negating it through a mocking of both the DIM and individuals who claim to have mothers who fall in line with the DIM. Towards the end of the utterance,
Meredith’s talk centers the DRM by noting that all mothers have issues that prevent them from doing it all for their children therein privileging the DRM by centering the idea of mothers as unique individuals who are providing what they can. In this use of sarcastic negation of the DIM, in addition to voicing the universality of mothers all having difficulties, Meredith’s talk clearly centers the DRM.

**Countering.** Similar to negating, countering also involves the voicing of multiple discourses of motherhood within a single utterance. Unlike negating, a speaker does not voice alternate discourses for the specific purpose of rejecting them but rather grants some legitimacy to them. However, after granting the alternate discourse some legitimacy, the speaker counters with what is ultimately the privileged discourse in the utterance. A participant utterance may grant some credence to one of the discourses of motherhood but ultimately grant more power and legitimation to the alternate discourse. Unlike negating in the data set, the majority of countering in participant utterances surrounding motherhood involved the DIM countering the DRM. In other words, utterances granted some legitimacy to the DRM but ultimately placed understandings of motherhood within the DIM.

For example, Susan recalls that prior to her mother’s depression her mother was highly involved and active in her life. After her diagnoses her motherhood changed drastically leaving Susan with the task of renegotiating her understandings of motherhood and her relationship with her mother. Susan even notes that she is currently learning to “mourn the loss” of her mother (P31: 138) in accepting that the kind of mother she once had is likely never going to return. As an individual who also self-identified as currently having depression, Susan notes that there is some new understanding of what her mother
was going through now that she herself has experience with the illness. Here she describes her current sense making surrounding her understanding of her mother.

My mom had a lot of issues. Since I resented her for not being able to get up and get out like other parents could. Not being able to be a mom. Then I just think I finally understood how hard it is to get up and get out of bed . . . Like I understand and I accept that it sucks but I kind feel like I grew up without a mother. Because I took care of her more than she took care of me at times. (31: 62-65)

Susan’s talk first centers the DIM in noting that she resented her mother for not being able to mother like she wanted. Her talk then allows for the DRM in noting that she understands why her mother could not mother like other parents because of her mother’s depression and the difficulty it placed on her mother even performing basic tasks like getting out of bed. However, her talk then counters with the DIM by noting that despite this understanding, she ultimately believes that she did not have a mother because she had to be the caretaker for her mother. In positioning her mother’s absence of caregiving as a loss of having a mother, Susan’s talk ultimately privileges the DIM and its focus on caregiving as paramount to claiming the identity of motherhood. Although her talk grants some legitimacy to the DRM in noting that she understands and accepts her mother, her statements privileges the DIM in noting that her mother should have taken care of her rather than Susan taking care of mother.

Like Susan, a story from Samantha also gives credence to the DRM but ultimately privileges the DIM in constructing the meaning of motherhood. Samantha notes that as the only girl among her siblings, she became her mother’s closest confidant
in the family, often hearing about her mother’s depression and the various aspects of her life that were causing her to feel depression. Samantha’s mother would also detail how her therapy sessions went. Here Samantha describes her reaction to hearing about one of her mother’s therapy sessions:

So after a particularly difficult session where she would be telling me how she was feeling and I was expected to feel strong, I would go upstairs to myself, alone, and cry. You know? It was things like that. And it’s definitely like, “What’s going on here? You’ve got to be my mom” . . . But I understand it’s not her fault. It’s a mental illness and I don’t think she is fully aware of it, you know? . . . It sounds very bad to say and I know she’s my mom. And I know like what a mom does and I know she does so much for us and for our family, but I feel like I don’t have a mom sometimes. I feel like I don’t, I don’t personally know motherhood. (23: 448-459)

Samantha’s talk first speaks to the DIM and its second tenet of mothers providing full support in describing her need as support her mother as unfair. However, she then notes that she understands why her mother needed help, thereby drawing on the DRM by describing mothers as people who provide what they capable of providing. Samantha’s talk finally centers the DIM and in particular the second tenet of the DIM in noting her perceived absence of having a mother because of the absence of support. Though Samantha’s gives some credit to the DRM in noting that the lack of support was not her mother’s fault and that her mother does in fact provide some support (e.g., “she does so much for us and our family”), her utterances centers the DIM in noting that she does not
know motherhood. By describing the lack of support as the lack of motherhood, Samantha firmly establishes the DIM as paramount to the meaning of motherhood.

**Entertaining.** Though less common in the data than negating and countering, there were some instances of entertaining. Unlike negating and countering entertaining does not involve a final privileging of DIM or the DRM. Rather, the two sit in continual contention with one another and demonstrate a participant’s inability to discursively give more weight to either or reconcile their differences. For example, Jen describes the frustrations she experienced when interacting with her mother during her mother’s more down times. Diagnosed with depression when Jen was in middle school, Jen describes her mother’s depression as cyclical in nature wherein she would be happy and up some weeks but sad and down during others. Here Jen describes a moment during one of her mother’s down periods:

It was the first time I was taking biology and I was reading this book and it was saying there are frogs in the United States somewhere that literally freeze in the winter. Like literally their heart stops and they freeze but then they come back to life. Like isn’t that crazy? It blew my mind for a week! So I was really excited about it. It was this great book I was reading and it had all sorts of these fun facts. I was trying to get my mom to read the book and telling her about it and like I could tell she was in one of her moods. But I was being selfish and I didn’t care but I just wanted to tell her about it—for her to share my enthusiasm. I could really tell she just wasn’t there, like: “oh that’s great.” And kind of would talk and ramble, and I would just stop mid-sentence because I could tell she wasn’t listening. And she would—absolutely nothing. Like I might as well be talking to
the wall at this point because you are not here. And I kind of felt bad because I can realize she’s really going through something. Like my mom to do that, she’s really in a bad place. So I really need to stop thinking about myself and kind of try to figure out what to do with this situation. But at the same point of like mom!

(17: 617-636)

Jen’s utterance displays a back and forth of the DIM and the DRM. We first see the DIM in Jen’s description of her desire for her mother to show support and care by sharing in her enthusiasm for Jen’s passions. Jen’s talk then shifts to the DRM by describing herself as being selfish for wanting her mother to care when she could tell that her mother was not feeling up to sharing her enthusiasm. Jen’s talk then shifts back to the DIM again in her last phrase of “but at the same point of like mom!” In noting that she needs to understand her mother but also wishing that her mother would share in her excitement, Jen’s talk give equal voicing to the DRM and the DIM and ultimately fails to privilege a discourse of motherhood.

Like Jen, Kathleen describes her inability to land on a singular understanding of motherhood when describing her views. As the youngest of three daughters, Kathleen spent the majority of her adolescence living just with her mother as her parents divorced while Kathleen was a child and her older sisters both moved out to attend college. Kathleen described having an unusual understanding of motherhood both because her mother tried to fill the duties of two parents after the divorce and because of her mother’s depression. She describes the added influence of culture into her sense making process.

I don’t know. Since my parents were divorced and I mainly lived with my mom she was kind of both parents. So I think my view might be altered because she
was both. I mean she was, except for money she was every emotional part, every emotional role in my life was her except my dad pays for things. So she was kind of like super mom mother even with depression. I don’t know, maybe others’ moms are like that too? Or if that’s too much? I don’t know. I’m taking media and sexualization class and we kind of talk about gender roles so I kind of don’t know what I think right now. Of like if I think the mom should stay home and be like the main emotional support for the kid. I don’t really know. (26: 284-294)

Kathleen’s talk first voices the DIM and in particular its second tenet of mothers providing full care and support. She notes that her mother provided everything for Kathleen except for money. Her talk then shifts to the DRM in noting that perhaps her experience with motherhood is not like other’s experiences and specifically voices the DRM in questioning if perhaps the view of a mother providing everything except financial support is too much. Kathleen’s utterance also notes that messages about motherhood can come from culture (e.g., a college course focused on the media and gender) and add to the complexity of her meaning making. Although Kathleen describes her experience with motherhood in a way that voices the DIM, her talk contains an inability to affirm this as her understanding of motherhood. In her explicit statements that she does not really know what to think about motherhood, Kathleen’s talk demonstrates an entertaining of the DIM and the DRM.

Overall, instances of both diachronic separation and synchronic interplay demonstrate a continued struggle for meaning making in participant narratives of motherhood. Both the amount of polemic interplay in addition to the diversity of which discourse was privileged demonstrate the salience of both the DIM and the DRM in
constructing understandings of motherhood. In other words, not only did the data reveal instances of countering, negating, and entertaining, but also differences in which discourse was negated and countered across the set. With these instances of polemic interplay reviewed, we now turn our attention to instances wherein new meanings of motherhood were made, discursive transformation.

**Discursive Transformation**

Unlike instances of both diachronic separation and synchronic interplay in which one discourse is eventually given the privileged position in defining motherhood or two discourses continue to sit in contention with one another, some participant talk constructed motherhood in a way that allowed for new meanings of motherhood to emerge. In some instances, this was done through extracting wherein a discourse was qualitatively changed by removing one of its central components but keeping the rest. In the current study, extraction involved the removal of the cultural script of motherhood from the DIM.

For other instances of discursive transformation, both the DIM and the DRM were combined discursively in ways that allowed for discursive hybrids to emerge. In one hybrid, both the DIM and DRM sat in equal footing with one another rather than in continued contention or confusion. In a second hybrid, the DRM was subverted wherein it was not in contention with the DIM but rather the way in which the DIM could be achieved.

Although Baxter (2011) also notes aesthetic moments as an additional type of transformative dialogue in which discourses combine in completely new ways and are accompanied by an affective (reported) feeling of wholeness and positive affect, no
aesthetic moments were identified in the data set. Beyond a lack of textual evidence of aesthetic moments, participant talk did not include descriptions of moments of wholeness in their understandings nor did I note any affectively charged moments during my interviews.

Extracting

Though not articulated in Baxter’s (2011) original descriptions of the various ways in which transformative dialogue can occur, Norwood (2010) notes extracting as a potential new form of interplay. Extracting as defined by Norwood (2010) occurs when participant talk voices a discourse but removes one of the core components of the discourse. Norwood argues that removing a component of the discourse while adhering to its other components creates a qualitatively different discourse and as such argues for extraction as a form of discursive transformation. In my study, extraction was identified through the reworking of the DIM wherein motherhood was still articulated as a mother providing full care and support but the expectation for a mother to adhere to the cultural scripts of motherhood was removed. One example of this discursive move came from Molly when describing her view of her mother:

Like my Aunt Patty, we call her Patty Home Maker because she’s like the mom who comes to the PTA meetings and she bakes for the bake sale. And she does all the things that you would think that like the perfect mom would do. And my mom doesn’t do those things. Like she does them a little bit, but not like not a lot. But she’s still a really awesome mom because she’s still extremely affectionate and she’s very. Like my family is always telling each other we love each other all the time. She’s really supportive. But she doesn’t really have the time to do all
that bullshit stuff. Because I think she just doesn’t feel that great all the time. Like I mean she’s great at cooking and baking and stuff, but she’s not the mom that’s going to send you cookies at college. That’s not her thing. Or she’s not going to show up at your house, like hey I made you some cookies. Like that’s not her. But she’s like, I mean I talk to her almost every day. And she’s very caring and affectionate. But I think that there’s some parts that she’s like, I can’t do that. It’s too much work. It’s hard enough to get out of bed sometimes. (1: 390-406)

Molly’s description of her Aunt Patty clearly adheres to the first tenet of the DIM as motherhood as cultural script in noting that her Aunt Patty “comes to the PTA meetings,” and “bakes for the bake sale.” At first it seems as though Molly’s talk is shifting to the discourse of DRM in noting that those motherhood activities are “bullshit.” However, Molly’s talk negates the necessity of these by pointing to the second tenet of the DIM in noting that her own mother, though unable to enact the cultural script of motherhood, is still able to provide full care and support. As such, Molly’s talk extracts out the necessity for enacting the cultural script of motherhood and instead positions mothering as offering love, care, affection, and emotional support and availability. Molly’s talk ultimately centers the DIM as the definition of motherhood but does so in a qualitatively different way than other utterances privileging the DIM. In a similar example, Sarah describes her understanding of motherhood:

I don’t think motherhood has to do with anything but being the best person you can for your child. And whether that is the best person you can be despite or the person you can be because or the best person you can be and. I think motherhood
is your child knowing that their mom loves them and is there no matter what. And that doesn’t mean that you can’t be going through your own things and that doesn’t mean that you can’t acknowledge that things are different. Maybe harder or even sometimes more emotionally draining. And maybe sometimes you don’t want to be a mom that day. And I think that’s something really real. I don’t think that has to do with anything but maybe sometime, like today I just don’t want to be a mom. I’m not interested in packing lunch or telling you you’re so amazing. And I feel like that’s something that is normal. And again I don’t think that’s something that makes you a bad parent. And even if that’s something that is like long standing. This is the way I’m showing you love and that’s something your kid is accepting and knows. It would be different if your kid is like I feel like you don’t love me, that’s something different. But if you have, I guess it’s just always, your kid knowing you’ve got them. That makes you a good parent. Yes. Yeah, I do. (3: 462-482)

Sarah’s utterance begins with the DIM in noting that motherhood means being the best person one can be for their child and that a mother will support a child no matter what happens. Sarah’s talk then gives voice to the DRM by noting that a mother may have to mother differently or may be going through situations of her own, thereby highlighting the tenet of the DRM that mothers are individuals and may not be able to give their full support. Sarah’s talk then takes on a sarcastic tone again calling up Bakhtin’s (1981d) notion of the rogue in noting that mothers may not want to pack lunches or tell children they are amazing. In framing these actions sarcastically, Sarah’s statement mocks the necessity of a mother to adhere to the cultural script of motherhood.
as articulated by the DIM. However, the statement then shifts back to the DIM by stating that ultimately it is about children knowing that their mothers love and support them. Like Molly, Sarah’s talk extracts the need for mothers to adhere to cultural scripts of motherhood while still maintaining that full love and support are paramount to its definition. Unlike instances of countering, negating, and entertaining wherein the DRM and DIM maintain their meanings as they move between privileged and marginalized positions in participant talk, transformative dialogue in participant talk demonstrates the potential for new meanings of motherhood to emerge in small, yet noticeable ways by teasing out the various tenets of the DRM and the DIM to formulate new meanings of motherhood.

**Hybrid**

Beyond extracting, some participant utterances were able to move entirely beyond the adversarial nature of the DIM in DRM and their tenets in the creation of discursive hybrids. Participant utterances in several instances shifted meanings of motherhood beyond a centripetal-centrifugal struggle wherein the DIM and the DRM moved between privileged and marginalized positions in talk and instead transformed the DIM and the DRM into new meanings of motherhood. These transformations occurred through two types of hybrids involving the melding of the DRM and the DIM into new meanings of motherhood.

**Hybrid A.** Transformative hybrid A emerged in participant talk when the DIM and the DRM were positioned as discursive equals, with motherhood resting in-between the expectations of both the DIM and the DRM. Rather than centering either the DIM or the DRM, these utterances created a meaning of motherhood that allowed for motherhood
to be defined and experienced through both the DIM and the DRM. Unlike entertaining, participant talk did not describe a confusion of this center ground. Rather, the center became the meaning. This shift from either/or to both/ and is evident in Kim’s discussion of how she now understands motherhood based on her experiences with her mother growing up.

Somewhere in between. Like I know it’s not the extreme of what my mom became but also know that like moms aren’t superwomen. I think, you know, at some point she pushed herself too hard as well. So I think its somewhere in between. You know there’s going to be issues, there’s going to be arguments, there’s going to be struggles. But I also think that motherhood is something you can’t just give up on. That’s your role, that’s who you are . . . You know I think of motherhood like you know it’s an obligation and a role and a duty. But at the same time there’s going to be struggles and depression and things that come up that sort of thing. But I still, I wouldn’t think of it as something overly complicated and like motherhood is this like fictitious thing. You know I think it’s somewhere between. Like hey they’re a person. Nobody’s perfect. There’s going to be struggles and things go up and down. But things can’t go up and down until things are completely gone, like the motherhoods out the door. (16: 625-646)

In her utterance, Kim’s talk foregrounds understandings of motherhood with both the DIM and the DRM. Further, Kim’s talk positions both as equal both in their beauty and their faults. Her statement first gives voice to the DRM in noting that she understands her mother pushed herself too hard and could not be superwoman. She then
includes that even though motherhood is difficult and of course individuals are going to have obstacles (DRM) it is still important for mothers to try their absolute hardest to not give up on the construct of ideal motherhood (DIM). This double voicing continues as Kim describes that motherhood is a duty and obligation (DIM) but also noting that obstacles are going to come up such as depression (DRM). Unlike entertaining wherein the DIM and the DRM are voiced equally with a participant noting an inability to determine which discourse should be centered, Kim’s statement voices both the DIM and DRM as equally necessary and positions motherhood as “somewhere between.” In positioning motherhood as a space between the two, Kim’s statement creates a meaning of motherhood wherein both the DIM and the DRM are given equal footing in creating a meaning of motherhood.

Like Sarah, Megan provides an example of a discursive hybrid A in articulating her understanding of motherhood as one wherein the DIM and the DRM provide equally viable understandings of motherhood. She explains:

I think there’s two different types of moms. Because there’s moms where like it might not actually be your mom, it’s your friend’s mom that you call mom because she’s a nurturer and a caretaker and kind of a stereotypical feminine motherly roles. But then you have the realistic mother who I think is just someone who like watches out for you, makes sure you’re not dead and make sure you don’t go homeless . . . Yeah like my friend’s mom is mom. I call her mom. I’m like I love you mom, like thanks mom for the food. (28: 312-320)

In her utterance, Megan’s talk highlights both the DRM and the DIM as equally fitting in articulating the meaning of motherhood. Megan first voices the DIM in noting
that motherhood can be the stereotypical caretaker and nurturer. As such, Megan highlights both tenets of the DIM in describing motherhood as a woman providing support and also enacting the cultural script of motherhood by noting that motherhood can be stereotypical. Megan also voices the DRM in noting that motherhood can also be “realistic” and include a mother providing you with basic needs. Rather than privileging the DRM or DIM in defining motherhood, Megan’s statement places motherhood as a role that a woman can occupy with either the DIM or the DRM, therein giving equal weight to both. Unlike in entertaining wherein participants are unable to decide if the DRM or DIM is a more accurate definition of motherhood, Megan’s utterance comfortably places the space between the DRM and DIM as the best definition of motherhood. In giving voice to both the DIM and the DRM, Megan’s statement shifts the meaning of motherhood from privileging either the DIM or the DRM and instead allows for both meanings of motherhood to hold equal importance in constructing the meaning of motherhood.

**Hybrid B.** Transformative hybrid B emerged in one participant utterance. The transformative hybrid of the DRM and the DIM comes at the end of the utterance when Megan uses tenets of the DRM to demonstrate how a mother actually falls in line with the DIM. She describes how she views her mother:

> When I think about my mom, she’s never happy. Like there are moments when she’s happy, but most of my mom—she struggled with so much. Like a lot of people when they talk about their mothers I get a little jealous. But with her depressions, I have to remember that all the time. What she went through and
raising me on her own with so many obstacles. She’s like a superhero, the fact that she’s still here. (28: 86-92)

Megan’s talk first gives a nod to the DIM in noting that compared to other mothers Megan gets jealous, presumably in her mother’s inability to meet the standards as set forth by her friend’s mothers and the DIM. Megan’s statement then voices the DRM in noting that Megan’s mother has depression and had difficulties to go through in raising Megan as a single mother. In noting her mother’s personhood, Megan’s talk centers the DRM. The transformative dialogue comes in the final two sentences when Megan articulates that her mother is a superhero because she is still around and putting in the effort to mother Megan in spite of her difficulties. In other words, Megan frames her understanding of motherhood in the DIM (i.e., moms do it all,) using tenets of the DRM (Moms provide what support they can). Megan transforms her mother’s inability to mother perfectly because of her depression (DRM) and her continued effort to provide what she can (DRM) as what ultimately makes her an ideal mother (DIM). Her statement does not reject the DIM but rather positions mothering via the DRM as ideal, therein giving voice to both the DRM and the DIM.

Through both types of transformative hybrids, the DIM and the DRM are able to rise above their adversarial interplay to create new meanings of motherhood. In hybrid A, motherhood is articulated as an in-between of the DIM and DRM wherein both visions of motherhood can be celebrated equally and stand as viable definitions of motherhood. In hybrid B, one participant utterance was able to subvert the DIM by noting that a mother going through life’s difficulties and still attempting to mother in spite of those difficulties (DRM) actually creates the DIM. Although these two types of transformative
hybridity were identified in the data, it is important to note that the overall lack of such
moments across the data demonstrates the continued contested nature of understandings
of motherhood.

Participant utterances demonstrated a high amount of polemic interplay both
diachronically across time and synchronically within utterances and through hybrid
transformation. Overall, the presence of diachronic separation in participant utterances
demonstrates emerging adults’ shifting understandings of the meaning of motherhood in
large part from the DIM to the DRM. Similarly, instances of negating generally involved
a privileging of the DIM as meanings of motherhood via the DRM were given some
legitimation but ultimately pushed to the margins. Overall, the prevalence of polemic
interplay in addition to the small amount of hybrids and lack of aesthetic moments
demonstrates the continued and pervasive struggles of emerging adults constructing
understandings of motherhood as it sits in relation to the DIM and the DRM.
CHAPTER FIVE
RESULTS PART TWO
DISCURSIVE CONSTRUCTIONS OF DEPRESSION

Before unpacking the central struggles at play in participant meaning making surrounding depression, it is useful to note the communication surrounding depression as reported by participants and its occurrences within their families at large. First, a surprising number of participants noted not having any conversations about depression with their mothers at the time of being told about her depression. In fact, only five participants reported speaking with their mother directly when learning of her illness. The remaining participants described coming to the knowledge about their mother’s depression by seeking information from others or receiving information from others. More specifically, these realizations came from asking family members about it (e.g., finding medication and asking an older sibling or a father what it was for) or hearing about it directly from other family members (e.g., an older sibling explaining it). While a number of participants reported speaking much more candidly with their mothers about her depression in the present, half of the participants noted that the topic of maternal depression was still not one discussed openly with their mothers.

The lack of communication surrounding their mothers’ illnesses was a surprising finding considering the reported salience of the experience of maternal depression to participant lives. Although I did not ask participants to disclose the mental health of any
other members of their family beyond their mothers, a number of participants did discuss mental illnesses among their immediate and extended family. In fact, almost half of the participants noted that other members of their family were also diagnosed with depression ranging from siblings to fathers to extended family members such as grandparents, aunts, and uncles. Additionally, nearly half of participants noted that they themselves had been diagnosed with depression. In total, approximately two thirds of participants reported the occurrence of depression in a family member or themselves.

Because of these diverse experiences of depression beyond those with just mothers, a number of participants discussed understandings of depression through stories stretching beyond those of maternal depression. Certainly, all participants voiced stories of their mothers’ depression in the interviews and as such the experience of having a mother with depression was central to meaning making. However, a number of participants also called upon stories of depression in their fathers, siblings, grandparents, extended family, friends, and themselves.

Though one may argue that this multitude of experiences may take away from how participants understood their mothers’ depression, I argue and believe that participant talk surrounding these experiences with others’ depression became a part of constructing meaning for maternal depression. In other words, participants came to understand their mother’s depression not only through experiences with maternal depression but also through experiences with depression in other relationships and within themselves. As such, in examining how emerging adults construct meanings of depression I did not limit my analysis to participant talk solely centered around maternal depression but rather included any participant talk about depression.
Like understandings of motherhood, participants also pointed to late high school and early college when describing the times when their understandings began to shift. In a number of cases, this shift in understanding was attributed exposure to information about mental illnesses through courses offered in late high school (e.g., AP Psychology) and in introductory level college courses (e.g., Intro to Psychology). In other cases, the shift in understanding was attributed to exposure to other individuals with depression such as close friends in high school and college. Finally, a number of participants noted that their own experiences with and diagnosis of depression served as a major catalyst in shifting understandings of depression.

Overall, two primary sites of struggles emerged in participant talk surrounding meanings depression. Though both struggles center on depression, they do so in two markedly different ways. As such, two separate contrapuntal analyses were conducted and the results of each analysis will be presented in two separate sections of the following chapter. The first section centers on the discursive struggle surrounding the construction of depression as a legitimate illness or as an emotion. In other words, participant talk revealed a struggle between validating depression as a real, experienced illness and constructing it as a more personalized experience of emotion. The second section centers on depression’s etiology. Unlike struggle one centering on depression’s existence, struggle two operates on the presupposition of depression as illness and moves the focus to its causes.

