

An Exploration of University Students' Experiences with Depression

By

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Abstract

This thesis explores how university students have experienced depression during their life in an attempt to develop a greater understanding of current mental health issues. Links between depression and schooling were also investigated in addition to factors which influence depression.

The study employed a phenomenographical research approach. Semi-structured interviews, field notes, and document analysis were the three forms of data collection. Interview participants were seven university students (19-25 years of age) who had a self-declared form of depression. They partook in an hour-long interview directed by a semi-structured interview guide. The data from all sources was organized into an outcome space to display the categories of description which illustrate a number of ways in which university students experience depression.

Findings showed that internal feelings and perceptions, environmental circumstances, family interactions, perceptions of others, positive processes, relationships, interactions at school, accessibility to aid, and mental health awareness were all prominent descriptive categories which the participants discussed in the study. Experiences could also be grouped into internally guided experiences, externally guided experiences, or mutually guided experiences. From connections between the findings and construction of an outcome space, a discussion regarding implications was composed to better understand the human experience of depression and what information might be useful in aiding initiatives to support those with depression.

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Table of Contents

Dedication.....	i
Abstract.....	ii
Acknowledgements.....	iii
Table of Contents.....	iv
List of Tables.....	vii
List of Figures.....	viii
Chapter One: Introduction.....	1
Statement of the problem.....	1
Research Questions.....	3
Definition of Terms.....	3
Educational research terms.....	3
Mental health terms.....	5
Personal Ground.....	6
Summary.....	7
Chapter Two: Literature Review	8
Introduction.....	8
Mental Health Literacy and Education.....	8
Perceptions of Individuals.....	11
Interactions with Others.....	13
Online Social Networking.....	19
Stigma.....	20
Summary.....	22

Chapter Three: Research Design and Methodology.....	24
Methodology.....	24
Research Methods.....	27
Participants.....	27
Recruitment and Consent.....	27
Data Collection.....	28
Data Analysis.....	29
Organization of the Data.....	29
Data Analysis Methods.....	30
Ethical Considerations.....	36
Summary.....	36
Chapter Four: Summary and Discussion of Findings.....	37
Participant Profiles.....	37
Findings.....	39
Internally Guided Experiences.....	40
Feelings.....	40
Internal Perceptions.....	42
Externally Guided Experiences.....	46
Environmental Circumstances.....	46
Family.....	50
External Perceptions.....	54
Mutually Guided Experiences.....	58
Positive Processes.....	58

Relationships.....	66
School Interactions.....	68
Accessibility and Awareness.....	76
Summary.....	82
The Outcome Space.....	83
Chapter Five: Discussion of Findings and Conclusion.....	86
Restatement of the Problem.....	86
Discussion of Findings from the Outcome Space.....	86
Implications for Positive Outcomes.....	87
Implications for Healthcare Practitioners.....	89
Implications for School Practitioners.....	89
Implications for Post-Secondary Institutions.....	92
Implications for Online Social Media Education.....	92
Implications for Future Research.....	93
The Research Questions Revisited.....	94
Limitations to the Study.....	97
Personal Reflections.....	98
Conclusion.....	99
References.....	101
Appendices.....	110

List of Tables

Table 1. Tabulated depiction of the outcome space.....	33
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List of Figures

Figure 1. Venn diagram of major predominant constructs	40
Figure 2. The outcome space of university students' experiences with depression.....	84

Chapter One: Introduction

Statement of the Problem

Mental health is an ever-growing concern in our society, especially with regards to youth. Today, one in five people deal with a mental illness at some point in their life, with 15 to 24 being the most susceptible age group (Canadian Mental Health Association, 2013; Center for Addiction and Mental Health, 2012). Depression affects roughly 12 percent of the Canadian populous and puts these individuals at an increased risk of suicide; the second leading cause of death in youth ages 15 to 24 (Birmaher & Brent, 2007; Canadian Mental Health Association, 2013). Since depression is dependent on personal and environmental factors, investigation into the experiential aspects of the disorder could prove useful in streamlining mental health initiatives and saving lives.

Learning about the different ways that youth experience depression would be useful to mental health experts, teachers, parents and medical professionals. Providing appropriate and effective education about the various disorders to students may also contribute to mental health literacy and heightened metacognition about their own mental health state. By understanding the variety of ways in which the disease manifests among individuals between the ages of 15 to 24, this age group may become better prepared to seek and utilize help for themselves or others. For example, if there are commonalities in the difficulties that depressed individuals face, then the various initiatives to educate this demographic and their supporters can be shaped to attend to these familiarities. Mental health education programs and initiatives may be streamlined and articulated to better suit a younger demographic.

Since depression is influenced by environmental factors, I want to explore the impact that school settings have on depression. There are countless ways in which a student can be affected

by school life. Social interactions, academic standings, behaviour issues, and extracurricular activities are examples of instances where an adolescent can be mentally impacted; implications should be acknowledged. Furthermore, depression is the most prominent reason for students to seek counselling at university healthcare facilities (Khawaja, Santos, Habibi, & Smith, 2013; Pledge, Lapan, Heppner, Kivlighan, & Roehlke, 1998; Voelker, 2003) making it an extremely important issue to healthcare professionals at the post-secondary level. Forms of aid from the institution, such as learning accommodations, are also not a completely 'black and white' area and there is still a need to address methods for helping students face adversity (Csoli & Gallagher, 2012; Souma, Rickerson, & Burgstahler, 2002). The experience of teens and young adults in school has co-evolved in a number of different areas: variations to the education system, curriculum alterations, teaching strategies, disciplinary measures, advances in technology and so on, are some contributing aspects. The implication of our evolving society on depression needs to be researched in order to maintain a current understanding. Links between depression and aspects of life can be uncovered to aid school administrators and teachers in their efforts to support students with depression.

Examining the experience of depression may increase the understanding of how the disorder is recognized and understood. Misconceptions, stigma and uncertainty of treatment options are major barriers that prevent the acknowledgement of depression and help-seeking actions. They represent significant factors pertaining to why depression has been so prevalent, but hidden at the same time. By identifying thoughts and perceptions of people with depression, methods may be found that dissolve barriers and open routes to engage in recovery. By addressing stigma and misconceptions as early as possible, young individuals can become better equipped for an onset of depression.

Research Questions

To inquire into this issue, the following research questions were posed:

1. How do youth experience depression? This research question was chosen as a very broad inquisition on how students experience depression, as there is likely a wealth of different contributions to an individual's experience which result in different implications.
2. How does school affect a student with depression? This question was chosen in order to inquire what particular elements of the education system were of interest, which were positive areas, and which areas could be improved upon.
3. What factors are instrumental in influencing the illness? This question entails looking at constructive and unfavourable contributions to the experience of depression as a whole in order to develop ideas which aid in alleviating negative experiences.

Definition of Terms

Educational research terms.

Adolescent. According to the Government of Ontario (2013), an adolescent is designated as a person between 13 and 18 years of age.

Bracketing. According Sandbergh (1997) bracketing is the process where the researcher holds back his/her known theories and prejudices in order to be fully and freshly present to the individuals' conceptions under investigation" (p. 209).

Category of description. As summarized by Ayene (2011), categories of description represent the variation in ways of depicting the phenomenon under investigation at the collective level (p. 3).

Externally guided experiences. In this study, externally guided experiences refer to experiences which are influenced or directed by other people around the participant with depression.

Internally guided experiences. In this study, internally guided experiences refer to experiences which were governed by personal factors, such as feelings or thoughts, within the individual who is experiencing the depression.

Meaning unit. According to Reed (2006), a meaning unit is a decontextualized fragment from interview data that refers to an experience of the phenomenon in question (p .8).

Mutually guided experiences. In this study, mutually guided experiences will refer to those that involve aspects of internally and externally guided experiences. They are directed by bodies and events surrounding the individual with depression, and the thoughts and feelings which the individual carries alongside these external stimuli.

Outcome space. According to Åkerlind (2005), the outcome space is a visual representation of viewing a collective human experience of a phenomenon holistically through an organization of the categories of description (p. 323).

Pool of meaning. As defined by Reed (2006), the pool of meaning is a collection of meaning units, and shows the different decontextualized ways in which the phenomenon in question was experienced (p. 7).