Similar to Chapter Four, this chapter will first explore RQ1 by reviewing each discourse of depression via an in-depth presentation of its tenets. After reviewing the discourses, the chapter will then explore RQ2 by illuminating the ways in which the
discourses of depression discursively construct meaning through their interplay. The first section will examine two discourses of depression as they pertain to the meaning of depression as illness or emotion followed by an examination of their interplay. The section will examine two additional discourses of depression as they pertain to its etiology followed by an examination of their interplay. With each of the four discourses of depression explicated in full, a third section will then explore the more complex interplay of all four discourses of depression as they intersect in participant talk surrounding meanings of depression.

**Struggle One: The Reality of Depression**

The first primary struggle in participant talk in constructing the meaning of depression centered on depression’s very existence as an illness. Overall, six primary themes emerged cohering around two distinct discourses of depressions’ reality. The first discourse, the *Discourse of Depression as Sadness* (hereafter the DDS), is comprised of three primary tenets and define depression as: 1) concomitant with sadness, 2) a personal trait, and 3) a chosen state. In direct response to the DDS is the *Discourse of Depression as Illness* (hereafter the DDI). The DDI is also comprised of three tenets that serve as a foil to the three tenets of the DDS in constructing depression as a true illness. In the DDI, depression is defined as: 1) distinct from sadness 2) distinct from one’s personhood, and 3) beyond one’s control.

**The Discourse of Depression as Sadness**

The DDS constructs depression as an emotional state and/or a personal trait. Historically, symptoms voiced as part of the depression experience such as hopelessness, helplessness, and lack of interest were often attributed to “feeling sad” or “feeling
depressed,” to the point that the depression became synonymous with them (Schmale, 1970; Horwitz & Wakefield, 2007). In a similar way, the DDS positions depression as tantamount with the negative affect of sadness. Additionally, the DDS marks depression as a pre-established personality trait rather than an illness separate from the individual. In doing so, the DDS delimits depression as an internal and pre-existent part of one’s identity that manifests outward. In naturalizing depression as both an emotional state of mind and a trait of the individual, the DDS constructs depression as a chosen state that individuals can elect to have or not have.

The Discourse of Depression as Illness

In direct opposition to the DDS is the DDI, which positions depression as an illness that originates outside of the body and, as a result, outside of one’s control. In the DDI, depression is not only experienced through a myriad of emotions (sadness, anger, hopelessness, anxiety) but also in some cases as an inability to experience any emotion at all, including sadness. In direct refutation with the DDS’s second tenet, the DDI places depression as separate from one’s identity. In the DDI, depression is a part of an individual only in that it is an illness one has. Finally, the DDI negates the inference that depression is a chosen state. In the DDI, depression is similar to any other diagnosable illness (e.g., cancer, diabetes) and as such is out of one’s control and requires the help of outside resources to handle. To demonstrate the contrasting nature of the DDS and the DDI, each tenet of the DDS will be presented followed by its contrasting tenet of the DDI.
Depression as Sadness/Illness

**Depression is concomitant with sadness (DDS).** In the DDS, depression is primarily connected to and/or conflated with an emotional state of sadness. As noted prior, the majority of participants noted not having explicit conversations with their mother about her depression but rather found out about it through other means. Whether because of this lack of communication or because of depression’s conflation with sadness in culture at large, a number of participants called upon the DDS in recalling their initial understandings of their mother’s depression. For instance, Ashley recalls her initial childhood understanding of depression:

I just thought it was sadness all the time. Her being sad or not wanting to play or I don’t know. It was more so sadness. I would spend a lot of time with my dad.

Yeah, sad. (6: 55-58)

Ashley’s talk invokes the DDS in its explicit centering of depression as sadness. Though Ashley’s statement pulls in an interesting time component to depression is noting depression as extended sadness, it ultimately equates depression as the emotional experience of state of sadness.

For Pam, depression’s presence in several family members created an environment that was more open to discussions of depression than in the majority of participants. However, because these discussions did not happen until Pam was in middle and high school, her initial sense making relied heavily upon the DDS. Like
several other participants, Pam actually describes her initial understanding of depression using the term “emo.”³ She states:

But when I was little though, I just thought she was sad. I remember I talked to my brother a lot about it and being like, “Why is she like, I don’t know what’s wrong.” Or if my parents were fighting about something, I’d be like, “Why is she crying?” I don’t think I really knew anything... But middle school, I remember, when I first started hearing stuff about mental illness it was like, “Oh, emo” and like really bad connotations towards mental illness. (20: 360-364)

In Ashley and Pam’s talk, the emotion of sadness not only becomes conflated with depression, but also positions depression as solely an emotional state. In recalling her evolution of understanding as a young child, Pam’s talk ascribes fully to the DDS in constructing an understanding of depression as purely that of sadness. In middle school, as Pam is exposed to the idea of depression as illness, she continues to articulate her understanding of depression via the DDS in stating depression as being “emo,” a cultural term often used to describe emotionally fraught young adults. In equating depression as a lowered emotional state, Pam continues to voice the DDS despite lexically moving away from the explicit term of sadness.

In framing depression as an emotional state rather than an illness, some participants described the difficulty in actually distinguishing depression from sadness.

³ Emo in this case refers to the shortened term “Emotionally hardcore.” A youth subculture peaking in popularity in the early 2000s, the emo movement began as a musical subgenre of punk rock. Music labeled as emo was often identified by its emphasis on emotionally fraught lyrics thought to capture teenage angst. Beyond listening to emo music, individuals engaging in emo culture often dyed their hair black, dressed androgynously, and sought non-conformity (Miernik, 2013).
For Renae, the departure between depression and sadness became even more difficult in that her mother herself often articulated her state as one of sadness. Renae notes prior in her interview that she knew her father abused her mother during their marriage and that her mother suffered from what Renae believed was undiagnosed alcoholism. As such, she believed that her mother certainly had a reason to feel sadness. Renae explains:

She used to justify it as something is sad, something awful happened to you of course you’re going to be sad . . . So I think she kind of warped it as like a, you’re supposed to be sad, go through the phases of that. So I guess she never really justified it as a problem so I never saw it as a problem. I just saw it as sadness. Like sadness and depression went hand in hand. And I was like this is stupid, why are they diagnosing people with depression? Like they’re sad. Like that happened to her. (30: 216-223)

Unlike many other participants, Ashley points out that her mother did in fact discuss her experiences of depression with Ashley. Ashley’s indirect reported speech of her mother includes the voicing of the DDS in recalling that her mother described depression as a normal phase of sadness. Ashley describes her own confusion with the DDS in parsing out the necessity of labeling that sadness as depression. In other words, because the emotion of sadness is not a diagnosable illness, Ashley notes no reason to diagnose someone with depression in that it is simply sadness. In doing so, Ashley’s talk provides a clear explication of the DDS in describing depression as an emotional state rather than a diagnosable condition.

Similar to Ashley, Allison notes having conversations surrounding her mother’s depression with other family members but still not quite grasping any understanding of
the illness beyond the DDS. She describes discussing her mother’s depression with her grandmother:

I just remember me and my grandma talking about it a couple of times. And I was little. I didn’t really know what depression was. I was just like, “Dang my mom is really sad.” I’m like “Oh she’s just sad my dad left.” And I thought it would blow over. (32: 222-225)

Similar to Ashley, Allison’s talk positions depression as sadness in connection to her mother’s separation with her father. As such, her statement highlights the DDS and creates in Allison the belief that the seemingly transient feeling of depression would subside once her mother’s feelings of sadness from the separation subsided.

**Depression as more than sadness (DDI).** Contrary to the DDS, the DDI complicates depression by moving beyond a singular emotional state of sadness. Participants voicing the DDI described the emotional component of depression by noting that depression involved a complexity of emotional expression in addition to the potential for emotional repression. Carol describes this complex state of expression and repression when describing how she understands depression. In addition to growing up with a mother with depression, Carol herself now identifies as suffering from depression. As she explains:

Depression is the inability to completely control your emotions. It’s not necessarily just feeling sad. It’s more you feel sad. You feel helpless. You feel like you aren’t in control of any of your emotions. Emotions are muted like all that fun stuff. (8: 53-56)
Carol’s talk invokes the DDI in positioning depression as emotionally complex in that it relates not to solely feeling sad, but rather to feeling a range of emotional experiences such as helplessness. In addition, Carol’s talk presents depression as the silencing of emotions, rather than the experience of them.

Similar to Carol, Adam also speaks of emotional repression in articulating his understanding of depression. Interestingly, Adam tells the story not of how he came to understand depression through experiences with his mother, but rather of how he came to understand depression after dealing with it himself. Although his mother suffers from depression, Adam explains the difficulties he had in communicating his own experiences to his parents and having those feelings legitimized as more than just sadness—even by his mother who had been suffering from depression since Adam’s childhood.

The beginning of the whole depression part for me and her involvement, most of it was the whole optimistic thoughts. Just think happy things. Both of my parents assumed that I was like just sad or under the weather because of school or something. They didn’t see it as depression. So that’s why for four years I never acknowledged [the depression]. The breaking point was when I told my parent’s one, I was contemplating suicide and two, that I don’t feel happiness. I know what happiness feels like. I don’t feel it. So that’s when they would actually take me seriously. (13: 278-287)

In his story, Adam recalls his parents as ascribing his behavior to sadness. Adam’s recalled response to his parents invokes the DDI and points to depression as repression of happiness rather than the experience of sadness. As such, his parents finally
recognized that he was in fact suffering from a legitimized mental illness rather than a state of sadness.

In addition to moving depression from a simple state of sadness into a complex state of emotional expression and repression, individuals voicing the DDI also noted specific lexical moves they make with others when communicating about depression. Voicing the DDI, these individuals explicitly separate out the meaning of depression by noting it as distinctly different from the meaning of sadness. Sarah, whose mother suffered from depression as long as Sarah remembers, recalls several instances when her mother made a point to teach her to delineate between depression and sadness and warned her of the danger of conflating the two in Sarah’s everyday talk:

She’s always taken medicine. And I always knew because when I would say:

“I’m sad and I feel like I’m so depressed” she would say like: “That’s not depression, you’re just sad. You’re just sad today. You can be sad” . . . And even in those instances where I was like: “I feel really depressed” and she was like you know “Know the difference and know where you are because it’s something important to distinguish.” (3: 168-175)

In her retelling, Sarah recalls voicing the DDS in using the word depression as a means to describe when she was feeling sad. Through the reported speech of her mother, Sarah’s talk references the DDI in noting that depression is separate from sadness and should not be conflated with it in everyday talk.

In a similar vein, Samantha recalls her frustrations with members of her social network using the term depression to denote difficulties with daily life. In reflecting on how growing up with a mother has shaped her as a young adult, she notes that she feels
more equipped to notice depression in others. However, she also describes the difficulty in articulating the illness as real because of the way her social network positions depression. She explains:

Some of my friends will throw around depressed like: “Oh, I failed my test, I’m so depressed” . . . And you’re like: “No, you’re not depressed. You’re feeling bad for the moment but it will be better tomorrow.” (23: 609-616)

Similar to Sarah and her mother, Samantha’s retelling directly refutes the DDS voiced by her friends and calls on the DDI in positioning depression and sadness as mutually exclusive terms. Interestingly, later on her in interview while describing the positive outcomes of having a mother with depression Samantha makes a similar lexical mistake to the one she describes above when describing what she believes are personal strengths she has gained from growing up with a mother with depression:

It’s just truly, it’s just awful and a lot of people just don’t understand it. And so I guess with this sense of compassion that I have kind of gained through everything, it’s like also like a broadened understand of how people work, and emotions, and things like that. So I feel like I can connect to people on a better level now. But also I feel like it’s kind of brought my mom and I closer together which is sad and kind of depressing—um no! Saddening! Ooh that was bad! (23: 740-747)

In her statement, Samantha talk places depression and sadness in the same vein by using depression as laymen’s term for a sad situation. Samantha then catches herself midsentence and essentially voices the DDI by noting her use of depression as a problematic instance in her own speech.
Depression is My Mother’s illness

**Depression is a personality trait (DDS).** The second tenet of the DDS positions depression as a character trait of an individual rather than an outside illness. The notion of depression as a part of an individual’s identity was most often noted by participants who described their mothers as having depression for the majority of the participant’s lives. In other words, participants noted that because their mothers had been diagnosed with depression for as long as they could remember, they had more difficulty separating out what behaviors could be attributed to their mothers’ depression and what behaviors could be attributed to their mothers simply being themselves. For example, Michelle describes how she came to understand her mother and her mother’s depression:

> I think it was just a part of mom. I always, I learned from early on that mom was very sensitive or that’s how I interpreted it. So mom is really sensitive. You know, that angsty teenage phase was really rough on her because I would say things. I think at one point I think I called her a bitch to her face. And you could just see the slumping . . . But a lot of it was just, I just kind of wrapped it as a personality kind of thing. I don’t know, just a part of it, some of her science of when she would go into a depressive state was she would want me to sleep in the bed with her. Like, it’s girls night and I would, like you know, she wanted to cuddle. Usually when my dad was gone, like one of those event kind of triggers. Dad would be gone for a week or two for work and then she’s like I don’t want to sleep alone so [inaudible] a child in the bed with me. I remember one time she actually had me stay home from school because she was having a bad day. So she called me in sick. I was in middle school, and we had a fun girls day at home. We
like rearranged the furniture and did arts and crafts and stuff. And I just thought it was a fun day. Retrospect it was mom doing some behavioral activation kind of stuff to kind of combat some of those feelings of depression. So it was a lot of that was just, you know some of those signs of depression were more of her personality. (2:128-152)

Voicing the DDS, Michelle’s statement describes how Michelle’s mother’s depression was almost indistinguishable from her mother’s personality traits, which in this case, were likened to being a more sensitive person. Beyond noting her own carefulness around her mother not because of her depression but because of her sensitivity, Michelle also recalls specific behaviors that her mother enacted while growing up, such as having her daughter sleep in bed with her or keeping her home from school that at the time were not viewed as indicators of depression but rather behaviors caused by Michelle’s father’s absence for work. Although Michelle notes that perhaps in retrospect some of those behaviors were attributed to her mother’s depression, her talk ends with a voicing of the DDS by noting that those signs are tied into her personality.

Similar to conflating depression with sadness, a number of participants voicing the DDS recalled conflating their mothers’ depressive behaviors as a negative personality traits. Kim, whose mother is currently estranged from Kim’s family, spoke about the contentiousness of her mother’s depression as it related to her wider family circle and their understandings of the illness. Because a number of her family members had different understandings of depression, they often disagreed about the reality of the illness and whether Kim’s mother was actually suffering from a true mental illness. She explains:
You know my family I think as a whole, I think the big thing was depression is a weakness. You know I think that’s what everybody thought. This is a weakness that she has and like that’s kind of blaming the person instead of looking at the depression part of it . . . I think that was a big overarching thing like depression is a weakness that sort of thing. And I think that changed the dynamics kind of too because people wanted to tiptoe around and nobody should talk with her about it. Like don’t anybody ask her how she’s doing, we don’t want to start that! [Laughs] (16: 1155-1168)

Recalling her family discussions surrounding her mother’s depression, Kim’s description of her family’s reaction to her mother’s depression closely adheres to the DDS in positioning Kim’s mother’s depression as a part of her mother’s identity. In this case, the personality trait of weakness is ascribed to her mother rather than the potential acknowledgement that an illness may be creating her mother’s behaviors. As such, Kim notes her family’s insistence on silencing discussions surrounding depression in their potential for creating a space wherein the DDI might be voiced.

**Depression is an illness distinct from personality (DDI).** Unlike the DDS, the DDI works to negate the positioning of depression as a characteristic of one’s identity or a character flaw and instead centers depression as an illness distinctly separated from one’s personhood. In the DDI, negative behaviors exhibited by mothers are positioned as resulting from depression rather than as inherently enacted by their mothers regardless of illness. For example, Molly recalls being a young child and being told about her mother’s depression for the first time. She describes her initial reactions to finding out her mother was depressed:
When I first knew my mom was depressed, it was a really scary thing and I mean it’s still scary in a way, but now it’s like when she’s exhibiting certain behaviors or when, I don’t know. It’s just like oh it’s not really her, it’s like, and it’s her depression. (1: 105-109)

In her statement, Molly’s talk acknowledges the DDI in noting an ability to diminish the fear of her mother by explicitly separating out her mother from her mother’s depressive behaviors. Along with easing fear, participants noted the importance of separating out their mothers from their depression when trying to have constructive and healthy relationships with them. For Gwen, who was raised primarily by her mother on the West Coast after her parents’ divorce, the mother-daughter relationship became particularly important to maintain in that it was just she and her mother living together. When asked what advice she might give other young adults who have a mother with depression, Gwen’s story invokes the DDI as a way to enhance understanding for her mother’s behaviors. She explains:

Those are things that you can’t change about people that you will struggle with. But it’s easier, especially with depression. Once you are able to recognize it, to see it as it’s own thing separate from the person . . . So it’s like who they are as a person, what they give, just all positive things. And everyone has that side. And then the depression part is something that they, a burden that is on them and something that you should respect them for dealing with on their own. And you don’t need to make that burden any harder. (11: 396-404)

In her statement, Gwen’s talk centers the DDI in describing depression as an illness that is distinct and separate from an individual. Using the DDI, Gwen’s talk
allows for a separation between the negative aspects of Gwen’s mother, which are explicitly tied to depression and to Gwen’s mother herself.

Finally, in clearly locating depression as separate from a mother’s identity, several participants explicitly made note of depression as “disease” or “illness” in their descriptions. For example, Lisa notes the presence of illness when describing what advice she might give to a child who has a mother with depression:

I would just say know that it’s a disease and it’s not—it’s not them, it’s the disease taking over. And, you know, they’re the same person. Like nothing’s changed but it’s a problem. It’s a disease that you’re dealing with, you know? Like I’ve heard a few people describe it as, like, imagine you have a skin disease that’s constantly itchy and you want to itch it. And they’re like, no, don’t itch it. And it’s like, I have to itch it. Or scratch it, rather, sorry. And um, like, it’s a disease. They’re really trying to not scratch it, but it’s right there. (15: 737-741)

Here the DDI is explicitly voiced as illness. Lisa’s talk first makes a distinct separation between her mother as an individual and her mother’s illness. Beyond describing depression as distinctly separate from her mother, Lisa repeatedly uses the word disease to describe depression and likens depression to a physical condition of a skin illness in constructing her argument for depression as a real illness beyond her mother’s identity.

**Depression as (Un)Controllable**

**Depression is a chosen state (DDS).** The final tenet of the DDS frames depression as personal choice. Similar to the DDS’s tenet of depression as a part of a mother’s identity or personality, depression as choice attributes depression and the
negative effects of the illness directly to the mother. Similar to the first tenet of the DDS, the final tenet of the DDS focuses on depression as a characteristic of a mother and as such as a continued personal choice that the mother consciously makes in behaving in a certain way. Beyond choosing to act a certain way, the DDS also frames depression as a choice by framing an individual as able to move beyond depression by choosing to engage in certain behaviors. In other words, the DDS positions depression as a state that an individual is either choosing to engage in or choosing to remain in.

In a number of instances, participants voiced the DDS in recalling conversations with family members wherein those family members described participant mothers as consciously choosing to behave in certain ways. For example, Dana describes the difficulty her extended family had with her mother after her mother was diagnosed with several illnesses including depression. After the diagnoses of these illnesses, Dana’s mother was unable to work full time and in some cases could no longer help around the home despite becoming a stay at home mother. Dana explains the cultural significance of her mother being unable to work in recalling her aunt and uncle’s reactions to her mother’s situation:

I know like my uncle and aunt both give my mom a lot of like rude comments. Because like it’s something you can’t tell on a personal time. She might look fine, like she might look like a normal person. But on the point she’s not. And that’s hard for others to understand and see. And so she’s not working and that’s sort of like a thing in Norway. That’s big. If both your parents don’t work, that’s huge. And here it’s probably looked at different in America. It’s normal like if your mom doesn’t work. But it’s not and so they would give her a lot of
comments and be like: “You’re not trying hard enough. Like have you tried everything to get healthy again? Like to get this away?” (9: 177-187)

Dana’s reported speech of her aunt and uncle draws upon the DDS in framing depression as something her mother chooses to remain stuck in because of her inability to try hard enough. Similar to Dana, Erica also recalls hearing about her mother’s depression from other family members (in this case her grandmother). Prior in the interview, Erica explains that her maternal grandmother often served as an intermediary in dissolving conflicts between Erica’s mother and father and between Erica and her mother. She recalled one particularly memorable message during a conversation with her grandmother about her mother’s choice to be depressed. She explains:

I was talking to my grandmother about it and she’s always kind of been that, in-between: “I’ll talk to your mother” and she used to reframe things just like my dad. And he’ll be like: “Your daughter is going nuts today.” And she’s like: “It’s not your fault, leave her alone. You don’t have to live with her!” kind of thing. And she was like: “Well I did when I was younger.” And I think, we’ve [Erica and her grandmother] never explicitly talked about depression when she [Erica’s mother] was younger but I get the sense that she was always a hard headed. Well I guess I am too, but like this kind of almost angsty. I think my grandmother actually used the word angsty and she just said like: “When your mother has made up her mind about something you can’t change it.” And my dad, both of them have commented on that: “Your mother has decided that she is going to be sad, or going to be angry, or going to do it. Don’t try to fix it.” So I think that’s like, whoa. (14: 579-593)
In her story, Erica voices the DDS in recalling both her grandmother and her father’s statements about her mother. The reported speech of Erica’s grandmother clearly calls on the DDS in saying that depression is a choice stemming from a personality trait of stubbornness or hardheadedness. Similarly, the reported speech of Erica’s father frames depression through the lens of the DDS in noting that Erica’s mother’s depression cannot be fixed because it up to Erica’s mother to decide if she will be sad or not sad.

In addition to hearing the DDS as voiced from family members, several participants themselves called upon the DDS in narrating their understandings of and frustrations with their mother’s depression. For example, Erica herself recalls ascribing to the DDS when she recounts how she and her brother often framed her mother’s behaviors:

I think that our biggest problem was that we pretended it wasn’t there. Even in our conversations about, you know, don’t talk to mom today. It was still the same. She’s choosing to be pissed about everyone today. Like always talking about choice. So I think we framed it the wrong way. That is was a choice. (14: 736-739)

Erica’s talk positions the DDS as the primary lens through which she and her brother shared the view of depression as choice. In choosing not to engage with their mother and being frustrated by her “choice” to act in a certain way towards them, Erica’s talk ascribes to the DDS and the framing of depression as choice.

Like Erica’s story, frustrations with a mother’s behavior was a common thread throughout stories voicing the DDS and in particular its tenet of depression as choice. For Krista, who spoke at length about having to step into the role of motherhood for her older
brother and younger sister because of her mother’s inability to provide any support for them, the DDS both frames past descriptions of the illness and continues to find voice in her talk surrounding her current understanding of her mother’s illness.

Like the main thing I remember feeling was anger. Like I saw my mom as [inaudible] more than anything. That made me angry. Because as a child, her depression caused her to, like, not mother in the way that I felt like she should be mothering. And so it caused a lot of anger. It shifted family roles and put me specifically me in a role of a caregiver in the family. I became someone who was caring for my mother at a young age. And it in turn made me really angry. And it made me—it sounds bad. But like, when it comes to depression, like I—I never like, experienced it myself in the sense of like needing medication for it or anything like that. But I almost like, I don’t want to say, buy in to it. Because that’s absolutely ridiculous to say, but I almost like, part of me wonders if like, I don’t know. Because I’ve wanted someone, like there were so many times that I just wanted to shake my mom. Like stop. Just stop acting like this. Why? But then I just didn’t understand. And maybe it’s coming from coming from not experiencing it, but to me, it was just like, can’t you shake it off? Like can’t you just pull yourself out of it? And I didn’t understand why she couldn’t do that. And it made me really angry. And so I kind of like, I don’t know. So I think I still associate depression with like, do you really need medication? (5: 118-138)

Calling on the DDS, Krista’s talk describes her inherent frustration with her mother’s inability to mother her and her siblings as Krista wanted. In noting that she wished her mother could just “shake it off” or “pull herself out of it” Krista’s talk firmly
establishes the DDS in framing depression as a personal choice. When describing her current understanding, Krista’s talk continues to invoke the DDS by calling into question the necessity of medication for the treatment of depression.

**Depression is beyond one’s control (DDI).** Troubling the DDS’s third tenet of depression as choice is the DDI’s third tenet of depression as beyond one’s control. Where the DDS positions depression as an internal state distinctly tied to and within the control of the individual, the DDI shifts the focus of depression outside of the mother and again centers the idea of depression as illness. Similar to the DDI’s second tenet explicitly separating depression from a personal trait by labeling depression as an illness, participants used the DDI to again draw a clear line between their mother and their mother’s illness by ascribing to the DDI’s tenet of depression as beyond one’s control. For example, James describes how he eventually came to terms with his mother’s depression. Noting the presence of depression within his mother all of his life, James describes finally understanding his mother’s depression after being allowed to speak with her doctors and having his thoughts confirmed by doctors assuring him that his mother had a serious mental illness. He explains:

I always assumed like it had to be something you couldn’t really help. Or else, because not everybody’s like that. Like there’s something wrong . . . I think you have to do just whatever is best for you. But depression is for a lot of people, it’s an illness. And I think people need to, I wish people would understand, I don’t know. It’s not something you can just beat. It’s not something you can—you have to. Something has to happen and you can’t just do it yourself. (19: 347-370)
In voicing the idea that depression is not something you can just beat, James’ talk pulls depression out of the realm of internalized choice and into the realm of the DDI wherein depression is an illness that can occur in anyone and must be addressed with professional help in noting one’s inability to do anything about it alone.

Beyond coming to terms with a mother’s illness, participants also voiced the DDI when describing difficult conversations they have with other individuals pertaining to their mother’s depression. When I ask Allison what is difficult for her as an individual when it comes to having a mother with depression, she notes a frustration of dealing with people who privilege the DDS instead of the DDI in conversations surrounding mental illnesses. She explains:

I feel like the hardest thing for my mom is when people aren’t understanding. So I feel like being understanding and not treating it like it’s something that’s trivial. Something that is just a choice, you know . . . I don’t know I feel like a lot of, I’m sure there’s a better term for it than victim blaming, but I feel like that happens a lot. Where they feel like it’s their fault they’re depressed. Where they’ve not done something, they’ve not gone to see someone. Like when was the last time you went to see someone, you know? Like just constantly reframing conversations and trying to navigate without letting them off the hook completely for things that are not good. (33: 733-752)

Allison’s expressed frustrations call upon the DDI in noting that those adhering to the DDS may actually be victim blaming, a term often used when the responsibility of a situation falls squarely on the shoulders of those suffering. Allison’s talk notes the importance of adhering to the DDI in both understanding the illness and in how to
interact with individuals with depression. Though not as vivid as Allison’s statement, Ashley also voices the DDI in the retelling of the first time she found that her mother had depression. Ashley’s mother’s bouts with depression began after the birth of Ashley herself when her mother was diagnosed with postpartum depression. Her mother was later diagnosed with major depression when Ashley was in elementary school and continues with her illness today. Here, Ashley explains finding out about her mother’s postpartum depression:

I didn’t know my mom had postpartum until my cousins told me it. So I was like, I was in Oregon staying with my cousins. And they were like: “Yeah, your mom was on [talk show].” I was like: “My mom was on [talk show]?” I had no idea. They were like: “Yeah, because of you.” And I was like: “uh, I had no clue.” So they played the tape and they were like—and she was talking to [talk show host]—this is so weird. This is like the weirdest thing about—and [talk show host] was like: “How do you feel about your daughter?” And my mom was like, she was stoned face. Like totally not in the right state, and she was like: “Well I love her, but I don’t like her at all.” And I was like—I was like ten so I was in shock. I thought that like—I started crying. I didn’t understand because she had never told me one, and two, it’s just a hard thing to understand. Like your mom not really liking you when you’re a baby. So that kind of messed me up for a little. But then I talked about it with my mom and of course it wasn’t something she could help. It was just like, how things were. (6: 105-120)

While at first it appears that Ashley’s talk coheres around the DDS in describing how upset she was at finding out her mother had postpartum depression, she follows up
with a voicing of the DDI by saying that it was not something that she could help. Ashley notes that while the story was shocking, it ends in the resolution of knowing that her mother was helpless against her depression and as such not responsible for being unable to love and be excited about her daughter as Ashley would expect. In particular, the use of the phrase “of course” provides evidence of a powerful adherence to the DDI in framing the DDI as an assumed correct viewpoint.

**Interplay of the DDS and the DDI**

The DDS and the DDI represent a long-standing oppositional struggle in mainstream culture in constructing meaning for depression. In particular, the conflation of the experience of depression with the experience of sadness and/or the conflation of depression with one’s personality represents an ongoing struggle attempting to understand the line between negative feelings and illness (Horwitz & Wakefield, 2007). As long as forty-five years ago, the psychologist Schmale (1970) described the difficulty of hearing patients discuss their symptoms and differentiating “[w]hether an author is describing depression as an affect, a character style, or a disease syndrome” (p. 327). Though these scholars failed to examine this struggle at the discursive level, the DDS and DDI proved similarly polemic in their interplay.

The interplay of the DDS and the DDI occurred via both diachronic separation and synchronic interplay. Interestingly, no transformative dialogue emerged in the contrapuntal analysis, perhaps demonstrating the continued and pervasive struggle of understanding between the DDS and the DDI in contemporary culture. Additionally, neither the DDS nor the DDI were consistently given centripetal positioning in instances of countering, negating, and entertaining. In other words, the DDS and the DDI not only
found themselves in clear contention with one another across the data set, but also occupied both the centripetal and centrifugal position in participant utterances.

**Diachronic Separation**

**Spiraling inversion.** In recounting their stories of growing up with a mother with depression, a common theme throughout many of the interviews was the evolution of participants’ understandings of depression. Because the majority of participants noted having a mother who was depressed for as long as the participants could remember, they were often able to recall their initial understandings of the illness and its evolution into how they now articulate its meaning as emerging adults. As such, the data revealed several instances of diachronic separation. Baxter (2011) notes that examples of diachronic separation can be located productively in interviews involving a recounting of meaning making as it occurred across time. In the current study, several instances of spiraling inversion were identified. Also referred to by Baxter as cyclic alternation (Baxter, 1998; 2011), spiraling inversion is marked by a back and forth privileging of a certain discourse across time. For example, a couple might privilege the discourse of community in their relational talk at the beginning of a relationship but after a considerable amount of time shift their relational talk to the discourse of individualism. In examining participant meaning making surrounding depression, participants often privileged the DDS in recalling their initial understandings of depression. However, in recounting their current understandings of depression, the DDS was replaced by the DDI as the primary discourse of depression. For instance, Zoe describes her understandings of depression as she remembers them as a child and today. Zoe recalls recognizing her mother’s depression after the birth of Zoe’s younger sister and the subsequent break up of
her mother and stepfather (the father of Zoe’s younger sister). Around the time she was entering high school, state officials confronted Zoe and her mother after Zoe’s school finds out that she is being disciplined with physical force at home. After working with the state officials, Zoe’s mother begins seeing a therapist and taking medication for her depression. Zoe recounts this turning point and describes her evolving understanding of her mother’s illness:

She was just more like really stressed out. She was definitely more like sad . . .
She just kind of like slept a lot more. She didn’t do much . . . And then being as young as I was, I was a little bit like kind of like not really paying attention as much but when I noticed it throughout more and more often, I kind of started questioning like why is she like kind of like this? (21: 138-141)

Later in the interview, I ask Zoe to recall what she thought about depression once she was informed that her mother had depression:

I didn’t think it was a real thing like I don’t know what exactly it was . . . Like I’d hear people talking about it and like, “Oh, it’s a real thing.” But I think I was just kind of like—so there’s that. That’s it. You’re sad or you’re stressed out. It was never like a real thing . . . Like I’d see my mom go from really calm to really, really mad or sad. And I’ve seen the different levels of it . . . But it wasn’t, it just was always like, “Oh, that’s just her. That’s her personality or [inaudible], it’s not like a sickness or something. You’re not crazy or something” . . . Now I think I’ve begun to understand it a little bit more and I realize that it is there. And I realize that like, even now it could still, there’s still little things, like signs, that she’ll like even when she’s taking her medication. There’s still little things she’ll say or do
that I’m like: “That’s probably your depression speaking” or “That’s how you’re feeling right now.” But it didn’t really—it didn’t really affect me too much now just kind of like, I just kind of accept it. (21: 511-540)

Zoe’s story of her evolution of understanding provides a rich example of several tenets of the DDS and the DDI as they play out in her meaning making of depression. In recalling her childhood, Zoe’s talk retrospectively privileges the DDS. First, Zoe voices the idea that her mother’s behavior is a result of being stressed and sad. Second, Zoe’s talk positions those behaviors as a part of her mother’s personality when she notes that it was “just her.” As such, Zoe voices two of the tenets of DDS. Noting a progression of time to present day, Zoe then voices the DDI by pointing out that she now views depression as something that is there. More explicitly, Zoe notes that now when her mother exhibits certain behaviors she pulls the attribution of those behaviors from her mother’s personality to her mother’s depression, therein privileging the DDI by positioning her mother’s behaviors as caused by the external condition of the illness rather than the internal decisions and traits of her mother. In the privileging of the DDS in Zoe’s retrospective talk and the privileging of the DDI in her current articulations of depression, we see a clear example of spiraling inversion.

Similar to Zoe’s transition from privileging the DDS to privileging the DDI across time, Meredith also recalls how her understanding of depression changed as she aged. The daughter of two parents with depression, Meredith described depression as an often talked about illness in her household. As a child, Meredith’s parents informed her that they both were suffering from depression. However, her parents did not explain the illness beyond noting that they both were suffering from it. Here Meredith mentions the
centrality of taking an AP psychology course in high school from an instructor who believed it was very important to teach students in high school about mental illnesses. This class served as a turning point for Meredith in coming to understand her parents’ depression. She explains:

I think what changed was after I had actually started learning definitions and learning that these are real things that it started being more of, I started being less angry at the fact that like, you know, I have depressed parents. Because at first I was like get over it, you can choose to be happy. This is your choice. What are you doing? And now it’s like no, this is real. It’s a physical problem that we can’t see and it's just like—I’ve become much more understanding and I’ve changed my ways of trying to help them. Because my first method was like, be happy. You know? And now I know that’s like rule number one, you don’t do that! I missed that one! So I definitely changed my methods and more of just like, “Well then, let’s go on a walk. Or let’s go do something fun today. Like mom, do you want to paint your nails? Let’s get out of bed. There we go.” (24: 198-211)

In her story, Meredith’s talk first highlights the DDS in describing her frustrations with her parents’ inability to choose to get over their illness. She then notes that in present day she directly refutes the DDS with the DDI by positioning her parents’ illness as a physical illness and a real illness. Similarly, in noting that she originally attempted to help her parents by encouraging them to be happy, she gives a sideward glance to the privileging of the DDS by positioning depression as simply sadness and depression as
choice. She then notes that in present day she has changed her methods from suggestions of a change of mood to activities.

A final example of spiraling inversion comes from Megan. Although Megan’s mother was formally diagnosed with depression after the death of her uncle (her mother’s brother), Megan notes that she believes her mother was suffering from depression for most of Megan’s life. Like other participants, Megan describes the evolution of her understanding from the time she first tried to understand depression to the present day:

Mom was always sad. Mom was always grumpy. She never wanted to do anything. That was just my mom. I didn’t know it was because of an illness and stuff that had been going on in her life. I didn’t make those connections. There could be a death in the family and I’ll be sad but then I’ll be fine. But it would be like my mom is still sad. So as I got older I would talk to my friend and be like “Oh my mom is so depressed.” But it wasn’t like depression. I just said it out of carelessness and I know that word. And now I don’t say words like that when describing things until I know it’s a diagnosed thing. But back when I didn’t know any better like, “Oh she’s so depressed. Like oh that’s so annoying.” And now I know she has depression and she is depressed. I don’t know. It’s different. I have a completely different mindset about it. It was just all I knew. I didn’t know her any other way. (28: 338-352)

Here Megan voices several tenets of the DDS in recalling how she came to even recognize the existence of depression as a separate and serious illness. Megan’s talk first centers the DDS in noting that Megan believed her mother’s moods and behaviors were simply a part of who her mother was. Megan’s talk continues to privilege the DDS in
recalling her conflation of depression with sadness. In particular, she recalls making the same lexical mistake noted by other participants in using the word depression to describe her mother’s mood. In the present day, Megan privileges the DDI in noting that she no longer associates the term depression with sadness to the extent that she does not even use the word depression until there it is a confirmed mental illness.

**Segmentation.** Along with spiraling inversion, the data also revealed one example of segmentation, wherein one discourse or another is privileged depending upon the situation rather than across time. In the data set, the segmentation example comes from Meredith. As noted prior, Meredith describes being raised by both a mother and a father with depression. In her interview, Meredith notes that her mother and father often flip-flop with their periods of depression, with her mother being more depressed and “low” during her fathers more “up” times. She retells how her father tends to switch between privileging the DDS and the DDI when she and her father discuss their mother:

> My dad likes to think he’s perfect even though—it’s funny—when he gets out of his ruts, he’ll admit: “Oh, I was in a rut. But now, I’m totally fine.” Like, look at me go. And like he takes kind of like taking care of my mom and then he will openly talk about like: “Oh, your mom, she is just this and this.” It’s when he is happy that he explains it in a way of like: “It’s, it is just a mental illness. Like this is real.” And when he’s not happy it’s like: “Well your mom never gets off the couch and she just does this” and just like, you are just flopping on both sides of the same conversation . . . Sometimes I think my dad is on the same page until he is upset and in his own rut--and then he’s like: “No, she’s just lazy. She’s this. You’re crazy.” (24: 883-917)
Here Meredith’s talk expresses both the DDS and the DDI in describing the reported speech of her father and his opinions about her mother’s depression. When her father is depressed himself, he privileges the DDS, with Meredith reporting his voicing of her mother as choosing to be depressed and being lazy. However, when her father is not in a depressed state, he privileges the DDI and positions depression as a real illness that is not to be blamed on his wife. So, dependent upon the situation (i.e., the status of Meredith’s father’s depression), Meredith’s father’s talk privileges either the DDS or the DDI.

**Synchronic Interplay**

In addition to diachronic separation, the data also demonstrated a high degree of synchronic interplay wherein participants voiced both the DDS and the DDI concomitantly in articulating their understanding of depression. Instances of negating, countering, and entertaining were present in the data, demonstrating the pervasive struggle of meaning making between the DDS and the DDI in constructing understandings of depression.

**Negating.** Similar to diachronic separation where participants eventually privileged the DDI in present-day understandings of their mother’s depression, virtually all instances of negating involved a refutation of the DDS and centering of the DDI in constructing the meaning of depression. For some participants, this negation emerged in participant talk recounting discussions had with others about depression. For instance, Sarah brought up the death of celebrity Robin Williams⁴ as an example of a situation

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⁴ Robin Williams died approximately a month before data collection for the current project began. Initially reported and later confirmed by the Marin County Coroner as a suicide, Williams’ death became a platform...
when she finds herself having to defend her understanding of depression to outsiders. As
a celebrity famous not only for his career in comedy but also for his struggle with
depression, Robin Williams’ suicide brought discussions of mental illness, and in
particular depression, to the forefront of popular culture’s discussions surrounding mental
illness. In fact, three participants in the study specifically made note of Robin Williams
during their interview. Here Sarah describes her frustrations with outsiders who privilege
the DDS:

And then you see things like Robin Williams. Like he had a whole slew of issues
but he was depressed. He was openly depressed. You say things like “Oh cheer
up! Just go do things, live your life, go to the park, pet some ducks! Dogs, or
ducks.” And you think it’s something that someone can snap out of but you also
can’t—you don’t say that about other things. Like if someone is like: “I have
cancer,” you’re not going to be like: “Uh you’re just sick, like you’ll get better.”
It’s not something that’s talked about in a lot of different ways. So I don’t think
it’s treated the way it should be treated and I don’t think it’s regarded as important
as it should be regarded. (2: 120-130)

In describing her understanding of Robin Williams, Sarah’s talk first expresses
some generalized statements Sarah has heard from others regarding individuals with
mental illness. These instances of indirect reported speech from a generalized other first
center the DDS by positioning depression as something that one can simply snap out of
by choice or by engaging in a pleasant activity like going to the park. Sarah’s talk then

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for discussions of depression and mental illness after his wife publicly revealed that Williams’ had been
suffering from severe depression.
challenges the DDS with the DDI by noting that depression should be regarded as a serious illness in the same way that a more widely accepted disease such as cancer is recognized. Sarah’s talk directly refutes the premise of the DDS and privileges the DDI by noting that depression should not be regarded or talked about using the tenets of the DDS.

Similar to Sarah, Meredith also discusses her understanding of depression through the retelling of interactions with generalized others. She discusses her own evolution of understanding:

A lot of people think depression is sadness. It’s like you’re wrong, I’m sorry. People that are depressed are just people that cry all the time, and that’s not the case . . . Because everybody thinks depression is just sadness. It is a kind of shift in mood but it’s not necessarily the person’s fault. Because a lot of people think like: “Oh I’m depressed because I’m sad today.” Like that’s not really what it is. Depression is like more of a long-term undertone, shift of feeling and shift of mood. (29: 295-318)

In her statement, Meredith doesn’t recall a specific incidence wherein she refuted the DDS with the DDI. However, she does pull upon comments of a more generalized other and their voicing of the DDS in conversations surrounding depression. Meredith’s statement “It’s like you’re wrong, I’m sorry” clearly negates the DDS’s position voiced prior in describing depression as a sluggish feeling or a sad feeling. Meredith again describes a reported voicing of the DDS in noting that some individuals use the word depression as a way to describe their moods. Her talk again negates the DDS using
several tenets of the DDI by noting that depression is not a person’s fault and is a more long-term shift in feeling and mood and not simply sadness.

Speaking about a more specific encounter, Pam recounts the ways that her family differs in their understanding of her mother’s depression. Pam explains that her immediate family members all seem to be on the same page in their understanding of depression. However, she notes that not all the members of her extended family agree. She explains:

My mom has books laying everywhere about them [mental illnesses]. I don’t know what my dad thinks at all. But I know my dad’s side of the family thinks that mental illness is not real, like it’s all in your head. Like, you’re sad, get over it, people are having worse problems than you. That’s the kind of environment that my dad came from. His parents came over from Italy and worked and he had to do everything on his own so he is very like: “If you are upset about something, go for a run.” And I’m like: “that doesn’t help a lot.” (20: 300-307)

Here, Pam’s reported speech of her father’s statements about mental illness clearly centers the DDS by speaking about depression as a choice or a personal trait that can be fixed by individual action rather than an illness that is real and requires outside assistance. Pam’s own recalled talk directly dismisses the statement from her father’s side of the family by stating “That doesn’t help.” In doing so, she gives a sideward glance to the DDI in noting that depression requires help beyond what an individual can do such as going for a run.

**Countering.** Much like negating, instances of countering occurred via participant talk granting some legitimacy to the DDS but ultimately framing the meaning of
depression using the DDI. Though the DDS is granted some legitimacy in participants’
statements, the final position almost exclusively placed utterances in the camp of the
DDI. For example, Sarah provided a number of statements clearly positioning the DDI as
the primary understanding of depression as noted in her previous statements in describing
the DDI and in her negating example. However, there was also an instance of countering
in Sarah’s talk. This struggle between the DDS and the DDI was very apparent
throughout Sarah’s interview when she discussed the frustrations of her mother’s
depression when it began to interfere with things that Sarah wanted to be able to do with
her mother. Throughout the interview she notes the internal struggle of validating or
invalidating her mother’s depression. Specifically, Sarah describes the difficult
encounters she often has with her mother when her mother is unable to attend events or
spend time engaging with Sarah. She describes these overall conversations and her
thought processes during them:

I have a tendency to lose patience and get mad, I’m like: “I wish you would just
get up and do something and stop being depressed.” . . . Just those moments when
you’re like: “I’m tired of hearing about this, do something about it.” And then
feeling really guilty on my end for saying that and wanting to be like, “I love you,
I get it, I’m sorry.” It goes back to even when we [U.S. culture] know that
depression is an illness, it is an illness that we don’t put a lot of weight on . . .
There’s a difference between someone who is depressed and anxious and doesn’t
want to and kind of being like: “I know you don’t want to but let’s just do it.”
And I think that happens more often and it’s like: “Why don’t you want to do it?
You’re ruining everyone’s day.” Like you’re not going to say that to someone
who has cancer. Like: “You’re ruining everyone’s day by being in pain.” And you don’t do that even though someone who is depressed is in pain in their own way, right? Either physically or mentally. And you’re still like: “Do it. Because I know that you’re like not trying hard enough.” And so I think that is something that is there and is hard. It’s easy to forget that it’s real. (3: 514-547)

Sarah’s talk presents a vivid back and forth struggle between invalidating the DDS and positioning it as an understandable discursive space. Similar to her instances of negating, Sarah’s voices the problematic phrases of expecting someone to simply get up and snap out of their depression, thereby granting primary legitimacy to the DDS. However, unlike her instances of negating wherein she explicitly notes its issues, in these statements she grants some legitimacy to the DDS by noting that even when she recognizes it is problematic she still finds herself encouraging her mother to change.

Towards the end of her statement, we see the notion that in some moment’s Sarah’s talk does privilege the DDS (i.e., noting frustration and moments when she is tired of hearing about her mother’s depression.) However, Sarah describes these moments as “awful” and describes the effort that must go into coming back from those instances, therein re-centering the DDI. Sarah’s statement continues to privilege the DDI in describing the feeling of guilt about speaking about her mother’s depression that way. In addition to these two shifts back to the DDI, we also see a final mention of needing to apologize to her mother and therein in a clear privileging of the DDI in her need to delegitimize the DDS and privilege the DDI.

For some participants, even having depression themselves still required a negotiation of meaning between the DDS and the DDI. For example, Adam describes
trying to speak with individuals about both his depression and his mother’s depression. He notes that conversations surrounding mental illness often play out differently when they occur between individuals who have not experienced mental illness versus those that have. He explains:

You can really see the difference if you know someone has experienced it themselves. They know how you feel and It’s not as simple as just, “Oh, tell a depressed person optimistic thoughts.” Like, “oh, fake it till you make it.” I’ve heard that so many times and it really pushes a button. I don’t know. You understand that it is serious and that a lot of things around it [depression] are false, however a lot of it is still true. But it’s hard to relate to unless you’ve had it.

(13: 186-192)

At first, Adam’s statement appears to directly refute the DDS in noting the problematic nature of people dismissing depression as something that can be cured. However, his talk then counters the DDI by granting some legitimacy to the DDS in saying that a lot of things around depression can be false. However, the statement ends by noting that a lot of what is told about depression is true. As such, Adam’s utterance grants legitimacy to statements surrounding the DDS by noting he understands it is hard to relate to without personal experience but ultimately privileges the DDI.

Entertaining. Unlike countering and negating in which the DDI was eventually centered as the primary understanding of depression over the DDS, a few participants noted a continued struggle to reconcile their understandings of depression as they pertained to the DDI and the DDS. For example, in discussing her current relationship
with her mother, Meredith describes the confusion she often feels with her relationship with her mother as a result of her mother’s depression.

And it’s not like me wanting to blame her for all those things. Because I know part of it may be linked to depression but at the same time I’m like how can you not be involved I guess? It’s been that struggle that’s gone on and I haven’t understood it but I’m becoming more used to it. And now that I’m away from home I’m just kind of like that sucks but I’m moving on. So I’m recognizing the past and not dwelling on that I guess. (29: 569-575)

Meredith notes that her mother was not the mother that she necessarily wanted or needed growing up. However, her expectations of motherhood are tied with where to place blame for her mother’s depressive symptoms that Meredith sees as the cause of her mother being less than Meredith wanted. Meredith first voices the DDI in placing the blame of her mother’s behavior on depression. Her talk then calls on the DDS in her confusion as to how her mother simply could not be involved in spite of those symptoms. As such, Meredith’s talk is unable to negotiate the meaning of depression (and subsequently her mother’s behaviors) in the camp of DDS or of DDI. Because of this, she is unable to fully position her understanding of her relationship with her mother and instead notes that she can do nothing but move on from it.