Keywords in context (KIC). According to Leech and Onwuegbuzie (2007), keywords in context analysis is a method of analysis for qualitative research that analyzes how respondents utilize specific words (p. 566).

Phenomenography. As defined by Marton (1986), phenomenography is a research specialization that aims to map the qualitatively different ways in which people experience,

conceptualize, perceive and understand various aspects of various phenomena in the world around them” (p. 31).

Youth. In this study, the term youth will refer to an individual between the ages of 19 to 24 years of age. The term is used to describe various age groupings across numerous contexts, which has made it a loosely ambiguous term. However, this standardized definition will be used for this study to maintain specificity and reduce ambiguity.

Mental health terms.

Bipolar disorders. Bipolar disorders, as defined by The Diagnostic and Statistical Handbook for Mental Disorders (DSM-V) (American Psychiatric Association, 2013), are a class of mental disorders which includes bipolar disorder I, bipolar disorder II, cyclothymic disorder, and substance/medication induced bipolar. Characteristics of this disorder include alternating periods of mania and depression, unusual sleeping patterns, and abnormal social functioning.

Cognitive-behavioural therapy. Cognitive-behavioural therapy, according to Jackson et al. (2009), seeks to improve functioning and emotional well-being by identifying the beliefs, feelings, and behaviours associated with psychological disturbance, and revising them through critical analysis and experiential exploration to be consistent with desired outcomes and positive life goals.

Depression. The term depression, as defined by the Diagnostic and Statistical Handbook for Mental Disorders (DSM-V) (American Psychiatric Association, 2013), encompasses two types of mood disorders: depressive disorders and bipolar disorders.

Depressive Disorders. Depressive disorders, as defined by The Diagnostic and Statistical Handbook for Mental Disorders (DSM-V)(American Psychiatric Association, 2013), are a class of mental disorders which includes disruptive mood dysregulation disorder, major depressive

disorder, persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder. Symptoms of these disorders include “the presence of a sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function.” (p. 155). Timing, duration, and presumed etymology differ between the various forms of depressive disorders.

Health Literacy. Health Literacy, as defined by Nutbeam (1993), is the ability to gain access to, understand, and use information in ways that promote good health.

Public Stigma. According to Corrigan (2004), public stigma is a result of the stigmatization of a minority group due to endorsement of public prejudice and naivety.

Self-Stigma. According to Corrigan (2004), self-stigma is the personal stigmatization of an individual as a result of the internally created perceived public prejudice.

Stigma. According to the Canadian Mental Health Association (2013), stigma is a negative stereotype about a minority group due to a particular characteristic.

Personal Ground

As I have grown up over the past seven years or so, I have learned many different things about life. I’ve experienced the “ups” and had the privilege of feeling and experiencing things that I am truly grateful for. Things that make life worth living, like a good family, a roof over my head, food on the table, and the opportunities to pursue my own interests. At the same time, I learned that life comes with its own set of “downs” as well. And as difficult as they might have been to overcome, I believe it’s the most difficult parts of life that truly build who a person is.

So through all of my own experiences in life, I feel as though there is one fundamental idea that led me to undertake this research project and this master's degree: that I wanted to do something good. I wanted to donate my own time and effort to do something that could pull a little bit of darkness away from some of the "downs" which life brings forth and do something that could potentially help someone else. And if the work I do leads to something that results in even just one person finding some alleviation from depression for any amount of time, then I've accomplished what I set out to do.

Depression is an ugly thing, and I have seen it hurt too many people in this world. For that reason, along with my own desire to do some good, I decided to start looking into this field. As I move forward as an educator, I want to be as best prepared and knowledgeable as I can be to help others in this area and provide a contribution to the field. Words cannot do justice in describing the motivation and passion which I have for this topic. This thesis and research is where I decided to start, and I hope everything that I have gained here will help me with wherever my life decides to take me.

Summary

This chapter has given an overview of this thesis by identifying the problem at hand, defined the research question and related terms, as well as illustrated personal ground. The following work is based on the information presented in this chapter.

Chapter Two: Literature Review

Introduction

There are many different aspects that affect how a young person experiences depression. An examination of the literature reveals that much is known about depression in terms of adults, yet further investigation is still needed into the youth and adolescent perspective (Koplewicz, 2002; McCann, Lubman, & Clark, 2012; Wisdom & Green, 2004). This literature review will look at previous research done with regards to individuals within 15 to 24 years of age, and their experiences with depression. The ways in which a person thinks or interacts with the world may be impacted by ideas, knowledge, and perspectives that had surfaced throughout their lifetime. For this reason, the literature review will encompass research about both youth and adolescents, in order to gain perspective into understanding the multitude of ways which different individuals experience the phenomenon of depression at various points in their life and under different contexts. In the following sections, current themes which have arisen from past work regarding the experiences of youth and adolescents with depression will be presented. Such themes include mental health literacy and education, perceptions of individuals, interactions with others, online social networking and stigma.

Mental Health Literacy and Education

A young person's experience with depression has been found to be influenced by his or her existing knowledge base about the illness, as shown by a number of perspectives in the literature to be outlined in this section. This is known as mental health literacy. Health literate individuals are more knowledgeable towards identifying a disorder, and possibly know where to begin when seeking methods of relief and care (Swartz et al., 2010). In the early stages of adolescence, the level of mental health literacy within this age group tends to be weak, and

emergent stigmatizing attitudes are present (Hartman et al., 2013). A common problem with this young age group is that adolescents may not be aware of what depressive feelings are, or they may not be able to properly convey such feelings (Wilmshurst, 2005). Considering this, programs for enhancing mental health literacy could be put into place to help developing minds be conscious of depression as early as possible and equip students to be prepared for mental health related complications (Hartman et al., 2013). A study done by Hess et al. (2004) regarding the degree of mental health literacy in high school students found that a cursory knowledge of facts on depression exists within this demographic. However, the students showed gaps in their understanding of treatment methods and identifying symptoms. An incomplete understanding is problematic, and may only be helpful to a certain extent.

Mental health literate individuals have been found to “speak up” for themselves and their peers than less literate ones when addressing the issues of depression. Such results were determined in a study conducted by Ruble (2013), which assessed the correlation between literacy and treatment seeking measures. In addition, knowledgeable adolescents are more likely to present the problem to teachers rather than their friends, whereas less literate adolescents would present to the latter. A paper by Hartman and colleagues (2013) outlines a number of essential points on the strategic benefits of presenting mental health literacy programs at an early age. Doing so will allow false conceptions or stereotypes to be extinguished as early as possible, and prepare children and youth for the age where they could be most vulnerable to mental illness (late adolescence and early youth) (Oster & Montgomery, 1995). In addition, it will help alleviate self-stigmatizing attitudes as early as possible, thereby reducing the reluctance for these individuals to speak up and seek proper help when needed. O’Shaughnessy and Corrigan (2007) found that educating others through the sharing of personal experience is an effective approach

to alleviating stigma and creating meaningful perceptions about mental illness. Taking into account the work of Macdonald et al. (2005), who demonstrated that the personal connection of like-diagnosed individuals is a positive tool for living with depression, sharing personal experiences with others as an intended method to educate could be a formidable approach. Therefore, the degree of mental health literacy will play a part in coping with depression and whether or not help seeking procedures are initiated.

The Ontario provincial government has identified mental health as a pressing issue in recent years. Supportive measures for children and adolescents at risk are in the early stages. Ontario's mental health and addictions strategy – titled *Open Minds, Healthy Minds* – seeks to improve community programs and knowledge for all individuals, and places a focus on helping children and adolescents over the first 3 years of the program (Government of Ontario, 2011). In regards to the education system, the Ontario Ministry of Education has implemented the *School Mental Health ASSIST* program to help school boards organize support for the mental health and well-being of students, build capacity related to mental health and addictions, as well as select and implement mental health programming and promotions (School Mental Health ASSIST, 2013). All school boards in Ontario have been equipped with a K-12 mental health resource guide, opportunities for Professional Learning centres for teachers, as well as specialized mental health workers and nurses (Ontario Ministry of Education, 2011). In addition, mental health leaders have also been funded within every school board throughout Ontario to lead initiatives to support students at a school level. At a post-secondary level, college and university campuses across Ontario provide students with health and wellness centres for support (Olding & Yip, 2014). The services provided may include a general practitioner or personal counsellor to help students deal with mental health problems. These centres often distribute health and wellness

newsletters through email, provide awareness campaigns, or arrange public talks to educate students on the importance of mental health.