Much like Meredith, Krista also notes confusion in understanding depression as it relates to the DDS and the DDI. Though she never suffered from depression herself, Krista pulls on interactions both with her mother and with her close friend who has depression in coming to terms with what depression is. She explains:
Yeah sometimes I wonder if I have it and I don’t even—but then I’m like oh, well if I do then I’m okay. Because I’m getting by without taking medication or without feeling like I, but see then, I don’t know actually. Because I do, like, self-medicate so maybe, I don’t know. But I have wondered about myself a lot, very much. It’s a very real fear that I have of like, am I going to get to the place that my mother has been to? And I even notice myself sometimes trying to shut myself out. Like shut myself away like the things she used to do. And just like patterns. And I’ll be like, oh. Afterwards I’ll be like: “That was my mom.” And it just like, it’s hard. I just, like that’s not what I want for myself. So it’s kind of this constant battle between like, am I—is this a thing? Is it happening to me? Am I just imagining it? Am I, so I, its sticky. (5: 251-264)

In her statement, we see a genuine confusion between the DDS and the DDI in Krista’s talk. Upon hearing her friend’s symptoms, Krista’s talk calls upon the DDS in positioning depression not as a real illness but rather as a state in noting that Krista often feels exactly the same symptoms but does not have depression. In placing herself in Lucy’s shoes without pulling in the identity of an individual with depression, Krista’s talk positions Lucy’s situation as just that, a situation. However, Krista’s utterance then counters back to the DDI by noting that she often wonders if she perhaps does have depression because she feels the same way that Lucy feels and also notes similarities between her behaviors and her mother’s behaviors. In noting this, Krista’s talk re-centers the DDI by pulling that identity of depression in rather than invalidating it. At the end of her statement, Krista’s talk all but explicitly states an ambiguity between the DDS and the DDI by noting that she continually struggles with her own beliefs of whether
depression itself is a real illness and if it is something that is happening to her. Krista is unable to privilege either of the discourses but rather finds herself in a continuous back and forth between the two as she navigates her relationship with her friend, her mother, and potentially her own feelings of depression.

Overall, the prevalence of diachronic separation and all three types of synchronic interplay demonstrate the continued struggle for meaning that emerging adults voice in articulating their understandings of depression. While many participants voice the DDI as central to understanding depression in their current lives, the incidence of entertaining in the data along with a lack of hybrid examples or aesthetic moments is arguably telling in the continued interpenetration of meaning for emerging adults trying to make sense of the illness. With the first struggle surrounding the meaning of depression examined in full, we can now turn our attention to the second primary struggle that emerged in the data set surrounding the etiology (i.e. causes) of depression.

**Struggle Three: The Meaning of Depression (Etiology)**

The second primary struggle surrounding the meaning of depression stemmed from participant talk surrounding its etiology. Beyond grappling with whether depression was an emotional state (DDS) versus a legitimized, outside illness (DDI), participants voiced two primary discourses surrounding the potential set of causes for the depression: 1) the *biomedical discourse of depression* (hereafter the BDD), and 2) the *psychosocial discourse of depression* (hereafter the PDD). Both the *biomedical discourse of depression* and the *psychosocial discourse of depression* are foregrounded in the assumption that depression is a real illness rather than an emotional state of sadness or trait of an individual. Participants describing the causes of depression noted several
potential internal factors within their mothers when voicing both the biomedical discourse of depression (e.g., chemical imbalances in the brain) and the psychosocial discourse of depression (e.g., negative bias in cognitive processing or membership in marginalized community) but did not articulate either in a way that attributed those factors to an emotional state, a mother’s personal trait, or a mother’s choice. In other words, though the BDD and the PDD diverge on their definition of the causes of depression, both sit firmly within the DDI and operate from the framework of depression as a real illness. Both the BDD and the PDD expressed in participant talk adhered closely to the etiological narratives presented in Chapter Two.

**The Biomedical Discourse of Depression**

The biomedical discourse of depression (hereafter the BDD) aligns closely with extant literature on the biomedical model of depression. As noted in Chapter Two, the biomedical model of depression positions depression as a biological disorder or disease. This articulation of depression stems from Engel’s (1977) wider discourse of the biomedical model of disease, which assumes that diseases are caused solely by biological variables that depart from normal levels or functioning. The biomedical model of illness silences psychological, social, and cultural factors and instead focuses diagnostics and treatments solely on the body (Engel, 1977). Cohering closely to Deacon’s (2013) articulation of Engel’s biomedical model of illness as it pertains to mental illness, the BDD as voiced in participant talk rests on two tenets: 1) depression is caused by inheritable, chemical imbalances in the brain, and 2) depression is treated with medication.
The Psychosocial Discourse of Depression

Challenging the BDD which positions depression as bodily, the PDD follows the assumptions of psychosocial theories of depression that advance the causes of depression as stemming from a variety of social (e.g., stressful work environment), relational (e.g., marital issues), and cultural (e.g., low SES statue) factors. Additionally, the PDD notes the potential of cognitive factors as causational in the development of depression (Ainsworth, 2000). These cognitive factors may cause individuals with depression to process information differently and arrive at different cognitive products than non-depressed individuals in the ways they perceive and process information from their environment (Abrahmson et al., 2002).

In the PDD, one psychological or social issue can cause depression alone or concurrently with others (i.e., one may have a stressful work environment and have issues with cognitive thought processing). Although both the BDD and some variants of the PDD place the locus of depression in the brain, the PDD defines depression as stemming from a cognitive component via how an individual processes information and/or reacts to outside events whereas the BDD maintains its connection to the brain only in its physical components via chemical imbalances. In other words, though tenets of the BDD and the PDD both place depression as an experience within the brain, the BDD frames it as an objective, measurable, experience whereas the PDD frames depression as a subjective, cognitive experience.

As noted in Chapter Two, a number of psychosocial theories of depression exist in literature on depression. These theories range from issues with cognitive processing (Abramson et al., 2002) to sociocultural factors such as being a member of a
marginalized community (Horwitz, 2011) to interpersonal stressors or stressful environments (Harper, 2009). Overall, the PDD is comprised of two central tenets: 1) depression is caused by socio-cultural and cognitive factors, and 2) depression is best treated by addressing these socio-cultural and cognitive factors.

As the BDD and the PDD are each comprised of two central tenets that stand in direct contrast to one another, each tenet of the BDD will be reviewed followed by its contrasting tenet in the PDD. After the oppositional tenets of the BDD and the PDD are described in full, the chapter will explicate the interplay of the two in exploring the creation of meaning for the etiology of depression in participant narratives of maternal depression.

The Causes of Depression

**Depression is caused by inheritable, chemical imbalances in the brain (BDD).**

Echoing the wider biomedical discourse of disease, participant utterances voicing the BDD described depression as rooted in and occurring through chemical pathways within the brain. Meredith, who earlier described her enrollment in AP Psychology and as a major turning point in helping her understand her parents’ struggles with depression, discusses how she understands depression now:

I look at it [depression] through nerve transmitters. I look at it through, basically, chemistry. When I look at depression, I think chemistry. And that’s what I try to keep in my mind. This is just the thing that is happening because of real chemicals in the brain. And that just like makes me feel better. Even though that’s just a theory. There’s a thousand approaches to these things. That’s kind of the one that I like to look at. Like this is going on because there’s too little
dopamine. Or like, there’s too little serotonin and all we have to do is up those endorphins and let’s do this. (24: 320-329)

In her statement, Meredith’s talk gives voice to the BDD in noting aspects of depression such as “chemistry” and “real chemicals in the brain.” Her talk defines depression as stemming from chemicals within the brain and caused by abnormalities of these chemicals with phrases such as “too little dopamine,” and “too little serotonin.” This idea of a hypo or hyper amount of chemicals such as dopamine or serotonin circulating in the brain is noted as the primary cause of depression in biomedical research (Deacon, 2013). As such, Meredith’s statement pulls on the BDD as paramount to understanding the causes of her parents’ depression.

In agreement with Meredith’s talk, a number of participant statements voiced the BBD by specifically calling upon the idea of a chemical imbalance in a mother’s brain as the main cause of her depression. For example, Ashley provides a particularly interesting example considering the context provided earlier in her interview. Ashley notes that her mother suffered from depression after Ashley’s birth and again when her mother’s father passes away. Ashley also notes that her brother suffers from seasonal affective disorder. Despite noting that her mother’s depression occurred following life events and her brother’s depression occurred following seasonal patterns, when I ask Ashley how she might articulate to someone what depression is, she states: “It’s a chemical imbalance in your brain” (P3:324). Although Ashley describes three separate contexts in which her family’s depression emerged involving both internal and external attributions, when asked to explicitly describe what depression is, Ashley voices the BDD.
In keeping with the biomedical view of illness as innately tied to measurable and identifiable physical components in the brain, participants also voiced the BDD in describing depression as a genetic illness that can be passed down through family members. Participants described this inheritability factor predominantly through utterances describing their own potential predisposition or other young family members’ potential predispositions to the illness. For example, Seth describes this potential of depression to be passed down to his nieces and nephews when recounting the story of his mother’s depression. Seth’s mother was diagnosed with depression when Seth was in high school. Since that time, he notes that two of his four older sisters have also been diagnosed with depression. Because of this, Seth describes his family as now being very open when discussing depression with family members. He states that it is discussed even to the extent of joking about it at family holidays. When asked if his family all shared an understanding of depression and its causes he states:

I think we all have a shared understanding of what it’s like. I think it’s made us more aware maybe of recognizing it. I know my oldest sister, for example, her oldest son is you know 19. And she’s made a couple comments to me with things that he’s said and like: “I wonder if I should have him talk to somebody.” I think they’re just hyper sensitive to the presence of it and knowing it could be there if there’s a history in the family. I think we’re more watchful for it. (27: 385-392)

Seth’s statement indirectly invokes the genetic or inheritable aspects of the BDD in his use of the phrase “history in the family.” His statement notes that his family is hyper sensitive to the symptoms of depression and in particular describes his sister’s careful observations of his nephew’s behaviors and how they might align with symptoms
of depression. In noting that his sister realizes that it “could be there” because of the fact that his mother was diagnosed with depression, Seth’s talk ascribes to the BDD.

Similar to Seth, Kelly also describes the inheritability of depression when recounting some of the challenges of growing up in her family with multiple members suffering from depression. In particular, Kelly notes throughout her interview how depression manifested in her life not only in terms of her mother, but also within her brother. She describes the effect of these family members’ depression on her family:

I think the challenge is kind of knowing that there’s a darkness that kind of seeps in at unexpected moments . . . And the fact that, you know, my brother has sort of inherited some of those, some of that darkness as well. (4: 476-482)

In her statement, Kelly voices the BDD in noting that her brother has inherited the same feelings that creep into her mother and affect her family dynamic. In defining depression (i.e., darkness) as something that her brother inherited, Kelly voiced the BDD in vocalizing depression as an illness that can be passed down from mother to son.

While some participants voiced the inheritability of depression more indirectly by noting that it could be passed down or describing depression as an inheritable darkness as Kelly does, some participants explicitly note the genetic components of depression. For Jane, depression is described explicitly as an inheritable illness that could affect her based on family history from both her father and her mother’s side. For example, while discussing her mother’s depression she states:

But it’s genetic. Like, it’s not like, I can’t cope and I can’t—it’s the fact that you have a chemical imbalance you can’t control it and sometimes you just need a little help. (22: 123-125)
Jane’s talk clearly operates from the BDD and positions her mother’s depression as a physical illness caused by a chemical imbalance passed down through genetics. In this way, her talk fully positions depression as biological in that the genetic illness caused a chemical imbalance and thereby caused her mother’s depression.

Overall, the first tenet of the BDD defines depression as a genetic, biological illness located in the brain and caused by chemical imbalances. In articulating depression as a genetic illness, the BDD defines depression as an illness that can be passed down genetically from a parent to his or her biological child. Therefore, the first tenet of the BDD describes depression as an illness that can be physically identified (genetic mapping) and/or measured (chemical imbalances). In locating depression as biological, the BDD ties depression closely to the physical make-up of the body. Moving out from this adherence to the physical body, the PDD locates depression as stemming from issues not only in the body (i.e., in one’s mind) but also in the environment within which that body lives.

**Depression is caused by sociocultural and cognitive issues (PDD).** Similar to the pre-existing theories of depression as resultant from socio-cultural and cognitive issues (Harper, 2009; Horwitz, 2011), the PDD locates depression as an illness that can stem from both social (e.g., having poor interpersonal relationships), and cultural (e.g., being a member of a marginalized community) situations. Additionally, the PDD defines depression as potentially stemming from cognitive processing issues such as Beck’s Theory of Depression (Beck, 1967), which posits that individuals with depression actually perceive and process information from the environment qualitatively differently than individuals without depression.
In a number of participant stories, a mother’s depression was described as resulting from socio-cultural factors such as relational stressors within the family. For example, Sarah describes her understanding of the cause of her mother’s depression as a result of her mother’s poor relationship with her father in addition to her dissatisfaction with her own identity as a stay at home mother. Sarah explains:

I always thought it [depression] was because of my dad. I just thought it was because they didn’t like each other. That’s why. And I think it was her not getting to be, not being comfortable in her house. And not, but also not wanting to make, not wanting me to be sad. So like doing everything she could to not, to make me happy and me be a happy kid and do all the things I want. But she never got to do the stuff she wanted. So that was the biggest thing. But also because of him she couldn’t do the things she wanted. It was two fold in a lot of different ways. So she became a stay at home mom without really wanting to be a stay at home mom. And gave up a lot of her own dreams as she got married. I think it was maybe some resentment on both parties. But I always thought it was my dad.

I still do. (3: 86-98)

Sarah’s talk expresses the PDD in describing her mother’s depression as stemming from interpersonal turmoil with Sarah’s father. In addition, her story places blame on herself for being in a position requiring her mother’s selfless attention. Sarah notes her mother’s sacrifice of some of her own personal goals in order to maintain her position as a stay at home mom. Though the events of Sarah’s mother’s divorce took place almost two decades before Sarah’s recounting of the event in her interview, Sarah notes that to this day she believes her mother’s depression to be caused by her
relationship with her father. As such, Sarah’s statement calls upon the PDD in positioning the cause of depression as caused by these relational issues.

The attribution of depression to divorce and relational turmoil within the family was a common theme across many interviews. In fact, some participant narratives placed the cause of a mother’s depression on failures within social relationships between the participants themselves and their mothers. As Samantha describes:

I always thought it was our fault. Like I always thought, “Oh, we didn’t put the dishes away and that’s why mom ran away for the weekend.” You know? Like, “Oh, I got into a fight with Alex, my twin brother, so that’s why she is in bed.” So I just kind of made sense of it by putting it back onto myself . . . It was always like we did something wrong. So when she would come back, but she also kind of instilled that idea in our heads. Like: “I’ve told you this many times to do your chores and you didn’t do it so I’m going away.” You know, something like that?

(23: 103-107)

In noting her mother’s need to leave the house and describing some of her exhibited behaviors at home as directly related to her mother’s depression, Samantha voices the PDD by placing her and her brother’s behavior as influential in causing her mother’s depression. Her statement opens with an explicit voicing of the PDD in noting that she thought her mother’s depression was the families “fault.” She then describes instances wherein she connects problematic behaviors such as failing to put dishes away or fighting with her brother as catalysts for her mother’s depressive behaviors such as her mother leaving the home or retreating to her bedroom. Interestingly, Samantha’s reported speech of her mother also voices the PDD. Samantha notes that her mother
would make statements about her misbehavior as the cause for her needing to go away. Samantha describes these statements as part of what “instilled that idea,” arguably here the idea being the PDD, into her sense making of what caused her mother’s depression. 

While some participant utterances attributed their mother’s depression to social stressors that had recently happened (e.g., divorce) or were currently happening (e.g., disobeying their mother), a few participants also described their mother’s depression as related to a stressful life event that had occurred well before their time. For example, Krista describes finding out about her mother getting pregnant and giving a child away for adoption while in high school. Even though she and her mother have never openly discussed her mother’s depression or her experience of giving a child up for adoption, Krista notes the event’s importance when describing her sense making of her mother’s illness. She states:

My understanding of the root and kind of when it all began was when she was a teenager, when she gave up her first child for adoption. It was sort of the root of, or at least maybe there was stuff before that. Maybe her childhood growing up before that, but that’s when I think it really became an issue that she needed treatment for. Became diagnosed and—I think that’s when it started but we’ve never talked about it, actually. (5: 41-48)

Krista’s statement highlights several components of the PDD. First, her talk centers the PDD in noting that the adoption was likely the “root” of the depression. Krista also voices the notion that perhaps her mother was influenced by her negative childhood. Though Krista voices two separate attributions for her mother’s depression, both align
with the PDD in positioning depression as resultant from one’s social environment and/or negative social experiences.

Tying together stressful life situations with stressful environments was also evident in Lana’s story of how she believes her mother’s depression started. Lana explains that her parents were both living in a city close to family in California when Lana’s father decided to take a job in a Nevada. Unhappy with the move, Lana’s mother decided to move back to California with Lana. After seven years of living in separate states, Lana and her mother eventually move to Nevada to be with her father, which results in additional issues between her parents. When I asked Lana what she thinks is the cause of her mother’s depression she explains:

I guess looking back, if I were to guess, I would say the depression probably had something to do with when we moved to San Jose and my dad was working in Reno. My dad took that job in Reno like he took over a business that was centered in Reno and I think that I wasn’t even a year old. So my dad was like: “Okay, let’s move to Nevada” and my mom was like: “Hell no! I’m not living in Nevada—Nevada is gross.” If you’ve ever been to Nevada, you’ll understand . . . Everything is just dead and gross. But I think it might have started then. But I guess like being with an infant and then having your husband say: “Oh, let’s up and move here.” And I think that at one point he suggested that they live in a trailer because they couldn’t afford to buy a new house because they had just bought a new house like when they had gotten married and she was like: “Oh, no. This is not happening.” So I think that probably started then. And we went to San Jose and stayed with my great-grandparents who pretty much took care of me
during the day and my would take me to school, drop me off, and then my grandparents would take care of me for the rest of the day and my mom would work. So I guess that might have had something to do with it. When we moved back I think that like trying to move back in with someone that you hadn’t lived with for so long might have set things in motion a little bit. (25: 56-79)

Lana’s statement aligns with the PDD in noting that her mother’s depression was tied to several life situations occurring during Lana’s childhood. First, Lana describes the origin of her mother’s depression as potentially occurring when she and her mother decided to stay in San Jose while her father moved to Reno. Lana also highlights the fact that her mother had to spend most of her time working in San Jose leaving little time to spend with Lana. Finally, Lana notes that even after moving to Nevada to be with her father, the adjustment of living as a family of three resulted in additional issues. Overall, Lana’s description of when she believed her mother’s depression began (and why it continued) is centered entirely on life events (i.e., the moves to Nevada) and issues with relationships (i.e., adjusting to moving in with her husband). As such, Lana’s talk expresses the etiology of her mother’s depression using the PDD.

On a wider, cultural scale, some participant utterances gave voice to the PDD in describing depression as resulting from their mother being a member of a marginalized social group (Harper, 2009). For example, Zoe tells the story of talking about her mother’s depression with her maternal aunts:

When they talk to me [Zoe’s aunts] they’re always like: “You know, look at your mom. She had kids with like no help and she is a single mother and that’s why she’s depressed.” Kind of like, you know? But at the same time I think that it
definitely rooted, it had to have rooted way back when because her mom passed away and that’s something sad. And to grow up with like being poor—she was poor when she was younger, having, you know the pressure of like go to school and stuff. It’s a lot. (21: 1005-1012)

Through the reported speech of her aunts, Zoe’s statements highlights the PDD in noting Zoe’s mother’s depression as stemming from being a single mother; a situation that likely not only generates a stressful environment but also placed Zoe’s mother in a marginalized social group. Though Zoe’s talk somewhat negates this idea, this dismissal of being a single mom is done with an additional voicing of the PDD in noting that her mother’s depression likely “rooted” after the loss of her mother. Zoe again gives voice to the PDD by noting that her mother’s depression could also be attributed to growing up in a lower socio-economic-status home and therein again highlighting the idea of depression as caused by membership in a marginalized cultural group. Although Zoe’s talk offers up a number of theories about where her mother’s depression may stem from, each aligns with the PDD.

Beyond calling upon the PDD to describe depression as caused by socio-cultural factors, participants also called upon the PDD in describing depression as caused by cognitive factors. For example, Ellie described how she felt her mother was always viewing the world in a negative way in that her mother seemed to describe situations and handle situations more negatively in comparison to how she saw other mothers handling situations. When asked to describe how she understands depression based on these observations of her mother, she explains:
I guess you have a more negative outlook on the world than a positive. I guess the negative outdoes it . . . I think the negative outweighs the positive. I think that if something negative happens, it’s 10 times worse than if something positive were to happen. And it’s just kind of like, oh. Something happened good, but if a minute later something bad happens it’s like of course, something bad happens to me. (10: 251-259)

Ellie’s statement aligns closely with Beck’s Theory of Depression (Beck, 1967) in noting that the negative is processed as an expected event and the positive is muted. In her description of her mother’s depression as a negative outlook on the world, Ellie clearly voices the PDD. Similar to Ellie, Lisa also describes her understanding of the causes of depression as innately tied to the way that one attunes to and processes information. She explains:

If you’re in the wrong mindset and something bad happens I think you can honestly like, become a depressed person, you know? (15: 319-320)

Lisa’s description of depression is interesting in noting that outside factors can cause one’s depression but it more so comes down to being in the “wrong mindset” if and when something bad happens. In doing so, Lisa’s talk pulls on several tenets of the PDD. First, Lisa notes that depression can be caused by negative events (e.g., “something bad happens”). Lisa then points out that the experience of this in relation to having poor cognitive capabilities to handle it (e.g., “being in the wrong mindset”) can determine how those negative events are processed.

Overall, the first tenet of the PDD positions depression as caused by any number of negative social (e.g., marriage issues, issues with children), cultural (e.g., being a
single mother, being of low socio-economic status), and cognitive (e.g., viewing the world negatively) factors. Unlike the BDD which points to the physical body as the central cause of depression, the PDD points to individuals, events, relationships, and viewpoints in describing the core causes of depression. With the first tenet of the BDD and the PDD explored in full, we can now turn our attention to the second major tenet of both discourses. In locating depression either within the physical body (BDD) or the psychological mind and environment (PDD), the second tenet of the BDD and the PDD centers on best treatments for the illness as focused either on the physical body or on the psychological mind and environment.

**Treatment of Depression**

**Depression is best treated with medication (BDD).** Consistent with the understanding that depression as an illness caused by and experienced explicitly within the physical body, the second tenet of the BDD aligns with Deacon’s (2013) adherence to the biomedical model by defining depression as an illness best diagnosed and treated via medical means. Participants voicing the BDD often noted the importance of seeking professional help and in particular medication when trying to combat depression. For example, Samantha describes her mother’s depression and how it should best be treated:

> I know that in my mom’s case, it’s hereditary. You know, genetics. It plays into why she’s depressed. Cure-wise, she’s been on Prozac, I said for like medication I guess for longer than I can remember. (23: 330-333)

Samantha’s utterance provides a clear and explicit voicing of the BDD’s second tenet as a viable response to its first. Samantha talk first expresses the first tenet of the BDD in describing her mother’s depression as hereditary and caused by genetics.
Samantha then notes that Prozac is how her mother is taking care of her depression. In particular, her use of the phrase “Cure-wise” to describe her mother’s use of medication highlights the BDD in noting that medication is the best route for treating her mother’s depression in describing Prozac as a way for her mother to be alleviated from her depression.

Similar to Samantha, Molly also highlights a number of treatments that her family seeks for help with depression. As noted prior, a number of Molly’s family members suffer from depression including her grandmother, several aunts, her mother, and herself. Throughout the interview, Molly notes a number of treatments her family members have utilized for depression including therapy, medication, hospitalization, electric shock therapy, and a new type of electric shock therapy that her aunt is trying as part of an initial medical trial. Though she notes prior in the interview that it was a relief to understand that depression runs in her family so she can watch out for it in herself (via the BDD) and prepare for potential treatments, she explains that the need for treatment is itself a stressor for her family members:

I think you have to change it all the time [treatments for depression]. Like it’s not going to work forever. Like that’s the most frustrating thing about depression for my mom and my aunt. You have to always be like switching your medications or that you’re stuck doing the same thing forever. Like my aunts been doing ECT treatments for two years like once a month and she’s like so sick of it. But, like she sees old women going and having it done and she’s like I’m going to be that old women. Like I don’t want to. (1: 154-162)
Although Molly’s utterance notes that there are many different types of treatment for depression, each of the subsequent treatments noted pertain to the BDD. First, she describes the need to always be switching up one’s medication. Then, she describes the necessity for her aunt of having ECT treatments. Finally, Molly provides a more latent note to the BDD in noting that depression is always going to be something that her family must deal with and treat.

Overviewing the second tenet of the BDD, depression is once again centered as an illness that is directly connected to one’s body in locating its best treatments as those that are directed towards the body. Participants voicing the BDD primarily note the importance of seeking out medication when describing best treatments for depression. Again shifting the locus of depression out of the physical body and into the mind and physical environment, the PDD shifts treatments from those capable of changing the physical body to those capable of changing one’s mind (i.e., thought processes) and environment.

Depression is best treated with means that address socio-cultural and cognitive factors. Unlike the BDD, which positions treatment via medical pathways as necessary to helping with depression, the PDD positions treatment via cognitive help (e.g., talk therapy) and socio-cultural changes (e.g., addressing stressful life situations, reducing stress) as paramount to alleviating one’s depression. The PDD centers the idea that depression can be overcome through changes to one’s thinking, one’s relationships, or one’s environment. Beyond seeking professional help such as attending therapy, participants voicing the PDD also described taking small, everyday steps to enhancing one’s environment such as becoming more socially involved and/or being more active in
combating depression through activities. For example, when I ask Sarah if she encourages any type of treatment or help when talking with her mother about her mother’s depression, she describes how she encourages her mother to take a myriad of steps to address her depression:

I encourage therapy. So she does go to therapy. And I do encourage her to do things and you know have things to do outside . . . And I do tell her to go and join a class or do, go to coffee shops and just be there out of this space that you do associate with your depression—being home alone and watching TV. So I do ask her to attempt those things. If not for you know, immediate like relief for herself but also just to change her environment. And like I do notice positive changes when she does do those things. She had a class for a long time and she would call me and everything would be about how great that class was so we didn’t really talk about her being sad. And so when she stopped going to that class, again the conversation started to go back [to depression]. So times when she’s distracted and there’s a change of scene and starting to make friends and being out. I notice really positive changes so I encourage her constantly to be doing those things. (3: 255-270)

Sarah’s utterance centers the PDD’s second tenet by noting the importance of therapy, social support, and environmental changes in attempting to ease her depression. Sarah describes her mother’s home environment as causational to her depression in noting her encouragement of her mother to get outside or go to a coffee shop for her “immediate like relief.” She also notes that when her mother attends classes she believes her mother talks about her depression less. However, when her mother stops going to
classes Sarah notes that her mother goes back to focusing on her illness. At the end of her statement, Sarah notes that changing the scenery around her (i.e., attending classes and getting out of the house) in addition to making friends causes positive changes in her mother. As such, she voices the PDD in describing her primary way of helping her mother with her depression as speaking with her and encouraging her to engage in self-help behaviors such as attending social activities in addition to seeking professional help such as therapy.

This encouragement directed by participants towards a parent seeking out therapy was a pervasive theme across the interviews. As her mother’s main source of support, Krista described the frustration and anger she felt when she decided to move away and tried to put some support structure in place since she would no longer be around to help with her mother. When her mother refused to seek help beyond what Krista was expected to provide, she explains her frustration:

She’s never gone to therapy. She needs to. Like my whole life. Actually I kind of got mad at her too and I even like, and this is why I told her like, if she falls into one of these depressive funks . . . I’m going to tell her, go to therapy or I’m not going to speak to you until you start therapy . . . And I even asked her before I left, like talked to her about it. Like mom, I need therapy. Can we, like please go once? Just try it? And she wouldn’t and that makes me mad, like you’re not even trying to help yourself. (5: 643-652)

For Krista, her mother’s lack of commitment to therapy serves as a point of contention in her relationships with her mother. In noting a failure to attend and
participate in therapy as a cause of her anger and frustration, Krista’s talk draws from the PDD in noting that therapy serves as a useful tool in helping individuals with depression.

Overall, the PDD locates depression as resultant from a number of potential social, cultural, and cognitive factors. In moving the causes of depression from the physical make up of the body, the second tenet of the PDD moves the treatment of depression away from those means that change the physical body and into those that change an individual’s thought processes, relationships, and environment. By highlighting these mechanisms for change, medications take a back seat to other options such as therapy. With both discourses explicated in full, we can now turn our attention to the variant ways in which the BDD and the PDD interpenetrate in participant utterances to construct meanings of the etiology of depression.

**Interplay of the BDD and the PDD**

Similar to the discursive struggles surrounding the DDS and the DDI, the interplay between the BDD and the PDD proved highly polemic with a pervasive struggle between the two across the data set. A number of instances of synchronic interplay were found via negating, countering, and entertaining. Additionally, a number of instances of hybridity emerged in participant talk wherein the PDD and BDD found equal footing in descriptions of depressions causes and treatments.

**Synchronic Interplay**

**Negating.** The least prevalent of the three primary types of synchronic interplay, examples of negating in participant talk surrounding the etiology of depression typically involved the BDD negating the PDD. For example, Jane describes how her family has come to terms with mental illness. Jane’s story represents a complex web of meaning in
that she must untangle understandings of addiction as it intersects with mental illness. Jane was raised in a house with an alcohol and drug addicted father and a mother who suffered from depression. Although Jane’s father was eventually sent to prison after her parents’ divorce, she describes the continued process of making sense of both her father and her mother’s illnesses throughout her interview. When asked if her family understood those illnesses the same way that she does, Jane notes that her father’s side of the family understands depression differently than her mother’s side of the family. Specifically, Jane notes that her father’s side of family blames Jane’s mother as the cause of her father’s depression and the tumultuous relationship between Jane’s parents as the cause of her mother’s depression. She explains:

Jane: I think that for them, it was definitely like coming to an understanding of this is what this is. It’s not just because dad is awful. All of my dad’s family, though they’ve always been awful like that. Yet they all deal with depression, and bipolar and addicts of all kinds and they should understand that we are predisposed to different things. But they’re stupid.

Leah: Different families

Jane: Different families! Well, I think it comes to education, too. If you haven’t actually gone, and was like: “I’m depressed, let’s go see a therapist” and had conversations with them and done different studies you are never going to know if you have an imbalance or not. And if you aren’t going to be educated and take a psych class, you don’t know that you are predisposed to things. (22: 261-276)

Jane’s talk directly negates the PDD by calling upon past conversations with her father’s side of the family and noting that her mother’s depression was “not just because
dad is awful.” In particular, Jane clearly voices the BDD when she declares that her father’s side of the family is “stupid” for not understanding the fact that they may have a predisposition to mental illnesses. The BDD is also placed center stage in Jane’s utterance that getting an education about mental illnesses means learning about the idea of a chemical imbalance.

In another example of negating, Pam uses reported speech to describe how her mother made sure that her children did not believe that her depression had anything to do with her children. Pam notes throughout the interview that her family took a very open stance to talking about her mother’s illness and made sure to always share their feelings and ask questions. In describing how she handles her mother’s depression and how she thinks other individuals should handle having a parent with depression, Pam describes a memorable message about the causes of depression that her mother often told her.

Well I definitely think in terms of that person, my mom always told me: “Don’t think anything is about you. Nothing caused—you didn’t do anything. This is a chemical imbalance, whatever.” (20: 697-700)

Presumably, Pam’s mother speaks directly to the distal not-yet-spoken by anticipating the voicing of the PDD by Pam and her siblings and negates with the BDD. Pam’s reported speech from her mother negates the PDD and privileges the BDD in positioning depression as an illness that is not caused by Pam but rather caused by a chemical imbalance. In other words, Pam’s reported speech directly negates the PDD’s idea that depression is caused by poor interpersonal relationships or environments such as Pam or Pam’s family.
Beyond conversations surrounding the central causes of depression, a number of instances of negating also centered around the best treatments of depression. In describing how her mother handles her depression, Molly notes that she and her mother often disagree about the best ways to go about seeking treatment. Molly describes encouraging her mother to attend regular therapy sessions and being frustrated when finding out that her mother attends therapy sporadically and instead relies on medication only for her treatment. Here she recounts a time when her mother visits her and forgets to bring along her medication:

So she came to visit me in San Francisco last fall and she forgot her Xanax, which at that time was a really big deal because at that time she was taking like four Xanax a day. And every time she would feel a little bit anxious she’d be like: “I need a Xanax.” And I was like: “That’s not how it works.” But she was freaking out because she didn’t have her Xanax and I was like: “Mom, have you ever tried to do meditation?” And she was like: “Uh, please.” Like not interested in it at all. (1: 334-341)

In her recalled conversation with her mother, Molly voices the PDD in describing the encouragement of medication instead of taking Xanax. Molly’s reported speech of her mother directly refutes the PDD by responding to Molly’s voicing of the PDD with sarcasm. In responding sarcastically, her mother’s statement refutes the PDD by mocking it. As such, she centers the BDD’s definition of depression as best treated with medicine.

In a similar negating of the PDD, Angela describes how she and her mother actually disagree about the types of treatment for depression. Angela describes spending
the majority of her childhood caring for her three younger siblings because of her mother’s hectic work schedule and subsequent depression. She also reports developing depression herself as a result of her difficult childhood and notes that her mother comes to understand her own depression by watching Angela struggle with and seek help for the illness. Angela describes the tension between the viewpoints of her mother and her:

I know she’s also relied a lot to like church and going, focusing more on being Catholic. And that has helped her out a lot kind of thing. Because she’s not on medication but I am. As to where she’s just like: “God will help you.” And I’m like: “No Mom, I need medication. I need medication, Mom.” (18: 521-526)

Angela’s describes her mother’s view of help seeking as more aligned with the PDD in seeking help through means outside of the physical body by focusing on faith and spiritual practices. Angela then describes the reported speech of her mother actively voicing the PDD by saying that “God will help” her with her depression. Angela’s talk then works to negate the PDD with her own reported speech by directly refuting the PDD and stating that she must have medication to combat her depression. In specifically calling upon medication as a treatment, Angela directly negates the PDD by calling upon the BDD and privileging the use of medication for the treatment of her depression.

In sum, participants called upon both tenets of the BDD and the PDD in constructing meanings of depression. In almost all examples of negating pertaining to the causes of depression, participants utilized the BDD to negate the PDD’s assumption that depression was caused by sources of stress outside of the body. This negation was done by calling upon the first tenet of the BDD and stating that depression was a genetic illness and in fact caused by chemical imbalances in the brain. Similarly, some participants
negated the PDD’s assumption that depression could be helped by treatments other than medication by voicing the necessity of medication in the treatment of depression.

**Countering.** Converse to negating, countering almost exclusively presented itself in the form of the PDD countering the BDD. In other words, participant talk surrounding the etiology of depression granted some legitimacy to the tents of the BDD but ultimately gave more credence to the PDD in making sense of depression.

Like negating, a number of countering examples manifested through participant talk surrounding the best methods of treatment for depression. Unlike negating, these instances privileged the PDD over the BDD. For many participants, the need for treatment was an important topic both in terms of its effect on their mothers and for those individuals also self-reporting depression. For example, Krista describes what advice she would give to individuals seeking advice about how to treat depression:

> I would probably say therapy. Like absolute first step . . . If I had depression pretty severe and I needed medication like or what not, I would probably feel better about it. But I don’t like the idea of it. I like to think that it’s possible to overcome without like a chemical dependence on medication. (5: 193-198)

Krista’s talk first provides a clear centering of the PDD in noting that therapy should be the first step. However, her utterance then counters by stating that if she had depression and “needed” medication she might feel better about taking it. In both stating that medication might be a viable option for the treatment of depression or that someone might “need” it, Krista’s statement grants legitimacy to the BDD in framing depression as something that one might need medication for, thereby centering its bodily causes and treatments. However, Krista then counters by saying that she does not like the idea of
medication and overall believes that the illness can be overcome without it. As such, her statement ultimately aligns with the PDD.

Similar to Krista, Meredith also gives some authority to the BDD in describing treatments for depression but ultimately lands on the PDD. As a sophomore undergraduate majoring in Psychology, Meredith is very passionate about treatments and actually mentions that her goal is to better understand depression and in particular how to treat it. She describes her understanding:

I’m not the hugest fan of medication but you know, if that’s what works for some people that’s what works. I think if you are going to do medication, you should pair it with cognitive behavioral therapy. I think those two should go hand in hand. Because at some point you need to be prepared to be taken off the medicine. So that’s like my best treatment idea approach. (24: 348-353)

Meredith’s statement seems at first to grant legitimacy to both the BDD and the PDD by mentioning that both medication and therapy should be used in the treatment of depression. Her talk first grants legitimacy to the PDD by noting that she “isn’t the hugest fan of medication.” However, this statement is then countered with the BBD in noting that it does work for some individuals. Meredith’s statement then shifts back to the PPD in noting that cognitive therapy should always be in place and people should be prepared “to be taken off medication.” As such, Meredith ultimately delegitimizes the BDD by positioning the PDD treatments as essential and the BDD treatments as positive, but in the end something to slowly wean off. In a similar instance, Jim describes his own journey with depression and his opinions about how he seeks help
Drugs made me feel better. Prescription pills made it less but it never went away until I realized like, I’m going to do this. I’m going to make it better. And therapy and you know I work out almost every day to keep it away. Like you know, just kind of fight through it. I see my sister’s fighting through it now and my sister still won’t fight through it. And I think it’s honestly just the buckling down and just facing it head on and usually the biggest part is admitting you’re depressed.

(35: 317-324)

Jim’s statement first gives credence to the BDD by noting that drugs made him feel better when he was dealing with depression. Jim then counters by noting that the prescriptions did not actually make his depression go away. Jim articulates several treatments that adhere to the PDD such as working out, going to therapy, and making the mental commitment within oneself to face depression. Though Jim voices the BDD in noting medication as a way to treat depression, he notes that the medication was not enough to actually make it go away until he took steps adhering to the PDD. As such, Jim grants some legitimacy to the BDD as a viable treatment for depression but grants more to the PDD.

Although a majority of examples came from the PDD countering the BDD, in some instances, the PDD was actually countered by the BDD in describing best treatments for depression. We hear again from Molly, who above described her mother’s direct negation of using other methods of treatment besides medication for her depression. As someone who also self-identified as having depression, I ask Molly how she understands best treatments for herself and for her mother considering her mother’s privileging of the BDD:
I think for the severity of her depression I think it’s the most useful [medication]. Like for me, like I was on meds and I quit taking them, which I know all crazy people do. But I just like, I think that some depression can be managed through cognitive therapy and medication and all that stuff. But I don’t think my mom’s can. (1: 344-351)

Molly’s statement begins by centering the BDD in noting that the medical understanding of depression is the most useful. She then grants some legitimacy to the PDD by describing cognitive therapy as a way to treat depression. However, her statement then counters back to the BDD by noting that even though depression may be helped by methods aligning with the PDD, her mother requires medication. As such, her utterance lands squarely on the side of the BDD.

Unlike instances of negating, virtually all examples of countering involved the second tenets of the BDD and PDD. In other words, participants rarely granted some legitimacy to one discourse of depression before ultimately landing on another when articulating the first tenets of the BDD and the PDD. Rather, the interplay emerged most when trying to discursively construct best practices for treatments. In some of these instances, the PDD served as the privileged discourse of depression with participants voicing alternate pathways of treatment beyond medicine as best for the treatment of depression. In others, the BDD found centripetal footing with medicine noted as being paramount to the treatment of the illness.

**Entertaining.** Of the three struggles identified in the data set pertaining to meanings of motherhood and depression, the struggle surrounding the etiology of depression generated the most examples of entertaining. In these examples, participant
talk shifted back and forth between the BDD and the PDD and in particular between the idea that a mother’s depression was caused by an unfortunate event or by a chemical imbalance. We hear again from Krista, whose talk also demonstrated entertaining in the struggle around the DDS and the DDI. When discussing what may have caused her mother’s illness, Krista again finds herself discursively wrestling with multiple discourses of depression. She states:

> I’ve read some stuff. Like I know that there was like, scientific steps to back up and those chemical changes in the brain and I know that or I can read all of that. But it’s hard still not to connect it to some sort of experience, because, I think that I do that because of the people that I know that have it. It’s rooted in something. They’re able to connect it like, my mom was able to connect it to the adoption. My best friend is able to connect it because she was an only child and all the pressure she has and eating disorder. She was able to connect it to all of that. So I don’t know if there was like, I don’t know if like you’re born with it, if it’s circumstantial? Or if it’s like— I don’t know. But I mean, like is it genetic? Do you know? (5: 209-220)

At first, Krista’s talk appears to be a rich example of negating. In her narrative, we first see a clear positioning of the BDD in Krista’s statement of depression as caused by a chemical imbalance as backed up by scientific evidence. However, Krista’s talk then negates this idea by stating that her depression is connected to experience as was with Krista’s mother and friend. Had Krista’s utterance stopped there, her talk would indeed be an example of negation wherein the PDD finds footing as the centralized discourses and the BDD is pushed to the side. However, Krista then continues by noting
that perhaps an individual can be born with depression, thereby again giving some legitimacy back to the BDD. By the end of the statement, Krista’s talk moves back and forth between the BDD and the PDD to the extent that it actually ends in a set of questions posed to the interviewer. As such, Krista is unable to discursively grant any legitimacy to one cause of depression nor is she able to combine the two. Rather, her talk moves back and forth between the BDD and the PDD in genuine confusion.

Like Krista, Zoe provides several instances of entertaining throughout her interview as she grapples with understanding her mother’s depression. Raised by a single mother, Zoe describes her mother’s depression as beginning shortly after the birth of her younger sister and the subsequent break up of her mother and stepfather. She notes that her mother’s depression again got worse after the birth of another sister and subsequent break up with a third father. Although Zoe’s youngest sister now lives in another state with her biological father, Zoe describes often having to care for her other sister and herself throughout her childhood as her mother was unable. She describes her continued frustrations with understanding her mother’s illness:

I don’t know. Like one thing I don’t know about depression is like what, is it genetics or is it like, does it just happen out of the blue? Or what is it exactly that causes it, you know? . . . Because I know you can be sad. I know you can be depressed momentarily but there’s this like long period of depression that like never goes away and that’s what I’m always wondering. Like why did depression just kind of hit her like that? Like she’s happy and then she wasn’t . . . And I think that was like the trigger, something triggered it or something and it was just
always there but at the same time, I just don’t know the answer and that’s what bothers me. (21: 1222-1225)

Here Zoe’s talk clearly entertains the BDD and the PDD. First, she notes that perhaps depression is caused by genetics and therein voices the BDD. Her statement then moves to describing depression as something that “hit” her mother which positions depression as an outside influence and therein gives voice to the PDD. At the end of her statement Zoe clearly notes her confusion in stating that she just does not have an answer as to what caused her mother’s depression. Later in her interview, Zoe again entertains the BDD and PDD in describing her own fears when it comes to depression.

I think now what the scary thing for me is like, well, I don’t want to be diagnosed with depression. Like I don’t want it to like, I don’t know if it’s like something that is genetic like if my mom has it I am more likely to have it? And then now also through like my classes and stuff I am learning about it and I’m learning how women can have it from like media and I’m learning about all this stuff and I’m like: “What if it catches on to me?” because I know my mom has it and what if like I get depression and I become really sad. (21: 553-560)

Similar to her statement above, Zoe’s statement first voices the BDD in noting that perhaps depression is genetic and as such makes Zoe susceptible to getting it. Her statement then highlights the PDD in noting that depression might be caused from media and being a woman, therein highlighting the PDD in positioning depression as a resultant from membership in a cultural marginalized group (i.e., being a woman). In describing depression as something that could potentially “catch onto me,” Zoe’s statement privileges the PDD in positioning depression as an illness that can be contracted from
one’s outside environment. In her inability to discursively position neither the BDD or the PDD as the more legitimate discourse of depression, Zoe is not only unable to articulate a clear cause for her mother’s depression but also a clear cause for what she fears may become a situation that she may find herself in as she grows older.

Overall, participants’ inability to land squarely on the side of the BDD or the PDD demonstrates the continued tension between understandings of depression particularly as they relate to its etiology. This inability to clearly pinpoint a cause of their mother’s depression was often articulated as worrisome and problematic for participants (e.g., “and that’s what bothers me”) both in their inability to truly understand their mother’s illness and in their inability to predict and presumably prevent depression from occurring in their own lives.

**Discursive Transformation**

**Hybrid (BPDD).** In a number of instances, participant utterances surrounding the etiology of depression were able to rise above their discursive jockeying and give both discourses of the etiology of depression equal weight. As noted in Chapter Two, this hybrid combination of the BDD and PDD represents a growing conceptualization of depression known as the biopsychosocial model of depression (Dubriway, 2010). In the biopsychosocial discourse of depression (hereafter BPDD), factors relating both to the body (via the BDD) and mind/environment (PDD) are given equal footing in positioning the etiology of depression. Our first example of the voicing of the BPDD comes from Sarah, who earlier in her interview spoke about her father’s divorce as causation for her mother’s depression, here uttering a different view:
I think it’s a both/and. I think that it does have to do with some genetic predisposition. But also environment contributes to it. And you know, maybe if someone is depressed or has depression, it is always there under the surface. In certain spaces and times and places. And people can bring that out. And so I think it’s something that is sometimes manageable and sometimes not and is different for every person and everybody. But I do think it has to do with a little bit of both. Because you know. I think it just depends, I really do. (3: 304-312)

Sarah’s utterance demonstrates hybridity in a number of instances. First, the use of the term “both/and” serves as a clear lexical marker in noting times when discourses are equally validated not in confusion as in instances of entertaining but rather as a productive middle ground where both discourses can be granted equal legitimacy. Sarah’s utterance then incorporates both the BDD in stating that there is “genetic predisposition,” and the PDD in noting how “environment contributes to it.” Though Sarah’s talk does start to waver back and forth by stating that depression is “sometimes manageable and sometimes not,” it eventually lands back in the center by noting that “it has to do with both.” As such, Sarah’s statement grants legitimacy to both the BDD and the PDD equally and creates a new meaning of depression in which both the BDD and the PDD serve as interdependent in causing depression.

Similar to Sarah, Lisa also provides an example of hybridity in describing the etiology of depression. Lisa describes her family as relatively normal up until her parents divorce. After the divorce, Lisa begins to learn about her mother’s life prior to her marriage and of her difficult childhood. Additionally, Lisa begins to notice that her mother begins to drink every evening. Today, Lisa describes her mother as suffering
from both depression and alcoholism. Lisa also notes prior in the interview that today she and her sister both suffer from depression as well. When I ask Lisa whether she believes depression in her family stems from genetics or from more social aspects of her home environment she states:

I think it’s a good combination of the two, but considering almost every member of my family has depression, I assume there’s definitely some, you know, genetics involved. Because I mean everyone, my dad, everyone it streams on up. But yeah, then the family environment has definitely contributed to it, that’s very clear. (15: 329-335)

Like Sarah, Lisa’s talk begins by granting equal legitimacy to both the BDD and the PDD in noting that depression is a combination of the two. Her talk then centers the BDD in noting that genetics is likely involved considering almost her entire family identifies as having depression. Immediately following is the additional voicing of the PDD in noting that the family environment within Lisa’s home has also contributed. Unlike participant talk that voiced the BDD and PDD but ended in confusion over which to privilege, Lisa’s statement voices both the BDD and PDD in describing depression but does so without questioning which is more important. Rather, her talk positions both as equally important, thereby allowing the BDD and the PDD to combine to form the BPDD.

Finally, Michelle discursively constructs a hybrid of the BDD and PDD in describing the BDD and the PDD as interdependent. Michelle provides interesting insight into understandings of depression in that she is working towards a degree in
clinical psychology. She describes this effect on her view of her mother in addition to pulling in some of her own observations and understandings:

I don’t know if I ever thought about what caused mom’s depression. And of course I get, and I don’t know, there might be an outlier to your study because I have a degree in Clinical Psychology. [Laughter] So I know, sometimes it’s clinical imbalance. Some of it can be event triggered, some of it can be a combination. And I don’t know if any, like I think that mom. With my mom I really want to say it was a chemical. I don’t know if . . . It was chemical which caused event issues. So that cycle as well. Just maybe chemical imbalance occurs and she’s not taking the right amount of medication for it, which causes depression symptoms, which make other things in life tougher. And you get those cycles. (2: 68-79)

At first, Michelle’s statement voices the BDD and PDD as separate understandings of the etiology of depression dependent upon circumstance when she notes that in some cases it can be clinical (BDD) and in some cases it can be triggered (PDD). In describing depression this way Michelle’s statement seems to represent an example of segmentation, wherein one discourse is voiced and another is silenced dependent upon a situation. However, Michelle then notes that it can be a “combination,” which then constructs depression’s etiology as a joint causation of the BDD and the PDD. Michelle describes an interdependence of the BDD and PDD when describing her mother’s depression. Her statement first positions the BDD as centered in noting that her mother’s depression was chemical. Still, she then notes that the side effects of not taking the correct amount of medication cause negative symptoms which
make her mother’s life harder which arguably positions the PDD as centered in voicing the importance of one’s environment. Michelle’s final statement notes the idea of a “cycle,” wherein depression causes symptoms, which causes depression. As such, Michelle’s statement has combined the BDD and PDD in noting both come together in the creation of a cyclical experience of depression wherein chemical imbalances may cause unfortunate environments. Both of which can cause depression.