Perceptions of Individuals

A number of qualitative studies on the experiential aspects of adolescent depression have been conducted, with personal views being a common ground. One of these studies was a recent investigation by McCann (2012) aimed to explore the experience of youth diagnosed with depression through field interviews. Four prevailing themes were identified, with three of them pertaining to personal perceptions. The first was a difficulty in understanding their situation and how they viewed themselves to fit in with other individuals the same age. Participants of the study felt unsure about what was happening to them, and attempted to make sense of their own unique situation. A second theme was a feeling of “life spiralling downward” (p. 337) alongside a sense of weakened mental and physical state. Participants possessed an overall sense that their quality of life was diminished, and would likely continue to deteriorate. Depression was an integral part of their lives, and was dealt with on a regular basis. The third theme was the contemplation of self-harm or suicide. The ideation of suicide appeared to arise as a solution to the problems and feelings brought on by depression.

Other qualitative studies have found some overlapping perceptions in depressed adolescents, such as Farmer (2002) and McCann (2012). Farmer (2002) not only uncovered the same three personal adolescent perceptions as McCann (2012), but found others in the process. A major commonality among interviewees was powerful and persistent anger, which was easily triggered by external stimuli and fluctuated with the level of depression. This anger was also found to lead to impulsive acts, such as lashing out against family or society. According to Edwards (2002), the origin of distress in the eyes of the depressed individual is a determining

factor for real depression and a temporary bout of sadness. Depressed individuals will place fault on themselves, while individuals who are feeling the human emotion of sadness will focus on outside factors. Anger is an emotion or facet of depression. From this, consideration needs to be made on whether this anger is self-directed as a result of depression or simply a natural human emotion.

At the same time, positive perceptions were also found. The process of talking to another individual about their situation –whether it be a parent, teacher, counsellor, or friend-- was found to be very beneficial for the participants (Farmer, 2002; McCarthy, Downes, & Sherman, 2008). Simply having a confidant with whom to listen and talk alleviated stress. It also helped them realize that depression is a common problem, being nothing to feel embarrassed or ashamed about. Some sufferers of depression even felt pride in themselves for overcoming it, and possessed an optimistic view for combatting the illness in the future.

Another study by Wisdom and Green (2004) uncovered some important personal perspectives about accepting depression, and focussed on what the interviewees thought about themselves after receiving a diagnosis. The development of their depression was described as a lengthy process, taking months to several years to reach a detrimental level. Interviewees believed that their depression was caused by current stressful situations and most could pinpoint a significant event that preceded their distress as a cause for their current condition. Some examples of specific triggering events included parental divorce or separation, experiences with abuse, and sickness or death associated with a loved one. This is consistent with findings by Farmer (2002), who found that parental breakups were a contributing factor to depression.

The teens under study described their depression in various ways, but most commonly as “being in a funk” (Wisdom & Green, 2004, p. 1232). After receiving their diagnosis, Wisdom

and Green learned that the participants responded to the diagnosis in three ways: they either accepted it as a part of their personal identity, as a medical problem, or as a label to help them towards recovery. The acceptance of depression as a medical problem and not a personal flaw or fault appears to be a very beneficial conclusion. If depression is viewed as a personal flaw, it may be very hard to seek treatment for some, as it is simple human nature to not want to admit or express one's own personal imperfections.

A common misconception that depression is not a medical illness and patients can “snap out of it” (p. 194) has been found in Canada (Wang & Lai, 2008, p. 194). Describing depression as a medical illness or biological factor is not common among groups of adolescents. Only a small portion of students in a study by Geddes (2008) described it in such a way. From these sources, this appears to be a detrimental belief about depression.

Interactions with Others

The interaction with other individuals – whether they are parents, friends, teachers, or peers – is another theme present in the experience of depression. Youth find that talking to a health professional created a strong, respectful, and helpful relationship (McCarthy et al., 2008; Zalaquett & Sanders, 2010). The relationship with parents was also found to be instrumental in providing support for initial treatment as well as continued mental support. Likewise, Macdonald Sauer, Howie, and Albiston (2005) found that parents and valued family members played a vital role by simply sticking with their offspring through the process and listening to what they had to say (Macdonald et al., 2005). These cases also discuss the role of support after a diagnosis. The onset of depression and pre-diagnosis phase has been seen to proceed differently. Some individuals do not want to be seen as “crazy” (p. 951), a burden, or singled out to the adults in their life (Draucker, 2005). The lack of clear communication between the two parties due to

reluctance to discuss the matter can create a social barrier. Ignorance or avoidance of the problem appears to be extremely detrimental in preventing the youth or adolescent from reaching proper treatment options. Providing them with a welcoming incentive to talk and emotionally express themselves is proven to be the first step in pursuing mental well-being. When considering that relief from depression was found from talking with others, concealing or suppressing the condition may show little progress towards improvement (Hetherington & Stoppard, 2002; McCarthy et al., 2008).

Friendships are also found to play a role in how youth and adolescents deal with depression (Hetherington & Stoppard, 2002; Macdonald et al., 2005; McCann et al., 2012). In some cases, the role proved to be two-fold. Generally, studies have shown that friendships with individuals of similar age and mental disorder were helpful, as they allowed for avenues for support and discussion (Macdonald et al., 2005; McCarthy et al., 2008). A particular study on social relationships put teens and young adults who were in the early stages of psychosis together with one another in support groups, then monitored their progress. They found that new, comfortable, and trusting relationships were easily forged within the support groups, due to the fact that knowing others were progressing through the same chaos alleviated stigma (Macdonald et al., 2005). However, these participants felt singled out and misunderstood by their previous friends, causing them to disconnect. Similar detachment and withdrawal with friendships was also seen by McCann (2012), as individuals feared being stigmatized. While the role of friendships can be an asset in coping with depression, it can also be seen as a hindrance and a cause for separation and feelings of unhappiness.

Another life altering interaction, which a youth may experience, is that of a post-secondary education institution. This may be due to the changes in lifestyle, somatic cycles,

eating patterns, financial stress, changes in family relationships, and academic uncertainties associated with the post-secondary experience (Ibrahim, Kelly, Adams, & Glazebrook, 2013). A systematic literature review by Ibrahim et al. (2013) on depression in university and college students around the world has identified some interesting, yet troubling trends over the past decade. Approximately one third of the students questioned in the studies suffered from depression, with a higher prevalence among females in comparison to males. They also found that most of the included studies claimed that younger students displayed higher rates of depression. In addition, an increase in family income was seen to correlate with a decrease in depression. Assuming that this is depression and not stress or sadness, this general trend gives a basic idea of the most susceptible age groups in post-secondary education. Future research may help to gain a deeper explanation into why these trends exist.

Since stress has been shown to aggravate depressive disorders and bipolar disorders (Kim, Miklowitz, Biuckians, & Mullen, 2007), these new experiences in post-secondary education may trigger a new or existing disorder. A common change associated with university or college transition is the student moving into a new setting, which may be distant from family and have reduced parental support. Emotional isolation, financial difficulties, and pressure due to expectations of academic performance may follow alongside this move (Demery, Thirlaway, & Mercer, 2012; Verger, Combes, & Guagliardo, 2009). The heightened level of independence may feel overwhelming for some students, especially those with an existing untreated mental disorder or a lack of personal maturity. The positive relationships between the young student with friends and family that were previously discussed in this literature review would possibly become weakened if the student has moved away from home, and the existing social support would become more difficult to access.

The lack of mental health literacy and awareness from the adolescent period has also been shown by Lauber (2005) to be a factor when a student moves into their post-secondary education. Detection of depression by a friend or family member could be very difficult due to the lack of personal connection while a student is away at school, and the close professional relationships with teachers and school administrators that may have existed in secondary school is essentially non-existent in first year university or college studies. This idea of having reduced social support has also been found by Demery (2012), where the limited contact of health support services and lack of information surrounding such support services was found to create negative experiences. Limitations to the regular accessibility of counselling as a result of the low counsellor to patient ratio proved to be detrimental in the effectiveness of the service. The main idea conveyed through the interviewees in the qualitative study by Demery is that the support systems available through the university were not as helpful as they could have been or once were in secondary school life.

Post-secondary education can also bring forth new financial responsibilities through tuition and living expenses, which may or may not be supported by family or other sources. With the average undergraduate tuition cost in Ontario being \$7,259 (Statistics Canada, 2013) and the addition of cost of living expenses, the financial demands of school can become very high. Since many students access student loans, the idea of owing money has the potential to add to the stressful living situation and exacerbate symptoms of depression. This theme of financial stress in post-secondary education has been found in a number of studies (Andrews & Wilding, 2004; Demery et al., 2012; Hysenbegasi, Hass, & Rowland, 2005).

In many cases, there is also an increase in academic demands of college or university on a student compared to high school or any previous education. Such academic demands have been

found to enhance symptoms of depression (Demery et al., 2012; Verger et al., 2009), or create psychological distress (Andrews & Wilding, 2004; Hysenbegasi et al., 2005; Verger et al., 2009). Women were found to be more susceptible to increased stress as a result of academics than men (Verger et al., 2009), and the idea of perfectionism in academics that leads to subsequent stress and psychological discomfort is suggested (Hunt & Eisenberg, 2010; Rice, Leever, Christopher, & Porter, 2006). With regards to depression as a cause for poorer academic performance, a qualitative research study by Hysenbegasi, Hass and Rowland (2005) found that students diagnosed with depression reported a significant drop (about half a letter grade or about 0.5 points on the GPA scale) in their marks after the diagnosis. One can then consider how academic failures and financial stressors may collaborate to create the impression of school expenses being misused if credits are not achieved. Both academic and financial stressors could then be pictured as an integrated cycle, with one leading towards the other. As one can see, there are many transitional aspects from secondary to post-secondary education that contribute to stress and subsequent depression that were not present in earlier years.

In addition to the aspects of post-secondary education that were previously mentioned, there are new challenges with regards to social circles and substance abuse, such as drugs and alcohol, that students may face. These influences could alter how depression is experienced. The study by Demery (2012) found students describe the life-changing paradigm of moving to university as a shock due to the responsibility of forging new relationships and having to meet new people. Such a process was found to be very difficult for the participants with existing depressive conditions. Similarly, one study by Andrews (2004) found that roughly 30% of the participants experienced stress due to either pre-existing or new relationships with others. This could have included separation from a past relationship or a new one. Another consideration is

that youth (ages 19-24) gain greater accessibility to drugs and alcohol as they get older. Alcohol has been found to cause depression from both short term and long term use (Edwards, 2002), and the wide spread social acceptability of drinking through post-secondary institutions does not bode well with depression. A literature review by Ham (2002) summarizes a number of studies with mixed results. Some of these studies found that excess drinking can contribute to depression in a general sense, while others found that particular demographics (such as women, non-caucasian men, college or university freshmen) were more likely to have this particular substance abuse problem than the rest of the student population. Other research work explored in this review, claimed that their results were not conclusive enough to label alcohol or other substance abuse problems as a sole factor of depression. When considering other substances, marijuana use is common despite it being an illicit substance in almost all parts of North America. A study conducted by Allen and Holder (2013) found that marijuana use among college and university students is inherently greater than it was in decades before, but contributes to both negative and positive health. They found that the frequency of marijuana was not a determinant of well-being, but the negative consequences (i.e with the law, personal relationships, etc.) correlated to stress and subsequent psychological problems. Alongside this, Durdle (2008) has reported that marijuana use is linked with major depressive disorder. However, Denson and Earleywine (2006) have reported the opposite, stating that regular marijuana users claimed to have fewer symptoms of depression than those who did not use it. All these results suggest a variety of ways in which the user may be influenced. As one can see, substance use and variations in social relationships can be viewed as new experiences that a youth may face when pursuing post-secondary education.

Online Social Networking

The birth of the Internet and social media networking in recent years has engulfed the lives of youth and adolescents in various parts of the world. Sites such as Facebook (founded 2004), and Twitter (founded 2006), have now become a dominating factor in our global society which was not present in years previous. For adolescents between 13-17 years of age in first world countries, 75% have social media accounts, and 58% have Facebook accounts (Jelenchick, Eickhoff, & Moreno, 2013; Lepi, 2013). Furthermore, the average teen spends approximately five hours per day online (Lepi, 2013). A vast amount of youth and adolescents connect with the world through social networking, and the impact of these social interactions on depression is a vague and unexplored territory. Only a small amount of research has been conducted specifically on how social media affects the experience of adolescent depression. However, it is a pressing field considering the growing amount of Internet use and the fact that, unlike past generations, future generations will no longer live in an age with an absence of social networking.

Existing research on relationships between Internet use and mental wellness has shown mixed results thus far. Most recently, findings suggest that frequent Facebook use is associated with increased psychological distress due to the overwhelming amount of communication (Chen & Lee, 2013). Furthermore, potential for users to experience depressive symptoms when comparing themselves to others on Facebook has also been demonstrated (Steers, Wickham, & Acitelli, 2014). The study also found that login frequency and time spent online were also mediating factors. Internet use itself has shown to be associated with depression, loneliness, and stress (Huang, 2010; J. Kim, LaRose, & Peng, 2009; Kraut et al., 2002; Steers et al., 2014). On the other hand, some studies have suggested that social media and Internet usage correlates to positive well-being, due to the increased accessibility to social interaction and less face-to-face

involvement (Mesch & Talmud, 2006; Shaw & Gant, 2002). As shown here, social networking can have mixed implications for individuals with regards to their psychological well-being.

Alternatively, another study has examined how social networking sites can act as an outlet for symptoms of depression. A quantitative study by Moreno et al. (2011) surveyed the Facebook statuses of early undergraduate students in the United States around the age of 20. They found that roughly 25% of the participants exhibited depressive symptoms through their social networking account, with 2.5% qualifying for a major depressive disorder. The results from this study led the authors to suggest that social networking is viewed as a “safe and indirect outlet for emotions” (p.453). Individuals who post frequently were likely to reference their depressive symptoms, and that depressive symptoms were more commonly displayed if the user regularly received feedback from others on previous status updates. These results suggest social networking could be a new source for the detection of depression, and highlight one aspect of how youth and adolescents exhibit their depression out to the world. But, another study by Whitehill, Brockman, and Moreno (2013) has found that the preferred method of raising concerns for a depressed individual is face-to-face interaction. This signifies that users still prefer a human connection when dealing with depression, and that social networking should only be used in certain contexts of interaction. These newly formulated trends and facets of how depression is conveyed by an individual could be vital in understanding how a young person copes with the disorder in our modern society.

Stigma

A major challenge faced by individuals with depression is stigma. Hartman et al. (2013) reported that “only one third of those who need mental health services actually receive them” (p. 29), due in part to stigma. Although only some research has been done on the particular

experiences of youth and adolescents with regards to stigmatization, the extensive work on the experiences of adults may help to provide perspective as well. Across the adolescent and youth age groups, the public perceived stigma has shown to be more dominant than self-stigma (Calear, Griffiths, & Christensen, 2011; Hartman et al., 2013). Mentally ill individuals feel that they are perceived differently, which alters their interaction with others as a result of the self-stigmatization received from having a diagnosis (Dinos, Stevens, Serfaty, Weich, & King, 2004; Macdonald et al., 2005). In adults, men have proven to be more at risk for self-stigmatizing perspectives than women (Griffiths, Christensen, & Jorm, 2008). This particular study also found that such risk increased with older individuals and those with lower amounts of institutionalized education. However, another body of work by Wang and Lai (2008) contradicts this finding, as they found that the highly educated populous held a variety of stigmatizing attitudes. These included the notions that mentally ill individuals are dangerous, and should not be employed or voted for in politics. These conflicting findings may suggest that other demographic or personal details influence present attitudes towards people with a mental illness, and that education is only one aspect. Stigma has also been found to rise with less exposure to illness, meaning that an individual is more likely to possess either of the two types of stigmatizing attitudes if they had not known or been around someone with a mental disorder (Griffiths et al., 2008). This relates to the previously discussed idea of mental health literacy, as more interaction and knowledge can help to reduce false perceptions. Corrigan (2004) has also done ample work towards relating stigma with personal barriers. Self-reluctance and perceived shame are found to be factors which can contribute to individuals failing to seek proper treatment (P. Corrigan, 2004; Demery et al., 2012). In addition, they noticed stigmatization also deters patients from adhering to proper regimens and medication guidelines during such treatment. After consideration, it may appear

logical to consider that many of these discovered trends could apply to the experience of depression across age groups as well.