While one could argue that the BPDD is not a hybrid but rather a pre-established discourse of depression, participant talk in the current study centered on combining tenets of the BDD and PDD rather than voicing the BPDD as its own entity. Though literature focusing on how the general public understands depression has largely focused on its shift from the psychosocial to the biomedical model of illness, the ways in which participant talk constructed meaning for the BPDD demonstrates that perhaps these studies should consider the incorporation of the biopsychosocial model of illness when investigating how individuals understand mental illness.

Overall, the discursive struggle between the BDD and the PDD demonstrates the pervasive struggle for the meaning of the etiology of depression. In particular, the rich instances of entertaining in both chapters provide clear evidence of the difficulty that family members must undergo when constructing their understandings of mental illness. Unlike the discursive struggle between DDS and the DDI, participant talk surrounding the BDD and PDD was able to suspend the polemic struggle in the creation of a new understanding of depression’s etiology in the BPDD.
**Struggle Four: Widening the Web**

In constructing understandings of depression, participants called upon four major discourses of depression: 1) the *discourse of depression as sadness* (DDS), 2) the *discourse of depression as illness* (DDI), 3) the *biomedical discourse of depression* (BDD), and 4) the *psychosocial discourse of depression* (PDD). As explored prior, the interplay of the DDS and the DDI provided valuable insight into how individuals construct understandings of depression as it relates to the reality of the illness. Similarly, exploring the interplay of the BDD and the PDD provides valuable insight into understandings of depression as it relates to the etiology of the illness. Because all four discourses cohere around the primary semantic object of depression, we are left with one final interplay exploration that allows for a widening of the discursive web surrounding constructions of depression: The interplay of the DDS, the DDI, the BDD, and the PDD.

Because each discourse of depression has already been articulated in full with summaries of each tenet, each discourse of depression will be reviewed briefly, rather than in full, before moving into the interplay analysis. To explore the interplay of the four discourse of depression, four participant utterances will be explored at length. Because each utterance contains multiple discourses of depression and as such multiple discursive markers of interplay (i.e., negating, countering, and entertaining may all be present in a single utterance), this section will not be organized around each type of interplay. Rather, each of the utterances and their interplay will be explored in full in an attempt to showcase the complex meaning making processes surrounding depression in participant utterances.
First, the discourse of depression as sadness (DDS) defines depression as an affective, personal experience. Depression in the DDS is described as an emotional state of sadness, a personal trait of an individual, and often a chosen state by an individual. Troubling the DDS is the discourse of depression as illness (DDI), which defines depression as a legitimate and un-chosen illness. In the DDI, depression is explicitly noted as a state distinctly different from sadness, distinctly separate from an individual’s identity, and beyond an individual’s control in managing the symptoms it presents with as an illness.

Acknowledging depression as a legitimate and real illness, both the BDD and the PDD add further complexity to understandings of depression by defining the illness as caused by qualitatively different pathways. In the biomedical discourse of depression (BDD), depression is described as an inheritable illness identified by irregularities within one’s physical body. As such, the BDD defines the best help for individuals with depression as medication to help with these issues within the physical body. Unsettling the BDD, the psychosocial discourse of depression (PDD) defines depression as more contextual in nature, with the illness occurring because of socio-cultural and/or cognitive factors. In the PDD, depression is only “inheritable” to the extent that individuals in a family may be privy to the same negative environments or relationships. In framing depression as caused by socio-cultural and cognitive issues, the best treatments for depression are noted as those which address these problems such as cognitive behavioral therapy or talk-therapy.

Taken together, the four discourses of depression stand to construct a complex meaning of depression as articulated in participant utterances surrounding experiences of
maternal depression. With each of the four discourses reviewed, we can now turn our attention to their interplay within participant talk. Our first excerpt comes from Jon. As noted earlier, Jon’s mother began to suffer from depression around the time that Jon was in middle school. In his interview, Jon attributed his mother’s depression to a family move away from a community where Jon and his family had spent most of their lives. Jon also notes in his interview that two of his four older sisters have also been diagnosed with depression as adults and as such, the family has become much more open about discussing depression and about trying to recognize it in Jon’s nieces and nephews. Here, Jon describes his overall understanding of depression after going through the experience of having a mother with depression.

Jon: I think my biggest take away honestly was that at that point, when I was younger you always think of depression as kind of like a negative, right? Someone who’s really sad and I think now my biggest take away is that it can happen to anybody. It’s not necessarily someone who is having a bad time, there’s a lot more that goes into it

Leah: How would you describe it now?

Jon: I think you know, now it would just be more, like then I would have thought of it as someone who is sad. Now I think of it as someone now who, it can go further than that. Is it chemical? Or hereditary? There’s a lot more things than just that basic feeling of sadness or whatever. (27: 90-109)

Jon’s statement highlights several of the discourses of depression. First, Jon gives voice to the DDS in describing his initial understanding of depression as concomitant with sadness. Jon then shifts his talk away from the DDS and counters with the DDI by
noting that now he believes it is not necessarily just sadness that goes into depression but that it can be more complex than simple sadness and can happen to anyone. In Jon’s next utterance he again shifts back to the DDS in noting that his initial understandings of depression were centered on sadness. Jon again negates the DDS in noting depression is more than that, therein giving a sideward glance to the DDI in framing it as an illness rather than a feeling.

Operating within the framework of the DDI (i.e., discursively privileging depression as an illness), Jon then voices a slight entertaining of the PDD and the BDD by questioning whether depression is perhaps chemical or hereditary. Jon’s final sentence voices the DDI in again noting that depression is more than just sadness. Considering Jon’s earlier statements attributing his mother’s depression to a move but attributing his sisters’ depression to family genetics, it makes sense why Jon clearly negates the DDS but does so with a questionable voicing of the BDD. In other words, Jon’s talk certainly centers the DDI in noting that depression is a real and legitimate illness. However, in constructing an understanding of the etiology of the illness Jon’s talk never lands on a definitive etiology of depression.

In our second example, Kim describes what she thinks caused her mother’s depression. Kim notes in her interview that she believed her mother had always suffered from depression but did not see it emerge in a noticeable way until her mother began suffering from other illnesses and found out that Kim’s father had been unfaithful in their marriage. Here, Kim describes how she came to understand the causes of her mother’s depression:
I thought that like what caused it was like just like not handling it in the right way or also I thought what caused it was just having that you know, that oh whether it’s a genetic thing or what not. But that predisposition or what not where I kind of thought that like that played into it as well. (16: 264-269)

In the first segment of Kim’s statement, her talk highlights the DDS and the BDD. First, Kim highlights the DDS in noting that she thought her mother’s depression was caused by “not handling it in the right way.” In positioning her mother’s illness as something that her mother didn’t handle in the right way, her talk centers the DDS and its definition of depression as a choice and therefore something that can be overcome. Kim’s talk then notes the BDD by noting that depression could also be a genetic illness and something that Kim’s mother was predisposed to getting.

Subsequently, Kim continues to discursively thread out the understanding of her mother’s depression:

I think it’s either an event that happens. I think for my mom it was a lot events that piled up that happened to her starting from a young age until adulthood. And that’s also what I’m realizing going back to that one question. I’m realizing from childhood she’s had some crazy traumatic experiences that she never dealt with. So that like growing up has just snowballed into this you know this depression and that sort of stuff. And so I think its events and I also think it’s just managing your own mindset, your own feelings and like your own self-confidence your own motivation—what makes you happy. Like what makes you happy. I really feel like my mom didn’t know what made her happy and like whether that’s a hobby or exercising or hanging out with friends. I like think that she completely cut
herself off from the whole entire world and was just by herself in that emptiness and loneliness and loss of hope. And so I think that’s a lot of the causes. You know like completely detaching yourself from the whole entire world and not trying to find okay I’m upset what I’m going to do about it. Instead I’m upset and it’s never going to get better. (16: 380-400)

Again Kim’s talk calls upon numerous discourses of depression. First, her utterance expresses the PDD by describing her mother’s depression as caused by a series of events that happened. Specifically, Kim notes that her mother had some traumatic events that happened during childhood. However, Kim’s talk then voices the DDS by noting that her mother’s depression was also caused by her mother not managing her mindset, her feelings, her self-confidence, and her motivation. By noting these facets of her mother, Kim’s talk shows tenets of the DDS by framing her mother’s depression as something that her mother could have controlled if she would have taken control of her mindset and taken steps to find her own personal happiness. In framing depression as something caused by events (PDD) and something that can be overcome by these personal choices (DDS), Kim’s talk centers the idea of depression as a chosen state (and latently a personal trait in calling on her mother’s self-esteem) and positions depression as sadness rather than a genetic illness that requires the use of medication despite her prior notion above that genetics could play a part in addition to her mother’s predisposition.

Our final example comes from Jane. As noted prior, Jane’s parents both suffer from depression in addition to her father suffering from alcohol and drug addiction. Jane notes that her mother’s depression became evident after her mother and father divorced
and Jane’s family was forced to move in with Jane’s grandparents due to financial constraints. Throughout her interview, Jane notes an evolving understanding of depression from the time when she first realized her mother had depression to her current understanding. Jane notes that during high school she wonders if she herself suffered from depression but attributed it largely to her family situation. Because Jane’s father was in prison and her mother could not financially support the family, Jane and her sister both took on full-time jobs in addition to attending high school while sharing a single room in Jane’s grandparents house. Throughout her interview, Jane’s talk shifts back and forth between calling upon these hard times as they related to depression in her family in addition to highlighting the potential of genetics to play a part as she notes that a number of family members on both her mother and father’s side of the family suffer from mental illnesses. Here, Jane pulls on a number of discourses of depression when describing her initial understanding of the illness and how that understanding changed over time.

I didn’t understand that it was a chemical thing with my mom. I just thought it was because life was awful . . . Like, okay, get over it and move on with your life. But I was really unfair about saying that. Absolutely. Now that I am adult, sadly, I do recognize that that was an unfair assumption. But also learning more and taking psych classes and being at the end of high school I recognized that it wasn’t just because life is shitty it’s because there actually is a genetic thing. (22: 230-240)

Jane’s talk first centers the PDD in noting that she did not think that her mother’s illness was a chemical thing (BDD) but a result of life being awful (PDD). Whether because of this assumption or because of other circumstances, Jane’s talk then calls upon
the DDS in noting that she wishes her mom would just “get over it” and therein framing depression as a personal choice that Jane’s mother could control. Jane’s talk then negates this by noting that the assumption that her mother’s depression was something that her mother could get over (DDS) was an unfair one. In articulating her understanding as it sits today, Jane’s talk centers the BDD (and therein the DDI) by negating the idea that her mother’s depression was caused merely by life being awful (PDD) but rather by genetics (BDD).

Later in her interview, Jane again provides a rich example of the complexity of meaning making when she describes to me her overall understandings of mental illnesses and how they are perceived in culture and within her family specifically. As noted prior, Jane’s father suffers from addiction and depression, Jane’s mother suffers from depression, and Jane believes that her twin sister suffers from undiagnosed bipolar disorder. Jane notes prior in her interview that consistent with recent literature on addiction, Jane considers her father’s drug and alcohol addiction to be a mental illness. Here, Jane talks about her own health in relation to both of her parents’ illnesses

With alcoholism, that’s something I can control in this season in my life. I’m saying that as not being an alcoholic. I know that I have predisposition of having an addictive personality. That’s something, being aware of, that I can control . . . But if I am saying that my mom and my grandma were both depressed, and are depressed, that has something to say about me and my genetic makeup—that I am predisposed to depression and that it is a very high potential that I will have a chemical imbalance—or that I do, I just haven’t had issues enough that I am on
Prozac yet . . . But with society thinking that it’s get over it and move on, you don’t need to see a therapist, the foofoo medicine (22: 1188-1206)

If we frame alcoholism and specifically addiction as a mental illness as Jane does in her interview, we then see an interesting contrast between how Jane views addiction and how she views depression. Jane describes her father’s alcoholism as an illness that she has control over. She recognizes that she has a predisposition (BDD) but also notes that her awareness allows her to maintain control over her this predisposition, which speaks to the DDS in describing addiction as a personality trait that she can chose to abate by choosing to avoid alcohol. Jane’s talk then moves into describing her mother and grandmother’s depression and switches to privileging the DDI and the BDD. Jane notes that depression is in her “genetic makeup.” She again notes that she is predisposed to depression (just as she is predisposed to addiction) and that she likely has a “chemical imbalance” (BDD). In her final sentence, Jane circles back to describing how society tends to call upon the DDS in framing depression as something that an individual can get over and move on from rather than seeking professional treatment. As such, Jane’s talk provides an interesting example of the intricacy of making sense of mental illness at large. While Jane declares both addiction and depression as genetically incumbent, she discusses alcoholism with a framework of personal accountability and control but depression as an illness that is out of her control.

Overall, meaning making surrounding depression in the current data set resulted in highly complex discursive interplays. While the first two analyses showcased the intricacies of discursively constructing the reality and etiology of the illness, these textual examples provide evidence of the complex web of meanings that emerging adults called
upon in constructing their understandings of the illness. Further, the examples
demonstrate the dynamic nature of meaning making in each discursive moment. In
Kim’s case we see this explicitly as her articulations of depression change even across
her utterances within our interactions during data collection. While participants voiced
an awareness of the fact that their understandings of both motherhood and depression
changed across time from when they were younger to their current understandings, what
they perhaps are not aware of is their continually evolving meaning making in the
present.
CHAPTER SIX

DISCUSSION

Examining emerging adult talk surrounding the experience of having a mother with depression provided rich insight into unpacking the complex, discursive sense-making processes occurring at the nexus of family and health communication. Using RDT and contrapuntal analysis, results demonstrate a pervasive and continual negotiation of meaning for both motherhood and depression in addition to the intricate and complex effects of understandings of each on the other.

In this final chapter, I provide an overview of the results from each of the three contrapuntal analyses and discuss the findings as they interrelate to one another in wider webs of meaning. I then examine the findings as they specifically relate to the intersection of family communication and health communication in addition to illuminating the importance of applying a critical lens to this intersection. Specifically, I discuss the insight RDT provided for the current study and interrogate how future work might move the theory forward theoretically by working at the nexus of family and health communication. Finally, I discuss practical applications of the study for emerging adults, mothers with depression, and families overall in making sense of having a family member with depression.
Overview of results

Meanings of motherhood

Discursive constructions of motherhood were fashioned through two primary discourses of motherhood: 1) the *discourse of the ideal mother* (DIM) and 2) the *discourse of the real mother* (DRM). Pulling from several centripetal discourses from the distal-already-spoken circulating in contemporary U.S. culture at large, the DIM drew meaning from both cultural templates of motherhood and from the preeminent ideology of intensive motherhood. The DIM constructs motherhood as a family role performed through adherence to a set of culturally specific scripts such as cooking family meals, driving children to activities, and being actively involved in children’s lives on a daily basis. Drawing on the predominant ideology of intensive motherhood (Hays, 1996), the DIM also defined motherhood as one charged with selflessly providing full care and emotional support for children’s needs.

Troubling the DIM is the DRM, which destabilizes the DIM by defining motherhood as a role occupied by a unique individual mothering to the best of her individual ability. The DRM refutes the view of motherhood as a role performed by in a culturally specific way and instead privileges the individuality of mothers and their unique performances of motherhood. In doing so, the DRM presents motherhood as one of a number of roles occupied by a mother rather than as an all-encompassing identity. The DRM also challenges expectations of the performance of motherhood as set forth by the DIM. Disrupting the DIM and its view of motherhood as all intensive in providing full care and support, the DRM defines mothers as those who provide as much as they are able rather than expecting consummate support.
Results of the interplay analysis demonstrate the complex and continual negotiation of motherhood in emerging adult talk. Discursive negotiations of motherhood occurred both diachronically and synchronically. Diachronically, participant talk commonly centered the DIM when describing initial understandings of motherhood but shifted to centering the DRM in describing current understandings. Synchronically, participant talk shifted the DIM and the DRM as the privileged discourse via negating and countering and in instances of entertaining noted an inability to privilege a single discourse of motherhood. The back and forth of the DIM and the DRM as they occupied centripetal and centrifugal positions via negating and countering across participant interviews (and in many cases within participant interviews) in addition to the presence of entertaining provides evidence of the continual struggle for emerging adults in constructing meanings of motherhood.

Participant talk surrounding motherhood also generated a number of instances of transformative dialogue in the study. Via extracting, participant talk separated out the first tent of DIM but maintained its definition of motherhood as one providing full care and support. In other words talk defined mothers as individuals who provided full care and support but did not need to enact the more culturally specific performances such as baking cookies or driving children to activities. As such, mothers were still defined within the framework of intensive motherhood but not expected to carry out this role through scripted expectations as explicated by the first tenet of the DIM.

In addition to extracting, participant talk also generated several hybrids wherein the DIM and the DRM were able to suspend their combative tenets and instead combine to form new meanings of motherhood. This discursive transformation occurred through
two primary means. First, motherhood in several instances was defined as a role sitting equally between the DRM and the DIM wherein mothers could be the cultural template of a mother but could also be a unique individual. Unlike instances of entertaining wherein a participant noted an inability to articulate the DIM or the DRM as the more centripetal discourse, participants constructing these hybrid understandings of motherhood placed them as discursive equals in their ability to define the expectations and essence of motherhood. In other words, participant talk shifted from an either/or between the DIM and the DRM and moved instead into an understanding of motherhood in terms of a both/and where the tenets of the DIM and the DRM are celebrated. Finally, in one instance of hybridity, participant talk actually defined the DIM through the tenets of the DRM. More specifically, the participant described her mother as ideal in her ability to mother despite having depression and being unable to meet the cultural expectations of motherhood. In describing the discourse of ideal motherhood as attained through the tenets of the discourse of real motherhood, the utterance subverted the power of the DIM and placed the DRM and DIM as discursive equals in articulating ideal motherhood as that attained by mothering in one’s unique way and providing what one was able.

**Meanings of Depression**

Two primary struggles animated the meaning of depression. The first struggle surrounded the existence of the illness itself, with participant talk voicing two primary discourses of depression: 1) the *discourse of depression as sadness* (DDS), and 2) the *discourse of depression as illness* (DDI). Invoking a common and culturally pre-articulated conflation of depression with negative affects of melancholy (Horwitz &
Wakefield, 2007), the DDS defines depression as an emotional state of sadness. In positioning depression as an affective state, the DDS marks depression as part of one’s personality and as such, an emotional state of choice. Directly refuting the DDS is the DDI, which contests the DDS by defining depression as an illness that is distinct from feelings of sadness, distinct from one’s personality, and as such beyond one’s volition. In contesting the DDS’s definition of depression, the DDI validates the experience of depression as one of true, legitimate illness.

Similar to the struggle surrounding motherhood, results of the first analysis surrounding meanings of depression reveal a continual negotiation of its meaning both diachronically and synchronically. In instances of diachronic separation, participant talk often centered the DDS in re-counting initial understandings of depression and the DDI in describing present day understandings. Unlike diachronic separation in which the discourse of DDI was most often given centripetal position in defining current understandings, examples of synchronic interplay were much more volatile in nature with an inconsistent positioning of the DDS nor the DDI as centripetal to meanings of depression. Across instances of both countering and negating, there was no common positioning among participant talk of the DDS or the DDI as centripetal or centrifugal. The continual struggle between the DDS and the DDI was most evident in the examples of entertaining where participant talk voiced an inability to conclude which discourse of depression to give more discursive weight too in constructing understanding. In addition to the prevalence of entertaining and the inconsistent privileging of the DDS and the DDI in countering and negating, no transformative dialogue emerged in the analysis providing further evidence of the intensity of the struggle for meaning in participants’ inability to
discursively reconcile the DDS and the DDI when making sense of depression, and specifically its existence as emotion or illness.

The second struggle voiced within participant talk constructing understandings of depression centered on the etiology of depression. Two primary discourses found voice in participant utterances: 1) the *biomedical discourse of depression (BDD)*, and 2) the *psychosocial discourse of depression (PDD)*. Operating from the biomedical model of illness (Deacon, 2014), the BDD frames depression as a measurable and identifiable illness that can be passed down genetically. In the BDD, treatments are defined as those reconciling issues within one’s physical body. Resisting the BDD is the PDD, which defines depression as a psychosocial illness caused by psychological, social, and cultural problems. In locating the cause of depression within realms of experience and cognition rather than within the explicit physical body, the PDD challenges the BDD’s assumption of treatment via the medical model of illness instead privileging treatments that focus on alleviating the sociocultural and cognitive factors.

Diachronic separation was not a prevalent form of interplay in the third analysis. Considering the fact that some participants described initial understandings of illness using the DDS, it stands to reason that some participants may not have formulated understandings of the causes of depression since they were not conceptualizing depression as an illness. However, the data did have many instances of synchronic interplay pointing to a more dynamic understanding of depression’s etiology in spite of this lack of diachronic separation across time or situation. Similar to the interplay surrounding motherhood, instances of negating and countering involved an incessant shifting of the BDD and the PDD as centripetal. Entertaining was again a frequent form
of polemic interplay in the analysis with a number of participants expressing an inability to reconcile the PDD or the BDD as centripetal in articulating their understanding of the etiology of their mother’s depression.

Finally, participant talk did produce a number of instances of transformative interplay in the form of discursive hybrids wherein the BDD and PDD were combined in understanding the etiology of depression. Participant talk articulated what one may refer to as the BPDD (*biopsychosocial discourse of depression*). Noted in Chapter Two as an emergent explanation of the etiology of depression (Dubriway, 2010), the biospsychosocial model of depression takes into account both biological and psychosocial factors. Like the biospsychosocial understanding of depression, participant talk voicing the BPDD described their mothers as having predispositions to depression due to genetic inheritance but also noted that negative life events were what essentially drew that predisposition for depression out. As such, both the BDD and the PDD were integral to understanding the cause of a mother’s depression.

As a whole, the interview texts proved to be a dialogically expansive text (Baxter, 2011) with a high degree of interplay in each of the three sites of struggle in addition to a number of instances of transformative dialogue. That is not to say that instances of monologue were not present in participant talk. As demonstrated by the exemplars provided in each of the tenets of the discourses, participant talk did in many cases voice one understanding of motherhood and depression in certain utterances. However, a significant number of utterances constructed meanings of motherhood and depression through the voicing of multiple discourses with meanings for both emerging from their interpenetration.
Considering the reported centrality of motherhood and the experience of maternal depression to participant lives, the level of discursive expansiveness in the text provides evidence of the rich and nuanced discursive struggles that surround meanings of motherhood and depression in emerging adult narratives. Additionally, the presence of transformative interplay in participant talk (i.e., extracting and discursive hybrids) demonstrates the immense potential of communication in the creation of emergent meanings of motherhood and depression.

**Making Meaning**

The polemic interplay and transformative dialogue present in the data demonstrate several important findings in understanding how meanings of motherhood and depression are constructed in emerging adult talk. First, results show the continued cultural salience of both the current cultural script of motherhood and the ideology of intensive motherhood as voiced in the DIM. Participant talk voicing the DIM articulated motherhood as a widely understood and universally performed familial role. This was perhaps most apparent in participants’ voicing of nondescript phrases such as “mom stuff,” “mom things,” and having a “stereotypical mom” during their interviews. In addition to the use of indistinct and assumed shared understandings of motherhood, several participant utterances spoke to the proximal not-yet-spoken link on the utterance chain in framing talk around motherhood apologetically to me. Prior to describing more negative aspects of their mothers and their relationships with their mothers, participants voiced comments to preemptively combat negative reactions such as “Probably sounds terrible the way I’m talking about her” (31:302), and “I know it sounds bad” (5:125). In anticipating a negative response prior to articulating a less than ideal view of
motherhood, participant talk demonstrates the ubiquity of the cultural assumption that mothers are inherently good and the relationship between a child and mother is inherently close and happy.

Despite the cultural salience of the DIM, participant utterances were able to refute it as the sole understanding of motherhood through their negating and countering with the DRM. In doing so, participant talk worked to construct meanings of motherhood that allowed for the expectations and performances of motherhood to move away from those presented by the historically privileged DIM while still maintaining their value to the family. Further, the prevalence of discursive transformation via extraction and hybrids demonstrates the ability of talk to create new and emergent meanings of motherhood that refashion these deeply embedded in contemporary U.S. culture.