When considering public and self-stigma for adolescents, a variety of factors can potentially come into play. Adolescents may not talk to their parents or caregivers (potentially key supporting figures in their life) out of fear for the reactions they could receive (Draucker, 2005). This is particularly problematic, as many adolescents will not have access to counselling or medication at a young age without parental consent and support. Another prominent factor could be the social constructs of high school or university, as individuals may hide from labelling by their peers. Recent work conducted by Demery (2012) was based on documenting the experiences of individuals with mood disorders in university. Academic, social, and personal lives were found to suffer immensely as a result of the stigma from a mood disorder such as depression. The students feared the label of being depressed, which forced them to avoid treatment and continually disguise their symptoms. Relationships and personal image among high school and university students is commonly a highly valued aspect of this age group. Superficial views and lack of personal maturity with regards to health are two elements of the adolescent view that may not translate to be the same as adults. These aspects should be taken into account when comparing stigmatization at varying levels, as commonalities for adults may not be the same as that of younger age groups.

Summary

This chapter has provided an overview of the current research regarding the various aspects that may influence how a youth or adolescent experiences depression. Themes which were addressed include, mental health literacy, personal perceptions, interactions with others, stigma, and interactions through social networking. This collection of research provides a broad

overview of how depression pertains to youth and adolescents, and provides background and context for this thesis project. This review of the literature will also support the interpretation of the interview data as analysis proceeds and findings and conclusions are drawn.

Recommendations from the findings will also take the literature into account.

Chapter Three: Research Design and Methodology

In this chapter, procedures on the collection and analysis of the research data through the phenomenographic framework are outlined. Ethical considerations, participant recruitment, and data interpretation techniques are also discussed.

Methodology

When I was initially considering how to go about investigating how university students experience depression, I acknowledged that the phenomenon of depression is a very personal, emotional, and social entity. There would undoubtedly be a number of ways in which someone perceives, constructs knowledge about, draws conclusions about and is affected by this mental illness. With this in mind, I chose to explore the topic through a qualitative research approach, since it is best suited for exploring and understanding human meaning around a construct (Creswell, 2014; Gay, 1996). Qualitative research searches through the socially constructed nature of reality and relationships between researcher and topic while providing the contextual framework on the topic (Denzin & Lincoln, 2011). Furthermore, it is best employed when answering questions pertaining to “how?” or “why?” (Denzin & Lincoln, 2011; Neuman & Robson, 2009), which is fitting considering the research questions put forth in this particular study are such types of questions. As opposed to quantitative methods, which are used to primarily test theories on a topic (Creswell, 2014), qualitative research works on an inductive setting and is open to any form of meaningful information which could arise during the inquiry process.

My next steps in deciding upon a research methodology had to consider the best ways to study interrelationships between depression, school, and the youth demographic. A proper investigation and analysis must be open to any experience and constructed inductively from what

people feel is meaningful to them. Phenomenography is a qualitative research methodology which seeks to uncover different ways people experience, conceptualize, realize and understand various aspects of a particular phenomenon in their life (Marton, 1981, 1986; Richardson, 1999). This methodological framework, developed by Marton (1981), was originally formulated for educational research in order to view learning from a student perspective, but was found to be useful for investigating phenomena in many other disciplines since it provides alternative outlooks on how phenomena are understood (Ashworth & Lucas, 1998; Ornek, 2008). It also asserts that experience at any given point in time is partial depending on context, therefore allowing for many different ways which phenomena can be conceptualized (Åkerlind, 2008).

As opposed to phenomenology, which seeks to uncover an “essence” of a human experience (Creswell, 2014; Marshall & Rossman, 1999; Seidman, 2013), phenomenography aims to explore the variety of different experiences of individuals in relation to the phenomenon under study (Marton, 1981; Ornek, 2008). The goal here is not to make declarations or statements about the phenomenon itself, but to empirically search for a collection of personal ideas about what is being studied (Linder & Marshall, 2003). Since there is undoubtedly no single “essence” or individual entity which can encapsulate depression, I chose to utilize phenomenography as a methodological framework to investigate the number of ways students may experience depression. From collecting accounts of their experiences, I hoped that some commonalities would arise within the data to give a broader sense of the major contributing factors about the phenomenon itself within the context of post-secondary education.

The ultimate goal in phenomenography is to create something called an outcome space, which consists of numerous categories of description. In phenomenography, the groupings which express the central meanings of conception about the phenomenon are known as categories of

description (Barnard, McCosker, & Gerber, 1999; Reed, 2006). They are a way to express conceptions about the phenomenon at that particular time and place by the object or person studying the phenomenon. According to Marton (1988), these categories of description are relational between the subject and object under study, experiential in the sense that conceptions are based on experience, content oriented around the meaning of the phenomenon and qualitatively descriptive. Such groupings arise after the data have been processed and analyzed. Once these categories are formulated, they assemble to form a final depiction of the experience called an outcome space: a diagrammatic illustration of the relationships between conceptions which arose from the data (Barnard et al., 1999). This is the final product of a phenomenographic study, as it brings all the categories of description together to foster an illustration for the researcher to understand the phenomenon and draw implications from the research (Ashworth & Lucas, 1998; Ornek, 2008). All of the individual ideas, beliefs, or facts which make up this outcome space are known communally as a collective intellect (Marton, 1981). By looking at this outcome space and the categories of description which it provides, I will be able to provide answers to the posed research questions and discuss the many ways which youth are affected by depression, how school affects a student with depression, and which factors influence this mental illness. There will likely be no single answer to each of my research questions. Fortunately, phenomenography provides for a multitude of responses to these questions due to the nature of its methodological framework. Furthermore, the relational nature of the outcome space may contribute to an analysis of how these different factors in the experience of depression could be related to one another. This could lead to a deeper analysis of the data towards proposing implications for positive actions which can apply to multiple categories of description.

As with many forms of qualitative research, there is a desire for the researcher to remove any of their own conceptions about the phenomenon in order to focus on what others perceive (Creswell, 2014; Denzin & Lincoln, 2011). This is also the case with phenomenography, where the researchers own conceptions are not the focus of study and the researcher must remove their own preconceptions in a process called bracketing (Marton, 1986; Ornek, 2008). For my study, I kept a series of field notes to monitor my own thoughts, conceptions, and viewpoints which arose during the interview process and data analysis. These reflective field notes included personal reactions and reflections, and acknowledged any preconceived idea which may influence how I saw the research. These notes were taken consistently throughout the course of the study and were a formidable tool towards helping me identify personal biases.

Research Methods

Participants. The study involved seven university students between the ages of nineteen and twenty-five who had self-identified that they experienced depression at different stages in their life. I chose this demographic of participants because they accurately reflect the criteria of the study: university students within the majority age group of other university students who may have depression. One male and six female volunteers came forth to participate, all of whom were residents of Ontario and attendees of the same university in the province.

Recruitment and consent. For recruiting volunteers to participate, posters which contained all vital information for the study were placed on major bulletin boards around the main campus at a university in Ontario (Appendix A). In addition, the study was discussed at the start of three undergraduate education courses on campus, where I gave an outline of the study and made a call for participants. Potential participants could then contact me through phone or email.

Once I touched base with the participants, I electronically sent them a copy of the cover letter and consent form for this study (Appendix B). These forms contained a comprehensive outline for the study and met all requirements set out by the Research Ethics Board (Appendix D). After receiving and reviewing the forms, the participants agreed to such terms and an interview was scheduled within the following week.

Data collection. Interviews are predominantly the main source of data for many phenomenographic studies (Ashworth & Lucas, 1998; Barnard et al., 1999; Marton, 1986) in addition to being utilized by other forms of qualitative research (Creswell, 2014; Seidman, 2013). It has been said that “~~int~~erviewing is one of the most common and powerful ways in which we try to understand our fellow human beings” (Fontana & Frey, 2003, p. 62), which is why I felt confident in this research method being used towards understanding such a personal and unique human entity as depression.

The interviews were conducted face-to-face in a private office space on the university campus, and averaged about sixty minutes in length. Each interview was digitally recorded using a Sony ICD SX712 recording device. Since human experiences are very broad and diverse, a semi-structured interview approach was chosen to give the interviewee freedom in sharing whatever aspects of their experiences they found meaningful, yet structured enough to provide a focus on the research questions. Participants were encouraged to share any experiences which they found relevant to the topic. These interviews were framed by an interview guide of twenty preconceived questions, along with prompts to aid elaboration (Appendix A).

I put an extensive amount of consideration into the construction of the interview guide, with a high degree of consultation to the literature. The questions themselves were open-ended to allow for elaboration and clarification. As well, additional prompts or probes were created for

interview questions to ensure the interviewees were answering the questions fully and participants could present ample detail about the ways which they have experienced depression.

Once the interviews were conducted, the audio recordings of the interviews were transcribed to text using ‘DragonSpeak 9.5’ voice-to-text transcription software, followed by proofreading of the transcripts while listening to the recording. The data from the interviews was organized and coded with ATLAS.ti 7 qualitative data analysis computer software. The software is adept at managing codes within data, tracking word usage, increasing accessibility of the data during analysis, and so on (Friese, 2011), which made it a valuable tool in this aspect of the study.

After an initial review of the interview transcripts was completed, they were returned to the participants for member checking. Member checking allowed the participants to add important details about their experience which they may have forgotten about during the interview and to confirm that their recollections about the phenomena were true. Member checking was also done to establish credibility and trustworthiness in the data, as it is the most crucial technique in doing so according to Lincoln and Gruba (1985). By confirming that my obtained data is representative of the experience by the participant, this helps support the notion that the results are well suited for describing the phenomenon to others.

Data analysis.

Organization of the data. Following alongside the methods of phenomenographic research, the interview data for my study was mapped out and organized according to the constructs of this particular methodology.

To begin organizing the data, interview transcripts were given an initial read-over with care into considering how I interpreted the literal meaning of the text. With phenomenography,

particular attention must be made as to how the researcher is conceptualizing what the participants are saying to make sure the proper meaning is understood (Kvale, 1996).

Next, the transcripts were returned to the participants for member checking to make sure what had been said was accurate. They corrected and clarified any ambiguous phrasings or figures of speech, as well as added in pieces of information which they had forgot about during the interview but viewed as important. Bracketing reflections within my field notes were conducted during this exchange with participants, as well as through the analysis process. I then loaded the interview transcripts into ATLAS.ti. Coding and collection of relevant quotes was done using the computer software during the second read-through of the transcripts. Coding was done generatively, which allowed the codes to arise and emerge from the data (Creswell, 2014) and aided in identifying the most prominent aspects of the participants' experiences.

Data analysis methods. Even though there are a number of different ways in which the data in a phenomenographic study can be organized and analyzed, I chose to undertake the 'classic' method of phenomenographic analysis as laid out by Marton (1986). It has been used by a number of different researchers in their investigations (Barnard et al., 1999; Linder & Marshall, 2003; Reed, 2006; Richardson, 1999).

The first step in the analysis process was choosing quotes from the transcripts that depicted different experiences related to depression. These quotes were picked in relation to the dominant codes that arose from the data and were representative of the meaningful experiences in the interviews. Individually, these meaningful experiences with their representative quotations are known as meaning units. Once the meaning units were extracted from the interviews, I grouped them together to form a pool of meaning. The pool of meaning is a collection of

meaning units, and shows the different decontextualized ways in which the phenomenon in question was experienced (Reed, 2006).

Once a pool of meaning was formed, I arranged the meaning units together to form the categories of description (Table 1). In total, there were 9 different categories of description which arose from the data analysis. I was also able to group the categories of description into three predominant constructs: internally guided experiences, externally guided experiences, and mutually guided experiences (both internal and external). Patterns arose in the categories of description which were formed in the data analysis process, so I felt compelled to group the categories of description with similar structure and content into these constructs. This was done to draw stronger relationships between different aspects of the experience and provide insight and how different units of meaning could be related to one another.

Another method of data analysis that was used within this study was keywords-in-context (KIC) to examine how respondents utilize specific words (Fielding & Lee, 1998; Leech & Onwuegbuzie, 2007). Keywords that were commonly used or used in a unique manner were selected from the data. Then, the context of words used before and after those keywords was noted and examined. From this, I was able to probe deeper into various word usages in the interviews. I chose this method of data analysis to search for deeper meaning behind the usage of dominant words which may possess unique denotative or connotative significance.

The final task in the data analysis process was the construction of the outcome space from the categories of description. The purpose of an outcome space is to visually represent all the ways in which people may experience a phenomenon (Marton, 1981). The formation of the outcome space must also arise as much as possible from the data itself, and not the personal judgement of the researcher on how the space should be organized (Åkerlind, 2005). From this,

my intention during the construction of the outcome space was to present a concise array of ideas which the participants presented, as well as to try to draw connections between these ideas as categories of description. Specifics regarding how I built the outcome space will be discussed in more detail after the space is presented.

The pool of meaning for the study was organized as follows (Table 1):

Table 1.

Tabulated depiction of the outcome space

Predominant Constructs	Categories of Description	Meaning Units	Sub-meaning units
Internally guided experiences	<i>Feelings</i>	<ul style="list-style-type: none"> - Positive Feelings 	<ul style="list-style-type: none"> - Optimism for future - Proud/gained from experiences - Acceptance
		<ul style="list-style-type: none"> - Negative Feelings 	<ul style="list-style-type: none"> - Negativity - Lack of Motivation - Unclear/uncharacteristic mental state
	<i>Internal Perceptions</i>	<ul style="list-style-type: none"> - Acknowledging depression - Perceptions of self - Conceptions of depression - Turning a blind eye to problems - Trying to save face - Differences from person to person - Depression is a 	

		weakness	
Externally guided experiences	<i>Environmental Circumstances</i>	<ul style="list-style-type: none"> - Triggers for depression - Traumatic event 	
		<ul style="list-style-type: none"> - Online Social Media 	<ul style="list-style-type: none"> - Positive effects of online social media - Use of online social media for keeping in touch with others - Reluctant to interact on online social media - Online social media aids in triggering depressive symptoms
	<i>Family</i>	<ul style="list-style-type: none"> - Positive Family Aspects 	<ul style="list-style-type: none"> - Strong connection with family members - Family helps to acknowledge depression - Family members are supportive
		<ul style="list-style-type: none"> - Negative Family Aspects 	<ul style="list-style-type: none"> - Lack of understanding about depression in family - Family members have mental health problems
	<i>External perceptions</i>	<ul style="list-style-type: none"> - Perceived lack of health literacy exists in society - Other people have misunderstandings 	

		about depression	
		- Stigma	- Perceptions which others have - Stigma prevents communication
Mutually guided experiences	<i>Positive processes</i>	- Positive factors - Coping mechanisms - Health literacy is helpful - Communication is helpful - Medication - Coping, keeping occupied - Personal connections with positive processes are important	
		- Counselling	- Counselling as a conversation is helpful
	<i>Relationships</i>	- Relationships are supportive	- Communication is difficult - Other individuals with depression/mental health issue are supportive - Friends were supportive/positive for coping - Other people help distract from depression

			<ul style="list-style-type: none"> - Building an understanding in relationships is important - Relationships with like-minded people are helpful
		<ul style="list-style-type: none"> - Communication with other people is difficult 	
	<i>School interactions</i>	<ul style="list-style-type: none"> - Positive school effects 	<ul style="list-style-type: none"> - Supportive teacher - School helping to acknowledge depression
		<ul style="list-style-type: none"> - Negative school effects 	<ul style="list-style-type: none"> - Academic struggles
		<ul style="list-style-type: none"> - Teacher/student relationship 	
	<i>Accessibility/Awareness</i>	<ul style="list-style-type: none"> - Lack of knowledge about depression - Lack of physical accessibility - Perceived lack of accessibility - Lack of direction in finding treatment 	

Ethical considerations. In order to maintain complete confidentiality and anonymity of the interviewee within the research, pseudonyms were given to each participant in all transcripts and reports.

Regarding the associated risks behind the collection of data, the discussion of a past traumatic event could potentially trigger negative emotions and feelings during the interview process simply due to the nature of this sensitive issue. Before agreeing to participate in the study, participants were informed of these potential risks, but none occurred during the actual interviews. After the interviews were complete, participants were given the name, contact information, location, and available services of local mental health institutions if they were needed for future reference.