Like motherhood, the exploration of the meaning of depression also provided a rich and complex discursive picture with four distinct discourses animating the meaning of depression. Similar to prior work examining depression, both the struggle between the DDS and the DDI and the struggle between the BDD and the PDD represent pervasive and persistent struggles surrounding the meaning of depression (Horwitz & Wakefield, 2009). In particular, participant utterances were unable to discursively reconcile the DDS and the DDI, instead constructing meanings of depression based on which discourse of depression was privilegeing in the moment. One possible explanation of this inability to reconcile the DDS and the DDI is the fact that both occupy centripetal positioning in culture at large depending upon one’s context. While the DDI is given centripetal position in professional understandings of illness (Deacon, 2014), the DDS is still a pervasive understanding of depression within the general public (Santana & Fontanelle,
Unlike understandings of motherhood where the DIM occupied a clear, centralized positioning within culture that participants could either align their talk with or divert from, both the DDS and the DDI occupy powerful positions in culture at large. Further, because the DDS and DDI completely diverge on defining the very existence of depression, it is hard to conceptualize how participant talk might reconcile the two together.

Despite the lack of transformative dialogue between the DDS and the DDI, participant talk was able to construct a discursive hybrid in analysis three by combining the BDD and the PDD into the BPDD. In fact, this hybrid was the most common across analyses. The voicing of the BPDD in the current study aligns with Schomerus’s (2012) finding that individuals in the general public are moving towards a biopsychosocial view of depression wherein both biological and psychosocial components play into constructions of it’s etiology.

**Theoretical Implications**

Results of the study demonstrate the value and importance of using RDT and contrapuntal analysis in examining how individuals make sense of both familial relationships and health. First, it is clear that meanings of motherhood and depression continue to evolve across time. Overall, the identification of both diachronic and synchronic interplay demonstrated the ongoing struggle of discursively constructing the meaning of familial roles and health within the family. While the examples of diachronic separation provided interesting ways to explore how emerging adult talk shifted understandings across time, the prevalence of synchronic interplay in the data also
provided evidence that these same sense making processes continue to evolve as participants build upon understandings to discursively construct meaning in the present.

The lack of any aesthetic moments across the three analyses provides additional evidence of the pervasiveness of the discursive struggle surrounding both motherhood and depression. Despite the presence of hybrids and extraction, no participant talk was able to transform competing discourses in a way that significantly reconstructed the original discourses. This lack of aesthetic moments could be due to a number of factors. First, considering that participant talk was unable to rectify the competition between some discourses in any transformative way (i.e., the DDS and the DDI) it is perhaps not surprising their talk was unable to construct entirely new meanings of depression accompanied by a felt sense of wholeness. Second, the discourses of the BDD and the PDD are explicitly tied to static concepts such as the human body and one’s life. While participant talk was able to combine the BDD and the PDD in noting that depression could be caused by both factors pertaining to the body and pertaining to one’s social environment, a new and emergent meaning of the etiology of depression wherein the BDD and the PDD combine in a way that causes them to lose these meanings makes the etiology of depression much more mysterious rather than clear. Finally, considering the importance of affect in identifying aesthetic moments, it is possible that participants are not yet able to discursively or emotionally reconcile their understandings of depression and motherhood. While I took extra steps to ensure that I was marking any identifiable emotional moments in the transcript (e.g., marking laughter, noting long silences), these instances were often marked by moments of sadness, confusion, and anger rather than a felt sense of wholeness.
Another valuable insight provided by RDT in examining meaning making was the framing of participant talk on the utterance chain (Baxter, 2011). For both discursive constructions of the meaning of motherhood and depression, participants called upon distal already-spokens and proximal-already spokens to inform their understandings. For example, when making sense of motherhood, participants often described their initial understandings of motherhood as cohering to the DIM and originating from larger cultural mediums (e.g., television shows and movies). This voicing of the DIM was then put into play with the DRM, a discourse constructed through interpersonal and relational experiences within their family and specifically between themselves and their mothers. In other words, while culture may have explicitly communicated the DIM, participants were also able to utilize their own relational pasts to explicate a divergent discourse of motherhood in the DRM.

Just as utterances and experiences in the proximal hold potential in refuting those in the distal, so too did discourses in the distal hold potential in refuting those in the proximal. For example, a number of participants recalled centering the DDS when describing their initial understandings of depression. However, they also described a shift to the privileging of the DDI after exposure to academic courses. In other words, participants constructed understandings of depression relationally (proximal) via the DDS when interacting with their mothers as children were eventually shifted to the DDI after exposure to wider cultural ideas (distal) about depression.

This interpenetration of the micro (i.e., proximal) and the macro (i.e., distal) demonstrates the importance of examining both in garnering a clear understanding of how individuals make sense of their personal relationships and wider concepts.
surrounding health. To examine only culture and its discourses at large runs the risk of failing to capture proximal and often new and emergent meanings as they challenge, subvert, and upend centripetal cultural discourses. However, to examine only the immediate relational communication between mothers and children runs the risk of failing to acknowledge the larger sociocultural contexts that those relationships are embedded in and operate within. As such, RDT proved advantageous in unpacking the complex meaning negotiations surrounding motherhood and depression.

**Family Communication and Health Communication**

Results of the study also provide evidence of the importance of examining family communication as it intersects with health. Using RDT, examining motherhood within the specific context of depression demonstrated the effect of health and illness on meanings of motherhood. While participants could articulate motherhood via the DIM as a culturally privileged and widely communicated discourse of motherhood, the experience of depression created relationships wherein mothers either did not adhere to the DIM or required their children take up the DIM for them. This rupture in normative standards of motherhood created discursive space for new meanings of motherhood to emerge as it did with the DRM and with the examples of extraction and hybridity. As such, the study provides evidence for the importance of examining health communication within the family in order to enrich the current field of family communication and more specifically research on motherhood. Just as scholars point out that the discourse of intensive mothering does not capture the experiences of those outside of its heteronormative, White lens (Ennis, 2015), this study demonstrates that it may also fail to capture the experiences of those who face significant health issues.
In addition to capturing diverse experiences of motherhood, the study also captures diverse perspectives of motherhood by examining the familial role through the perspectives provided by emerging adults. Consistent with McAdams and Olson (2010), emerging adults were able to provide detailed insight into understandings of motherhood in their ability to recall early understandings of motherhood in rich detail in addition to articulating their current sense making surrounding it. Further, because many reported the experience of parentification, emerging adults provided rich articulations of motherhood in describing both being mothered and mothering themselves.

Results of the study also enrich the small but growing body of work examining the specific intersection of family and mental health. First, the study gives voice to individuals within the family other than those with depression. In doing so, the study provides unique insight into the relational, rather than solely individual, experience of both motherhood and depression. In positioning emerging adults as active participants in the experience of maternal depression rather than simply passive receptacles to the effects of a mother’s depression, the study provides valuable insight into the much needed area of inquiry exploring the experience of having a parent with depression and the meaning making processes that go into making sense of it.

Overall, experiences reported by participants aligned with prior work on the experience of having a parent with mental illness. Participants noted feelings of stress and fear when describing their felt need to care for their parents (Meadus & Johnson, 2000), articulated frustrations with a lack or care provided by mothers (Mordoch, 2010; Trondson, 2012) and most commonly reported the experience of parentification in their
need to step into the role of parent in regards to caring for themselves, their siblings, and in some cases their parents (Van Parys & Rober, 2014).

Beyond supporting this existent work on children of parents with mental illness, the current study provides further insight by exploring the actual meaning making processes that children move through when making sense of these experiences. Scholars note that children often have difficulties in making sense of the experience of having a parent with depression (Gladstone et al., 2011). This study is the first of its kind to attempt to unravel those complex meaning making processes rather than simply describe their difficulty. Similarly, extant literature on parentification fails to take into account cultural discourses of family when exploring the experience of parentification. Virtually no studies examine the experience of parentification communicatively. Considering the necessity of continually renegotiating roles and expectations when a child is stepping into the role of parent, the experience of parentification should be examined through communication in order to explore these negotiation processes. In the current study, the importance of examining parentification with a communicative lens was most apparent in examining emerging adults’ discursive constructions of motherhood as it centered around experiences of parentification. For participants adhering to the DIM, the need to carry out activities traditionally done by mothers was described through the framing of parentification with participants noting that they felt as though they did not have a mother and were instead parenting themselves. Conversely, participants describing the need to engage in similar activities articulating their understanding of motherhood through the DRM did not report an experience of parentification. Though parentification is generally understood in scholarship as a role reversal in expectations of parent and child, what is
lacking in current research on parentification is the idea that not all families view these responsibilities as a role switch but rather as normative family functioning.

Results of the study also demonstrate the potential impact of understandings of health on understandings of familial roles. When articulating meanings of depression, participants voicing the DDS often described viewing their mother in a negative light. In defining depression as an emotional choice or trait of a mother rather than an illness, participants understandably noted frustrations in their mothers’ inability to mother them, as they believed she should via the DIM. Conversely, participants who adhered closely to the DDI tended to reject the DIM in noting that depression was a significant illness out a mother’s control. In framing a mother’s inaction or inability to mother to the best of her ability as a result of an illness rather than a result of a personal choice, participants both constructed variant forms of motherhood via the DRM and celebrated their mothers’ attempts at mothering intensively despite her illness via the discursive hybrid of the DIM and the DRM.

Clearly, the experience of depression affected participant understandings of the family role of motherhood. In a similar fashion, a number of participants described the effect of family on understandings of depression. In situations where a family did not communicate about a mother’s depression at all, participants noted understanding depression through the DDS. With no information beyond the witnessed behaviors of their mothers, participants framed depression as an affect of sadness or as a personality trait of the mother. In other cases, participants did note having discussions surrounding depression and the effects of those discussions on understandings of depression. For some participants, these discussions resulted in an adherence to a particular discourse of
depression. For example, Kim’s mother made sure to inform Kim that the depression was in no way her fault because it was a genetic illness. In communicating this way, it is safe to assume that Kim adhered to the DDI and subsequently the BDD in framing depression as a chemical imbalance. Across interviews, it was clear that the ways in which a family communicated about depression, or in many cases lacked clear communication, had an impact on how emerging adults constructed their initial understandings.

While scholars continue to note the importance of the family as a primary socializing unit both on topics of family and on topics of health (Pecchioni, Overton, & Thompson, 2015), current research continues to stop short of interrogating their intersection. As the current study demonstrates, examining relationships within the family as they occur concomitantly with illness is paramount to garnering an understanding of how individuals come to understand the meanings of familial roles and the meanings of illness.

**Approaching and Enriching Critical Family Health Communication**

A noted by Baxter (2011) in her second articulation of Relational Dialectics Theory and outlined by me in chapter two, RDT stands to provide a number of “seeings” to interpersonal and family communication in its attention to the discursive detail of participant talk and emphasis on locating power discursively rather than within individuals or social institutions. Results of the study provide strong evidence of the benefits of RDT by incorporating a critical lens to family communication and health communication scholarship in a number of ways.
First, results of the study exhibit the importance of dissolving the false binary of the public and private. Emerging adults did not sit in isolation to their wider sociocultural environment but rather within it when articulating meanings of motherhood and depression. As noted prior, participants constructed understandings of motherhood through proximal-already-spokens as they buttressed up against those voiced in the distal-already-spokens. Further, the interpenetration of wider cultural discourses with relational discourses also worked to create meanings for depression. Just as Baxter (2011) points to sociocultural life as relational and relational life a sociocultural, each clearly informed the other in emerging adult talk constructing meaning for motherhood and depression. As such, both family communication scholars and health communication scholars should note this false binary of the public and private when examining understandings of health and family.

A second benefit of utilizing RDT for the current study was the theory’s focus on locating and exploring discursive power within talk. Both the analysis of motherhood and the analysis of depression provided insight into the importance of discursive power in determining how meanings for motherhood and depression are made and the effects of each understanding on the other. For motherhood, participants voicing the DIM often noted being angry, frustrated, or sad about their mother in noting their mother’s inability to enact the DIM through its tenets such as baking cookies, driving kids to soccer practice, or providing strong and consistent emotional support. When participants were able to discursively reconstruct definitions of motherhood either through privileging the DRM or discursively transforming meanings of motherhood via extraction and hybrids, they were able to construct understandings of motherhood that fit with their experiences.
As such, they were able to reclaim their mothers as mothers. In other words, individuals who were not able to re-story motherhood in light of the DIM often noted a loss of motherhood whereas individuals who were able to re-story their experiences and their mother via the DRM and/or transformative dialogue still viewed their mothers as mothers despite her inability to mother as explicated by the culturally privileged DIM. In this focusing on discursive power, critical family researchers can better understand the impact of culture on the family and provide unique pathways to enhancing family functioning. In the case of maternal depression, this unique pathway may be in teaching individuals about cultural discourses of motherhood and how they might re-story their understandings of motherhood and their own identities within the family as they sit in relation to them.

Finally, the study demonstrates the utility of utilizing a dialogic approach to studying the family and health in its valuing of discursive transformation. According to Bakhtin (1984) and subsequently Baxter (2011), talk that allows discourses to transcend a zero-sum polemic and instead combine to make new meanings is ideal in that it represents a prime space for discursive creativity and growth. In the case of this study, that growth came through the creation of new meanings of motherhood. The valuing of a definition of motherhood beyond the DIM or the DRM provides an excellent example of the benefit of taking a dialogic approach critical family scholarship. Though centripetal discourses in contemporary culture can be problematic in their silencing of alternate, centrifugal discourses, it is important to note that centripetal discourses are not inherently problematic nor are centrifugal ones inherently deserving of a centripetal position. Though the DIM may in some cases place unfair expectations on women with its
standards of care, in other instances it may be a valuable discourse of motherhood by placing a child’s needs as paramount. Similarly, while the DRM in some instances can be viewed as positive in allowing for a mother to reclaim her individuality, in other instances this privileging of the self might cause issues for the family or result in negative experiences such as those reported by participants in the study when describing their experiences of parentification. In the same way that the DIM runs the risk of becoming problematic in its centripetal position and silencing of alternative forms of mothering, so too does the DRM if given centripetal position to the extent that it silences other discourses of motherhood. Therefore, the ability of participant talk to combine the DRM and the DIM in new ways is particularly exciting in considering the study’s theoretical and practical applications. As meanings of motherhood continue to evolve in contemporary culture, the ability of emerging adults to discursively negotiate and reconcile cultural and relational understandings of motherhood as they interpenetrate can provide insight into how they make sense of their own relationships with their mothers in addition to how they might discursively construct family roles in the future.

Furthermore, critical family scholars utilizing RDT have a unique opportunity to utilize critical methods as a way to continually create new understandings of family rather than simply working to shift out old definitions for new.

In addition to demonstrating the importance of taking a critical approach to family communication, the study also demonstrates the utility and importance of bringing critical methods into the field of health communication. While health communication scholars note the importance of social, environmental, and cultural factors on health and wellness in terms of health beliefs and behaviors, what is currently lacking in health
communication scholarship is an examination of how these beliefs come to fruition. For example, considering the noted prominence of the BDD in medical contexts (Deacon, 2013), the privileging of the PDD and move towards the BPDD in participant talk in the study is of particular note. As health professionals continually work to improve adherence to medical treatments given to individuals seeking mental health treatment, the divergence in understandings of depression between professional caregivers and patients becomes critical. In other words, if health professionals are seeking better adherence to prescribed treatments, they should first understand how their patients themselves approach understandings of mental illness as it will arguably affect the ways in which patients engage (or fail to engage) in prescribed treatments.

In sum, taking the time to understand the ways that an individual actually makes sense of an illness can have profound effects on the ways the illness is handled. As such, understanding the culturally privileged discourses of an illness such as depression can have profound effects on how individuals construct their own understandings of and behaviors towards those illnesses. In this study, participants who voiced the BDD often noted a self awareness that they themselves might be predisposed to having depression whereas participants voicing the DDS made less mention of their own potential in developing depression with their belief that depression was more about being sad than about having a legitimate mental illness. Though long examined with post-positive lenses, it is vital that health communication scholars begin to take into account both the potential of interpretive methods in studying health and illness and more specifically a critical approach in examining how cultural at large affects understandings. Our relationships with our very own bodies, just like our relationships with others, do not take
place in a vacuum. Rather, we understand our health as it plays out in wider sociocultural contexts. As such, understanding privileged and marginalized cultural discourses surrounding health stands to provide new and important insight both in the field of family communication and health communication.

**Future Directions**

Overall, results of the study demonstrate the rich potential of examining the intricate meaning making processes that occur at the intersections of health and family. As such, a fruitful avenue of future research should work to further enrich this complex nexus. Beyond providing evidence of the importance of understanding the ways in which health affects our understanding of family and vice-versa, examinations of communication in particular stand to provide unique insight to practical and theoretical applications of the knowledge garnered from such explorations.

Theoretically, the study provides several avenues of future research that could serve to enrich current knowledge on family communication in addition to providing new and unique layers to the use of relational dialectics theory. First, the experience of parentification in the current data set represents a fruitful avenue through which to examine what Bakhtin (1984b) defined as the carnivalesque. Noted as an event or spirit wherein the normal social order is upended, queered, or reversed, carnivalesque events represent rich dialogic sites of exploration in their potential to suspend centripetal and normalized ways of beings for new or subversive ways. Baxter (2011) notes that very little work in interpersonal communication has given attention to the phenomenon of the carnivalesque. Beyond providing research to fill this gap in the discipline, examinations of the carnivalesque in personal relationships stand to provide paths for what Bakhtin
believed to be a way to instantiate social change (Baxter, 2011). Therefore, examinations of the carnivalesque as they pertain to social relationships can ideally help critical family communication scholars expose and explore the ways in which carnivalesque situations within the family can create the catalyst for new and emergent meanings of family relationships.

Because the experience of parentification represents one where the expected hierarchical role structure of mothers providing and caring for children is suspended in a way that either places a mother and child on an equal playing field or inverts the hierarchical structure in a way that places a child above a mother, the experience of parentification represents a unique site at which to examine the relationship between parent and child. In the current study, the experience of parentification resulted in two different paths of sense making. For some participants, the subversion of normative expectations of the mother-child relationship resulted in the emerging adult stripping the mother of her title and placing it on themselves. For these participants, the lack of caregiving and the requirement of providing care rather than receiving care resulted in communicatively framing themselves as parents and noting a loss of motherhood. Conversely, other participants negotiated this role flip as a renegotiation of what it means to be a parent and what it means to be a child. Participants describing their experiences in this way did not frame themselves as mothers but rather reconstructed the meanings and expectations of mothers and children and placed caregiving as an interdependent responsibility. Here, in the renegotiation of familial roles and in the voicing of the parent/child relationship as intact despite its differing function we see the potential for
new and emergent meanings of familial relationships to emerge and the potential in
examining the family and its relationships through the lens of the carnivalesque.

In addition to the carnivalesque, the study also provides evidence of the
importance of widening the web of discourses when examining meaning making. While
the current study attempted to take a small step towards this expansion in examining the
interpenetration of the four discourses of depression, future work should also note the
intricacies and complexities of multiple discourses surrounding a semantic object. In
particular, a fruitful site for future work surrounding meanings of depression involves
identifying the cultural discourses of cultures beyond the United States. In total, three
participants noted either growing up outside of the United States themselves or being first
generation U.S. citizens. All three of these participants noted the various ways that their
parents’ first culture articulated the meanings of depression affected their parents own
meaning constructions. As a result, cultural discourses of depression beyond those
voiced in the United States became a part of the discursive sense making of depression in
these families.

Considering the rich diversity of current U.S. citizens in addition to projected
demographic shifts in the population, communication scholars and in particular family
and health communication scholars should make note of these instances. While family
communication scholars have begun to call for work focused on underrepresented
populations, we must also make a note that simply selecting these populations on
demographic terms is not enough. Rather, we must include in our thinking the fact that
these underrepresented groups bring with them cultural discourses that may sit outside of
those voiced in the United States. Just as a historical overemphasis on White,
heteronormative populations in family communication represents an area for needed change in the future, so too will an overemphasis on U.S. discourse in work utilizing relational dialectics theory result in a similar situation if we do not take note of the importance of expanding our understandings beyond U.S. discourses.

In addition to widening the web of exploration in understanding discursive constructions of meaning, future work might also explore how discourses themselves come into being and reach “cultural discourse” status. In the current study, I considered the BPDD a hybrid discourse in that participant talk voicing the BPDD called upon tenets of both the BDD and the PDD as discursive equals. As I noted in Chapter Two, the biopsychosocial model of mental illness is one that has been articulated by the professional community as a legitimate model of mental illness. As such, I was faced with the question as to whether the BPDD was in fact a pre-established cultural discourse of depression being voiced by participants or an instance of hybridity in the discursive melding of the BDD and the PDD. Because the BPDD was not a commonly understood discourse of depression in prior work exploring lay understandings of depression, I chose to report the voicing of the BPDD as a hybrid discourse of the BDD and the PDD. However, future work might consider how scholars utilizing RDT might better identify and conceptually define when the meaning surrounding a semantic object becomes a cultural discourse.

In advancing RDT and contrapuntal analysis, future work might also consider diverse data collection techniques. One way in which work might build upon the current study is to collect data longitudinally across time. As noted by Baxter (2011), the collection of longitudinal data is ideal in unpacking how discourses play out
diachronically across time. While the collection of retrospective data can provide some insight such as in the current study, longitudinal data would arguably allow for a deeper analysis of diachronic separation and provide invaluable insight into the intricacies of how meanings surrounding family and health topics such as motherhood and depression evolve. Considering that some participants in the current study had only recently begun constructing meanings for depression because of a previous privileging of the DDS, this longitudinal data would provide rich insight into the meaning making process of both coming to accept and understand health concepts such as depression. In addition, this longitudinal data might capture the interesting negotiations of familial roles as those roles change over time. In the current study, no participants were mothers themselves. It stands to reason that capturing longitudinal data during which time individuals shifted into the role of motherhood themselves would provide valuable insight into whether and how individuals renegotiate understandings of motherhood when they themselves take up the role. Overall, this longitudinal data would provide rich insight into the continual process of meaning making surrounding topics of motherhood and depression.

In addition to longitudinal data, another fruitful avenue for future research would be the collection of data via diverse interviewing techniques. Although the current study allowed for the capturing of distal-already-spoken discourses of depression and motherhood as participants voiced their experiences to a generalized other (i.e., the interviewer), collecting discursive data through means beyond participating in an interview with the researcher might provide additional insight into these discursive sense making processes. For example, interviews might be conducted with multiple family members present such as a mother and her child sitting down together to answer
questions about their experiences. Since depression and motherhood are both individual and relational experiences, collecting data through a co-constructed narrative might provide additional and important insight into how families construct relational meanings together. Additionally, interviews might be conducted without the presence of a researcher such as family members interviewing each other. By removing the researchers, interviews conducted in this way might allow for the capturing of richer proximal data as participants articulate their experiences to a known other. Considering the importance of family when helping a family member handle a mental illness, data collected in this way might also shed light on how family members reach understandings of illnesses together and how that might impact the ways in which they provide and/or expect care.

**Practical Applications**

While the richness of the contrapuntal analyses surrounding depression proves exciting and informative for dialogic research, it is important to note the practical applications of the results as well. First, the high level of entertaining present in the data regarding the existence of depression as a real illness versus the potential for depression as an emotion or personality trait demonstrates the continued need for public education and familial education when a member is diagnosed with depression. While the point of this project is not to champion one discourse of depression over another, it is important to note that a number of participants shifted understandings of depression away from the DDS and towards the DDI after being exposed to courses in high school and college pertaining to mental illness. This information was regarded as a turning point for some participants in finally understanding their mother’s behavior. As such, education
pertaining to mental illness and the family should be enhanced in two primary ways. First, education about mental illness could and likely should be disseminated at an earlier age than in post-secondary school or be incorporated in larger part into pre-established courses on health and wellness currently offered. From a relational standpoint, information and education about mental illness should be dissemination to families after the diagnosis of a mental illness in a member. In particular, physicians might offer information to newly diagnosed individuals to provide to their family members.

Beyond the dissemination of information about depression, another important insight from the study was the overall lack of communication within the family about a mother’s depression. This lack of communication not only affected emerging adult’s abilities to construct understandings of depression as noted above, but also understandings of motherhood and their role in the family (e.g., parentification). Helping families learn to discuss mental illnesses and its effect on one’s ability to parent could open a number of positive communicative channels making it easier for children of parents with mental illness to understand the illness, their parent, and the illnesses effects on the parent and family at large.