Since I am not a trained mental health professional but would be interacting with depressed individuals during the course of the study, two factors were considered. The first was that participants were informed at the start of the interview that I was not to be used as a confidant or counsellor at any point. The second consideration was that screening on the level to which the participant was currently experiencing any symptoms of depression could not be undertaken. The researcher was also conscious to not ask questions pertaining to a diagnosis of depression during the interview. All experiences of depression were self-declared by the participants.

Summary

This chapter outlined the research methodology, research methods, and data analysis process to describe how the study was conducted. Furthermore, the predominant constructs, categories of description, and meaning units were summarized to outline the elaboration of the findings, which will be presented in the next chapter.

Chapter Four: Summary and Discussion of Findings

This chapter presents the findings and interpretations for the study, along with descriptions of the seven participants who were involved. Findings within the study are sorted into three categories, with three or four themes supporting each category.

Participant Profiles

The following vignettes describe the background details about the participants and provide an overview of their stories. All details on what they decided to share were voluntary.

Alison is a third year university student completing her bachelor of arts degree. She is 20 years old, and has lived in the same city for her entire life with her parents and sister. Alison's experiences with depression began around age 17, when she discovered that she would go through bouts of sadness on a monthly basis as a result of a hormonal imbalance. These sessions got progressively worse, until Alison decided to see her doctor for assistance around the age of 19. Today, Alison is still working to come to terms with depression, but has found success in alleviating her symptoms as a result of support from friends and family members.

Lee is a first year graduate student with a focus in women's studies. She lived in a number of different cities growing up, both small and large. One of the defining moments in Lee's life was when she was sexually assaulted at 14; an event which did and continues to cause her stress and anxiety. Lee has experienced depression throughout her life, from grade school to the present day, with the incident being a major source for exacerbating her depressive symptoms. However, it has inspired her into an advocacy role on sexual assault, serving as an activist and scholar on the issue to the present day.

Kate is a 21 year old concurrent education student, majoring in English, in her third year of university. The most influencing factor in Kate's experience with depression by far was a car

accident that occurred about a year prior to the interview, where Kate, her younger sister, and the passengers of the other vehicle involved were all severely injured. Kate's sister sustained brain damage and fell into a coma for weeks, while the passengers of the other car passed away from their injuries. The accident occurred as a result of Kate having a seizure behind the wheel, which still causes her to feel guilty, responsible, and sad.

Georgia is a concurrent education student, majoring in English, in her third year of university. She had grown up in a number of different cities and schools. When Georgia was seven, her mother passed away from substance abuse, and her father remarried shortly after. Many of Georgia's experiences with depression that she talked about in the interview involved her family in some way, as a result of strained relationships with her father and stepmother.

Rachel is a concurrent education student in her second year of university. She is a visual arts major and has a strong passion for teaching, due in part to peer-leadership opportunities and supportive teachers at her secondary school. Rachel had experienced depression through grade 10, but was able to overcome her feelings of sadness shortly after. She has attributed much of her success to her high school history teacher, who encouraged her and reminded her of her own self-worth.

Amanda is a 22 year old university student working on her bachelor of arts. She spent much of her life living in different parts of her province due to the changing job opportunities of her parents. As a result, she attended a number of different elementary and secondary schools. Amanda has experienced depression from a young age, and always felt she was "different" in terms of her mood. It was not until her psychology class in her first year of university that she felt motivated to seek treatment options.

Mitchell, the lone male participant in the study, was a 24 year old engineering student. He had recently graduated university, and moved out into the job market, where he struggled to find consistent employment. Mitchell described his experiences with depression as involving a lot of apathy, especially throughout university where it was difficult to motivate himself through the rigorous academic demands. At the time of the interview, Mitchell had found relief from his depression symptoms and appeared to have a well versed perception about what he had gone through.

Findings

A total of 9 categories of description emerged from the data: feelings, internal perceptions, environmental circumstances, family, external perceptions, positive processes, relationships, school interactions, and accessibility (Table 1). These themes could then be grouped into 3 predominant constructs: internally guided experiences, externally guided experiences and mutually guided experiences (Figure 1). Key points and quotations related to these findings will be discussed in the remainder of the chapter.

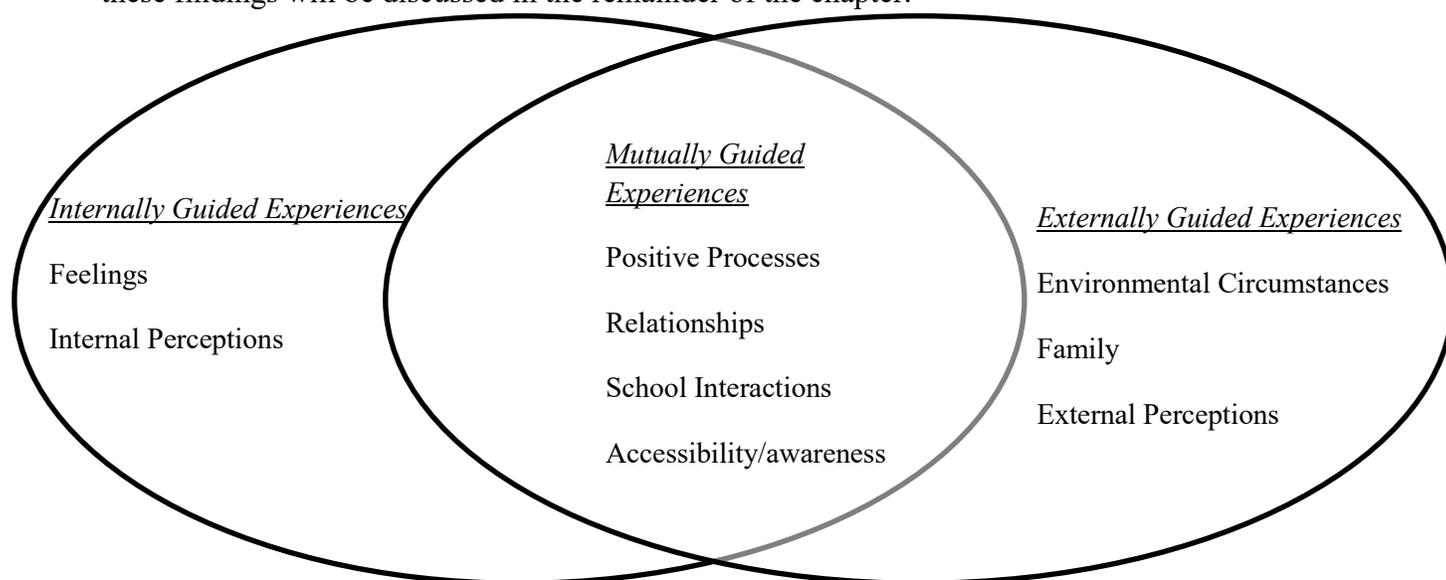


Figure 1. Venn diagram of major predominant constructs

Internally guided experiences. Internally guided experiences refer to experiences which were governed by personal factors, such as feelings or thoughts, within the individual who is experiencing depression. These introverted characteristics reflect the person's persona, and are the ideas and feelings which govern their subsequent actions and reactions. The units of meaning which were reflected in this category were feelings (both positive and negative) and interpersonal perceptions.

Feelings. The participants described a number of ways in which they felt the effects of their depression. Lee described the hardest parts of her university career while suffering from depression:

So it was the worst experience because it was where I probably experienced depression as people will probably more regularly talk about depression: not being able to sleep, or not being able to eat or eating too much. Not being able to function during the day. There were days where I would wake up and I go to class and I couldn't hear what the professor was saying. I would just sit there and blankly stare at the white board. Like I could physically hear them, but what they were saying was just bypassing me entirely because I wasn't able to focus. I was too busy thinking about . . . whatever. (October 15, 2014)

She also described her depression as a "zombie-like state" throughout high school (October 15, 2014), which was an identical descriptive word used in accounts about depression provided by Macdonald (2005). This is also similar to how Mitchell described depression: —Some people, or people that I know, when they do get depressed, they just shut down. They become completely antisocial and have no sense of humour. No sense of themselves. They just become a completely empty shell of who they are" (July 14, 2014). In general, feelings of sadness, isolation, and improper mental functioning were discussed. Much of the language and descriptions bore

similarities to findings collected by Wisdom and Green (2004). All of these are common characteristics about depression, as described in the literature and the diagnostic handbook for mental illnesses (American Psychiatric Association, 2013; Edwards, 2002; Huberty, 2006), making them predictable findings.