Conclusion

In seeking to understand the complex meaning making processes that emerging adults discursively navigate when constructing understandings of motherhood and depression, this study provides a valuable starting point for examining the nexus of family and health communication. The complex understandings of, and new meanings of, motherhood demonstrate emerging adults’ abilities to construct understandings of motherhood as they sit in relation to dominant cultural ideologies. In addition, the study
provides insight into the complex meaning making processes emerging adults engage in when constructing understandings of depression. Perhaps more importantly, the study provides evidence of the importance of examining the intersection of these understandings of the family and understandings of illness. The addition of a critical lens to each exploration demonstrates the importance of understanding this nexus as it sits in relation to our culture at large.
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APPENDIX A

INTERVIEW PROTOCOL

Date of Interview: ______________________

Start time: ______7:53___________________

Stop time: __________________________

Introduction and purpose

First, I wanted to thank you for agreeing to be a part of my project by talking with me about your experiences with maternal depression and what they mean to you. I am conducting this interview as a part of my dissertation project for a Ph.D. in Communication Studies at the University of Denver. I am interested in learning more about the overall experiences of families who navigate the experience of mental illness. For this project I am specifically interested in learning about how you as an emerging adult experienced your mother’s depression. Since I will be asking you to share personal experiences I thought it only fair to share a little information about me before we begin the interview to give you an idea of who I am and why I think this study is important.

My interest in mental illness essentially came about from interactions with my family and friends. Though my mother does not have depression, my father has been diagnosed with depression/anxiety for most of my life so discussions of what that means for our family are fairly common among my siblings, parents, and I. Growing up with a Dad with depression for me meant that my oldest brother would sometimes have to take care of instead of my dad if my mom was going to be gone for some reason. Sometimes we had to give my dad extra space or avoid him if he was feeling particularly anxious or sad. Sometimes trips we had planned would have to be cancelled at the last minute.

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because he would feel like he could not leave our family farm. It is important to note though that with the struggles of his depression also came some good. Over the years my father began seeking help for his depression/anxiety and through that process was able to grow closer to my brothers and I probably in a way that we would not have grown had we not gone through those situations. He was even excited to hear that I would be talking about his experience briefly with you during my interview collection process.

In addition to my father, one of my closest friends was diagnosed with severe depression during the last year of our undergrad. Despite the diagnosis, her family was unsure how to go about supporting her or addressing her illness. When her illness became too dangerous for her to handle on her own, I called her family and requested they take a bigger role in supporting her. Throughout both of these contexts, I realized how different families could be in their approaches to mental illness. These approaches weren’t right or wrong of course, but certainly had the power to affect the family and its members. So, I knew that learning about families and mental illness might eventually help me develop materials for best practices for them should they have to face the illness with little knowledge about how to proceed.

In addition to these experiences, I am also interested in mothers in particular based on some of my prior work here at DU. Since I started my program here three years ago I have consistently found myself circling around understandings of motherhood and motherhood in different forms. I have done a few projects that look at foster adoptive mothers and am working on a project about couples with infertility who want to become mothers and fathers. These projects examine more nontraditional or understudied experiences of motherhood in terms of how one becomes a mother. However, I thought
what was just as absent from research beyond different ways of forming families are those unique experiences of motherhood such as motherhood and depression. I will also say that research that takes into account a child’s perspective, rather than simply a child’s outcomes, are absent from research and especially research on mothers and mental illness. So, I really appreciate your willingness to share your stories with me today as I try to shed some light both on maternal depression and on what the experience is like for family members and specifically for children.

I wanted to share my story with you so that you know that even though I do not know what it is like to have a mother with depression or what it is like to have depression myself, I do know what it is like to be in a family with someone who has mental illness and can hopefully empathize with your experiences. I hope that you can speak freely with me and know that I am not expecting you to share anything that you are uncomfortable sharing. Also, if you want to skip a question or come back to a question just let me know. We can always take a break if you need one or if you are just feeling like you would like to stop the interview altogether. I have the sheet of questions and the audio recorder, but this is really about your experiences and the chance for me to have a conversation with you about it!

You have read and understand the informed consent? Do you have any questions I can answer before we begin? You have volunteered to participate in this project as an individual who identifies as someone who has a mother diagnosed with depression within the last five years, correct? You are over the age of 18 years? Would you feel comfortable with me audio recording this interview and occasionally jotting down notes? Please know that all information shared in this interview is confidential and cannot be
traced back to you. Once our interview is complete the recording will be transcribed and your information will not be attached to the recording or the transcript in any way. Any names, places, titles, etc. that you discuss in the interview will be swapped out for a pseudonyms during transcription so no identifying information in any way will be used in any papers written for the dissertation. Are you ready to begin?

**Interview questions**

1) I want to start by having you tell me a little bit about your family. Siblings? Hobbies?

2) In a similar way, tell me a bit of an overarching framework of your mother’s depression.

   Probe: Is there a time frame you can think of for your family and your mother’s depression?

   Probe: How old were you when you found out?

   Probe: How long has this been a part of your family story?

   Probe: Is this something still affecting your family today or more of an episode in the past?

3) Prior to your mother’s diagnosis what were your understandings of depression?

   Probe: Did you have a clear theory on its cause?

   Probe: Did you have a clear idea of how it should be treated?

   Probe: Do you think your family in general had any opinions about depression and its causes or best practices for treatments?

4) Let’s talk about the conversation or event during which you found out your mother had depression. Can you tell me the story of discovering or being told about it?

   Probe: At what point in your mother’s illness did you find out?
Probe: How did you find out?

Probe: What was your initial reaction when you found out?

Probe: Did you voice any concerns or questions about it at the time?

Probe: Did you express any feelings or thoughts to your relative?

5) If you had to describe to someone today what depression is how would you describe it?

6) An important aspect of this study is understanding depression specifically in the context of motherhood. Prior to your mother’s depression, how would you describe the role of motherhood? What constitutes being a mom?

Probe: Did your mother meet your definition of motherhood while she was depressed?

Probe: If not, how did you manage that divide between what you thought a mom should be and what was actually happening with your mom?

Probe: Has your understanding of the role of mother changed at all over the course of your mother’s depression?

7) Let’s talk about your relationship with your mom. How, if at all, did your relationship with her change?

Probe: Did the way you spoke to her or the way she spoke to you change?

Probe: Did you change any of your routines or activities?

8) Did you ever experience confusion about your relationship with your mother or find that you had to renegotiate your relationship with her?

Probe: What were you confused about? What aspects needed to be renegotiated?

Probe: Did you resolve the confusion? If yes, how?
9) Did you ever feel like you couldn't be honest with your mom or act a way you normally would have because of her illness?

    Probe: What sorts of changes in interactions or communication did you perceive?
    Probe: How if at all did this change your perception of your mom or your relationship with her?

10) Sometimes when individuals go through major transitions that may change their identities temporarily or permanently. Past research on family members and depression show that individuals sometimes feel like they've somewhat lost their family member. Did you ever feel like you had lost your mother?

    Probe: Were there particular parts of your mother that seemed to be lost or just an overall feeling?
    Probe: Did you think that who your mother was before might come back if the depression went away or did you perceive it as a more fundamental shift?
    Probe: Were you able to communicate those feelings of loss with anyone?
    Probe: How did you explain them to others or how did you explain them to yourself?

11) If you had to describe to someone today the meaning of motherhood or what it means to be a mom how would you describe it?

    Probe: Do you think depression has colored this understanding?

12) Did you ever speak with your mother about her depression?

    Probe: Who usually brought it up?
    Probe: What was discussed?
    Probe: Did you find the conversations helpful in understanding the situation?
13) Did you ever speak to other family members about your mother’s illness?

   Probe: Who usually brought it up?

   Probe: What was discussed?

   Probe: Did they ever share their feelings about the relative?

   Probe: Did you find the conversations helpful in understanding the situation?

14) Did you ever speak to people outside of your family about it?

   Probe: How did you describe the experience to them?

   Probe: Did you talk about the experience differently than you did when discussing it with your family? If so, how?

15) How would you describe your family’s reaction overall to your mother’s depression?

16) What do you think are the biggest challenges facing emerging adults with mothers with depression?

17) Do you think your family did anything particularly well or particularly not well in regards to your mother’s mental illness?

   Probe: What sorts of advice might you give to family members with a mother with depression?

   Probe: Do you see your family handling those not well aspects differently?

18) What do you think are the biggest challenges facing families with mothers with depression?

   Probe: What did you do to manage those challenges?

19) Are there any bright sides to your experience? So, for instance, can you think of any positive outcomes from the experience?

   Probe: Positive outcomes for yourself?
Probe: Positive outcomes for your relationship with your mom?

Probe: Positive outcomes for relationships within your family?

Probe: Positive outcomes for your family as a whole?

20) What advice might you give to other people in your situation?

21) Can you think of any questions that I did not ask that might illuminate your experience more?

Probe: Were there any parts of the experience that you are surprised we did not discuss?

Probe: Were there any parts of your experience you think are important to be included?

Your Sex

___ female

___ male

___ other___________

What is your race/ethnicity?

_____ Black/Non-Hispanic  _____ White/Non-Hispanic

_____ Hispanic  _____ Asian or Pacific Islander

_____ American Indian  _____ Middle Eastern

_____ Other ________________

Your age ___

How old were you at the time of your mother’s diagnosis? ___

Duration of mother’s depression: ___
Dear Friends,

I am conducting a study on emerging adults’ reported experiences of maternal depression. The study includes participating in interviews and discussing the experience of having a mother with depression. I am currently looking for individuals aged 18-25 who report having a mother with current or former clinically diagnosed major depression. Participants may be living at home or apart from their mothers and do not need to currently be in contact with them but should have been at some point during their mother’s depression. If you do not qualify but are willing, please share the announcement with anyone you feel comfortable with via email and/or post the announcement as your status through Facebook.

**Study Announcement:**

If you are between the ages of 18-25 and report having a mother with current or former clinically diagnosed major depression, please consider participating in a study conducted by Leah Seurer, a doctoral candidate in the Department of Communication Studies at the University of Denver. The study is being supervised by Dr. Elizabeth Suter, an Associate Professor in the Department of Communication Studies at the University of Denver.

I am conducting a study on emerging adults’ reported experiences of maternal depression. The study includes participating in an interview to discuss the experience of having a mother with depression. I am currently looking for individuals aged 18-25 who report having a mother with current or former clinically diagnosed major depression.
Participating in this study will involve one-on-one interviews with me and last anywhere from 30 to 90 minutes. The interview can take place on campus at the University of Denver or at a location of your choosing in the Denver metro area. All personal information will be kept confidential. Interview will be recorded. All recorded conversations will be kept in a password protected audio file. All personal identifiers will be removed from the data during transcription and kept in a password-protected file. If you would like to participate or would like further information about the study please contact me at lseurer@gmail.com or via cell at 605-216-4922. If you do not qualify but are willing, please share the announcement with anyone you feel comfortable with via email and/or post the announcement as your status through Facebook.

Thank you for your assistance in spreading the word!

Best,

Leah
APPENDIX C

EMAIL TO ALLIANCE ORGANIZATIONS

To whom it may concern:

My name is Leah Seurer and I am a doctoral candidate in the Communication Studies department at the University of Denver specializing in Family Communication. I found your contact information on the (organization) website as the point of contact and am hoping you don't mind my inquiry! I am currently seeking participants for my dissertation project.

I am conducting my dissertation on emerging adults’ (young adults aged 18-25) experiences of having a mother with major depression. I am currently looking for individuals between the ages of 18-25 who report having a mother with current or former clinically diagnosed major depression. I am writing to see if any of your facilitators would be willing to meet with me to discuss the possibility of disseminating information about my study to them.

Participating in this study will involve one-on-one interviews with me and last approximately 60-90 minutes. The interview involves sharing stories and experiences related to emerging adults’ experiences of having a mother with depression, how they have come to understand depression, and how the illness has impacted their family (including positively as this is sorely missing from current research!). The interviews will be conducted at a location of participant choosing or on campus at the University of Denver in the Communication Studies department. Participants would be compensated with a $30 gift card for participating. All information from the interviews would be
confidential. The University of Denver’s Institutional Review Board has approved the study.

I would be happy to share additional information about the study or answer any potential questions you have. Please feel free to contact me at lseurer@gmail.com or 605-216-4922 if you would like additional information such as the interview protocol, informed consent, IRB approval letter, etc. Thank you for your consideration! This study is being conducted under the supervision of Dr. Elizabeth Suter, an associate professor in the Department of Communication Studies at the University of Denver.

Thank you for your time and for all that you do!

Best,

Leah M. Seurer, M.A.

Department of Communication Studies

200 Sturm Hall

2000 E. Asbury Avenue

University of Denver

Denver, CO 80208
To whom it may concern:

My name is Leah Seurer and I am a doctoral student at the University of Denver currently seeking participants for my dissertation. This study is being conducted under the supervision of Dr. Elizabeth Suter, an associate professor in the Department of Communication Studies at the University of Denver. I am conducting a study on emerging adults’ experiences of maternal depression. I am currently looking for individuals aged 18-25 who report having a mother with current or former clinically diagnosed major depression. Participants may be living at home or apart from their mothers and do not need to currently be in contact with them but should have been in contact with them at during their mother’s depression. The University of Denver’s Institutional Review Board has approved the study.

The goal of the proposed study is to understand how emerging adults come to understand what depression is how their mother’s depression shaped their understandings of the illness along with their understanding of what it means to be a mother. The interview would last approximately 60 minutes. All information from the interviews would be confidential. I am writing to see if any of your facilitators would be willing to meet with me to discuss the possibility of recruiting family members currently utilizing your services. I would be happy to share additional information about the study or answer any potential questions you have. Please feel free to contact me at lseurer@gmail.com, 605-216-4922 if you would like this additional information. Thank you for your consideration!
APPENDIX E

UNIVERSITY OF DENVER STUDY ANNOUNCEMENT

Leah Seurer, a doctoral candidate at the University of Denver is conducting a study on emerging adults’ experiences of maternal depression. This study is being conducted under the supervision of Dr. Elizabeth Suter, an associate professor in the Department of Communication Studies at the University of Denver. I am currently looking for individuals aged 18-25 who report having a mother with current or former clinically diagnosed major depression. Participants may be living at home or apart from their mothers and do not need to currently be in contact with them but should have been in contact with them at during their mother’s depression.

Participating in this study will involve one-on-one interviews with me and last anywhere from 30 to 90 minutes. The interview can take place on campus at the University of Denver or at a location of your choosing in the Denver metro area. If you are not in the Denver metro area but would like to participate a phone interview can be set up at a convenient time. All personal information will be kept confidential. The Institutional Review Board at the University of Denver has approved the study.

If you would like to participate or would like further information about the study please contact me at lseurer@gmail.com or via cell at 605-216-4922.

Thank you!
Dear (Participant Name)

Thank you for contacting me and for your interest in the study! Before we set up a day and time for the interview, I do like to make sure that participants have a clear idea about the participant criteria and time commitment for the interview. As noted on your study announcement, to be eligible for the study you must be between 18 and 25 years old and have a mother with former or currently diagnosed major depression. You do not need to provide any official documentation to demonstrate your mother’s diagnosis but I do ask that you be able to communicate with me about how you came to know about your mother’s depression. In other words, if you have never been informed that your mother has depression but assume she has it you would not qualify for the study. You would need to have been told either by your mother or a member of your family. If you are unsure just let me know and we can talk it through.

I am attaching the official informed consent for you in this email. The informed consent is a detailed description of the study, risks, steps to protect confidentiality, etc. You are welcome to look over it and ask any questions you may have!

Best,

Leah M. Seurer
APPENDIX G

INFORMED CONSENT

Approval Date: 6/26/14

Valid for Use Through: 6/26/19

Project Title: Discursive constructions of the meaning of maternal depression and motherhood in emerging adults’ narratives of maternal depression

Principal Investigator: Leah Seurer

Faculty Sponsor: Dr. Elizabeth Suter

DU IRB Protocol #: 614022-1

You are being asked to be in a research study. This form provides you with information about the study. Please read the information below and ask questions about anything you don’t understand before deciding whether or not to take part.

Invitation to participate in a research study

You are invited to participate in a research study about emerging adults’ (young adults aged 18-25) experiences of having a mother with depression. The study seeks to understand the experiences of being an adult child of a mother with depression.

You are being asked to be in this research study because you have self-identified as being between the ages of 18-25 with a mother with former or current clinically diagnosed depression.

Description of subject involvement
If you agree to be part of the research study, you will be asked to participate in a one-on-one interview with the primary researchers. The interview will take approximately 60-90 minutes.

Possible risks and discomforts

The researcher has taken steps to minimize the risks of this study. Even so, you may still experience some risks related to your participation, even when the researcher is careful to avoid them. As part of the interview, you will be asked to recall specific events, conversations, and experiences relating to your mother’s depression. You may experience psychological discomfort when recalling these details. You do not have to answer any questions you do not feel comfortable answering. In addition, you can stop participating at any time or take a break from answering questions if needed. If you experience psychological discomfort, you may wish to speak to with a mental healthcare provider. DU’s Health and Counseling Center provides 24-hour support and can be contacted at 303-871-2205 or through their website at:

http://www.du.edu/health-and-counseling-center/aboutus/hours-location-parking.html

You may wish to speak with a mental healthcare provider outside of campus. The Colorado Department of Human Services provides a list of Community Mental Health Centers on their website:


Before the interview begins, the primary research will provide you with a list of these mental healthcare providers on the campus of the University of Denver and in the
Denver metro area. If you choose to be interviewed in the Communication Studies department conference room on the University of Denver campus, others may identify you as participating in a study on maternal depression. Steps will be taken to maximize your privacy. If you would like to be interviewed in the conference room but would not like to be identified you may simply tell staff upon arrival that you have a meeting with Leah Seurer. The primary researcher will not discuss the nature of the meeting with the administrative staff or faculty. You are also welcome to select another location on the University of Denver’s campus or within a drivable distance of Denver. The study may include risks that are unknown at this time.

A breech in confidentiality is a possible risk if the primary investigators’ password-protected laptop or audio recording device were to be stolen. However, the primary investigator will take steps to minimize this risk.

**What happens if I am injured or hurt during the study?**

The University has no plan to pay for physical or psychological injury. If you experience distress, you may choose to contact one of the healthcare providers listed on the resource sheet provided at the start of the interview and listed on this form.

**Possible benefits of the study**

This study is designed for the researcher to learn more about how emerging adults and their families navigate the experience of their mother’s depression. In addition, the study seeks to understand how emerging adults and their family makes sense of depression and their mother throughout the experience.

You may benefit from being in this study in being allowed to share some of the stories of your experiences relating to your mother’s depression. In sharing your story
and answering the questions posed by the researcher, the interview may also give you the opportunity to think about your experiences in new ways or bring additional insight. In addition, information gathered in this study will help us understand how emerging adults and families handle the diagnosis and maintenance of their mother’s depression. Therefore, your interview will be integral in developing beneficial, educational material for families in the future that are learning to navigate the experience of having a mother with depression.

**Study compensation**

If you are currently enrolled in a course at the University of Denver and choose to participate in the study, there may be an option to receive extra credit by participating in the research. This extra credit is not guaranteed and is dependent upon your instructor. In addition, you will receive a $30 Amazon gift card for your participation. If you begin the interview but are unable or would not like to finish the interview you will still be compensated the $30 for your time.

**Study cost**

As an interview participant, you will be expected to pay for your own transportation, parking, or childcare, if needed. The primary researcher will try to minimize these costs by setting up the interview at a convenient location and time.

**Confidentiality, Storage and future use of data**

The primary researcher and a professional transcriptionist will be the only individuals with access to the interview data. After interviews are complete, the primary researcher will immediately download the audio files onto a password-protected
computer and place them in a password-protected folder. In the case that the audio files cannot be immediately downloaded onto a password-protected computer, they will be kept in a locked office. After ensuring the audio files are downloaded and protected, they will be deleted permanently from the audio recorder used in the interview. The audio files will be sent to the transcriptionist who will sign a confidentiality waiver that states s/he will keep all information confidential. S/he will also keep the files password protected. During transcription of the data, any personal identifier such as names, dates or places will be replaced. Once the data have been transcribed the audio files will be erased.

Transcribed interviews will be saved as password-protected files on a password-protected computer. Demographic data will also be stored in a password-protected file on a password-protected computer.

The data will be saved until the primary researcher has completed the analyses and write ups of the study. The data will not be made available to other researchers for other studies following the completion of the current study. Results from this research may be shared at professional research conferences and/or published in journal articles. Any remaining information pertaining to participants’ identities will be kept private when information is presented at conferences or published in academic journals.

**Who will see my research information?**

Although we will do everything we can to keep your records a secret, confidentiality cannot be guaranteed because others, including federal agencies that monitor human subject research and the Human Subject Research Committee, may look at records that identify you and the consent form signed by you. All of these people are required to keep your identity confidential. Otherwise, records that identify you will be
available only to people working on the study, unless you give permission for other
people to see the records.

Also, if you tell us something that makes us believe that you or others have been
or may be physically harmed, we may report that information to the appropriate agencies.
If you tell us you are going to physically hurt yourself or someone else, we have to report
that to the state police or other agency. Also, if we get a court order to turn over your
study records, we will have to do that.

**Voluntary Nature of the Study**

Participating in this study is completely voluntary. Even if you decide to
participate now, you may change your mind and stop at any time. If you decide to
withdraw early the information or data you provided will be destroyed. If you withdraw
early from the interview we will ask if we may use any of your responses. If you choose
for us to not use the information, we will destroy it. If you withdraw early from the
interview you will still be compensated with the $30 Amazon gift card for your time.

**Contact Information**

The researcher carrying out this study is Leah Seurer. You may ask any questions
you have now. If you have questions later, you may call Leah Seurer at 605-216-4922.
The research is supervised by Dr. Elizabeth Suter who can be reached at esuter@du.edu.

If the researchers cannot be reached, or if you would like to talk to someone other
than the researcher(s) about; (1) questions, concerns or complaints regarding this study,
(2) research participant rights, (3) research-related injuries, or (4) other human subjects
issues, please contact Paul Olk, Chair, Institutional Review Board for the Protection of
Human Subjects, at 303-871-4531, or you may contact the Office for Research
Compliance by emailing du-irb@du.edu, calling 303-871-4050 or in writing (University of Denver, Office of Research and Sponsored Programs, 2199 S. University Blvd., Denver, CO 80208-2121).

**Agreement to be in this study**

_______ I have read this paper about the study or it was read to me. I understand the possible risks and benefits of this study. I know that being in this study is voluntary. I choose to be in this study: I will get a copy of this consent form. Please click/check this box if you agree.

_______ I give the researchers permission to audio record my interview to assist them with accurately obtaining my responses. Please click/check this box if you agree to be recorded.
APPENDIX H

MENTAL HEALTH RESOURCE

On Campus Resource:

DU Health and Counseling Center
2240 E Buchtel Blvd
Denver, CO 80208
Phone: 303-871-2205
After hours mental health problems: 303-871-3000
General email: info@hcc.du.edu

http://www.du.edu/health-and-counseling-center/aboutus/hours-location-parking.html

Denver Metro Resources

Colorado Crisis Services
24-hour support line: 1-844-493-8255
http://coloradocrisisservices.org

Walk-in Center Locations
2551 W 84th Avenue Westminster, CO 80031
12055 W. 2nd Place Lakewood, CO 80228
6509 S. Santa Fe Drive Littleton, CO 80120
2206 Victor Street Aurora, CO 80045
791 Chambers Road Aurora, CO 80011 7a.m.-11p.m.
1000 Alpine Avenue (West Entrance) Boulder, CO 80304
4353 E. Colfax Avenue Denver, CO 80220
APPENDIX I

TRANSCRIPTIONIST CONFIDENTIALITY STATEMENT

I, ______________________________ transcriptionist, agree to maintain full confidentiality in regards to any and all audio recordings and documentations received from Leah Seurer related to their research study on maternal depression. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-recorded interviews or in any associated documents. I understand that to violate this agreement would constitute a serious and unethical infringement on the participants’ right to privacy.

2. To not make copies of any audio recordings or computerized files of the transcribed interview texts, unless specifically requested to do so by one of the researchers.

3. To store all study-related audio recordings and materials in a safe, secure location as long as they are in my possession.

4. To return all audio recordings and study-related materials to Erin Willer in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any back-up devices.

Transcriber’s name (printed)

________________________________________________

Transcriber's signature __________________________________________________

Date _____________________________________________
APPENDIX J
IRB APPROVAL LETTER

DATE: June 26, 2014
TO: Leah Seurer, MA
FROM: University of Denver (DU) IRB
PROJECT TITLE: [614022-1] Discursive constructions of the meaning of depression and motherhood in emerging adults' narratives of maternal depression
SUBMISSION TYPE: New Project
ACTION: APPROVED
APPROVAL DATE: June 26, 2014
EXPIRATION DATE: June 26, 2015
REVIEW TYPE: Expedited Review
REVIEW CATEGORY: Expedited review category # 7

Thank you for your submission of New Project materials for this project. The University of Denver (DU) IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this committee.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of June 26, 2015.

Please note that all research records must be retained for a minimum of three years after the completion of the project.