Depression seemed to put participants in a different mindset than their “true” self. Rachel reflected on how depression made her confused about her actions:

A lot of the times I would just skip lunch or something. And I did a lot of things like that. Looking back on it now, I can't understand why. And I can't put myself in the mindset that I had been in at the time to understand why I did this thing. And so the things... I can't imagine doing to myself now. . . a lot of the times I just felt really; I guess just empty or something. (October 3, 2014)

Here, Rachel described an instance where she was confused as to why she acted the way she did and could not place herself back in that mindset. Being in a depressive state appears to be a descriptably unique feeling, one which distorts human perception of the world. Thoughts which may have previously not existed may suddenly come to light when depression arises, such as an instance where Amanda became stressed:

Well, like if I get really stressed I tend to [get depressed]. Or if I get something slightly wrong, I automatically tend to go to: “I'm stupid; I can't do it right; it's not working” type [of] thing. And stress is just a more emotion on top of everything else that just avalanches everything. (October 6, 2014)

There were some positive feelings associated with depression that appeared in the interviews which were associated with their personal perspective. The interviewees noted that

they were optimistic about their future, and that the experience is a mixture of good and bad days. Lee described how this increased understanding of herself has provided hope:

It sounds strange to say that I am hopeful about depression, but I would use the term hopeful in that I am hopeful that because more people are starting to realize that it is experienced by so many more people. (October 15, 2014)

Many of the participants described day-to-day feelings as a cycle of good and bad, such as when Rachel described: “Everybody has days, I have days, where I do still feel down and unimportant or inadequate or not a good artist in the art department. And I feel like I am not contributing enough. But everybody feels like that” (October 3, 2014). She continued on to talk about how she accepts and feels pride behind the fact that she faced her depression: “I’m comfortable and happy with what I’ve accomplished and what I’ve become” (October 3, 2014). Furthermore, similar feelings were expressed amongst other participants. This feeling of pride was one of the most positive feelings that arose during the interviews. To some degree, most of the participants had accepted their depression and found solace in how far they had come with respect to coping and living with their mental illness. This seemed to be coupled with optimism, in that the two feelings were mutually present. Participants also accepted the fact that they will experience both good days and bad days as they live with depression. Although the bad days were described as miserable ones, knowing that good days existed appeared to bring a small sense of comfort to the participants, and perhaps acted as a slight source of motivation for continuing with living life to the best of their abilities.

Internal perceptions. Internal perceptions of depression pertained to anything which the depressed individual thought in relation to depression, either theirs specifically or the illness as a whole. Acknowledging their own depression was something that the participants often talked

about, each with their own individual progression. For Alison and Mitchell, it was hard to distinguish depression from normality because it just seemed typical. Mitchell reflected by saying,

It's been part of my life ever since . . . And you don't really notice it until you finally do something about it and you have that breaking point, which was about a year and a half ago. So I said to myself: "You know what, maybe something's wrong here". (July 14, 2014)

Rachel had a similar experience, where she had an epiphany about her condition: "I was very negative. . . and then I decided no: I want to like people. I want people to like me. And in order for that to happen, you have to like yourself first" (October 3, 2014). She then went on to discuss how the acceptance of herself gave her the ability to like people. Finding personal perceptions of oneself to reflect on was something that several participants discussed, and the process appeared to be positive. I received the notion that the participants were able to move forward in coping with depression once they had personally accepted that they had this mental illness and something had to be done about it. Once that initial step in the process was taken, their stories then turned towards positive outcomes instead of continuing on with negative ones, such as feelings of sadness or uncharacteristic behaviours.

Each of the participants had their own views of what depression was. Lee said, "I use the term 'depressed' in the terms of an overarching sadness feeling" (October 15, 2014). Mitchell described it as chronic, by saying "I guess there really isn't any 'better' for depression. It's just always going to be around" (July 14, 2014). Rachel claimed that the term was vague to her: "I guess I didn't know what it was. It just seemed like one of those words you kind of hear. . . I didn't know what it was; I didn't know it affects people" (October 3, 2014). Another perception

of depression that surfaced was that depressed individuals are weak. Georgia had always carried this idea: —For me, it's the way I grew up: feeling weak that I have depression" (October 7, 2014). Similarly, Mitchell confessed, —I think that's probably the main reason why I kept it under wraps. I didn't want to view myself as being weak, I suppose" (July 14, 2014). Amanda also struggled with keeping an ordinary appearance:

It was just physically and mentally exhausting to always try and be fine. And I do tend to do it a lot, because I don't necessarily like people knowing. Or I'm fine with them knowing, not so much seeing type [of] thing. (October 6, 2014)

With a wide array of different ideas associated with what depression is itself, it shows that perceptions of this mental illness are scattered and that those living with the mental illness do not understand the fundamental nature of what it is.

Multiple perspectives on what depression is suggests that the public knowledge base and definition regarding depression is inconsistent, and that people formulate a variety of ideas based on their own personal and unique experiences. This finding is supported by work done by Farmer (2002), who found that there is inconsistency in how depression is portrayed by youth and adolescents. In order to treat any illness, whether physical or mental, it is essential that the nature of the illness is first understood before any diagnosis or treatment can move forward. This basic idea is one which seemed to be lacking in the participants. Also, the idea of feeling ashamed or weak as a result of having depression came up often in the study, and I would say it is a major barrier towards finding successful treatment and coping mechanisms. In very much a similar way to acknowledging and personally accepting that someone is depressed, it must also be understood that someone is not weak or any less adequate because they are depressed.

Another personal interpretation of depression was found using the keywords-in-context analysis around the use of the word “it”. Depression was perceived by the participants as an improper noun, so naturally the word “it” can be used as a replacement word. However, the word “depression” was sparsely used in multiple interviews, which could be considered unusual due to depression being the topic of the interview. Instead, depression was commonly referred to indirectly using the pronoun “it”. For example, Kate shared her perspective about depression:

I guess I really didn't understand **it**, and I know, like I have family members who have gone through **it** and stuff like **that**. But I didn't really bother to understand what **it** means to go through **that**. And I don't know, with family having gone through **it** and everything, I just never really, I just thought **it** makes you sad or there is a reason for **it**. I might just try not to think about **it**. I mean, if I'm not going through **it**, then why bother dwelling on **it**? (October 5, 2014)

The use of the words “it” and “that” to indirectly refer to depression could have multiple interpretations. One interpretation of this finding could suggest that the word depression was replaced by the word “it” as a mechanism to avoid having to verbalize the word depression. If such an interpretation were true, then it would suggest that a social and linguistic stigma exists alongside the word depression. Stigma is affected by word choice and the ways in which the mental illness is described (Alvord, 2012; O'Brien, Volkow, & TK Li, 2006; The National Alliance of Advocates for Buprenorphine Treatment, 2008) and internal perceptions of depression may affect how the individual talks about their experiences. It is possible that the stigma subconsciously prompted participants to avoid saying the word depression and avoid the negative denotations of the word; although, one might argue that the nature of the interview and the ease in using pronouns in speaking might have prompted the use of the word “it” as opposed

to the longer word “depression”. It is known that many who have a mental illness are embarrassed by their condition and are prone to hide it from others (Corrigan, 1999) and avoiding the use of the word depression in social interactions could be a way of doing so. However, other participants said the word “depression” often throughout their interviews, such as Mitchell and Lee who used the word when the conversation called for it. The unique case of these two participants is that I received the impression that they were knowledgeable and comfortable with the subject of depression itself. Both had admitted to spending time researching, reflecting, and adapting to their own personal experiences with depression. This finding suggests and supports the idea that stigmatization of depression is diminished as more knowledge and experience with depression is gained.

Externally guided experiences. Externally guided experiences refer to experiences that are influenced or directed by other people surrounding the individual with depression. They may also be thought of as external stimuli, which influence how the participant experiences the mental illness. Environmental circumstances, family, and external perceptions were the categories of description which made up this predominant construct.

Environmental circumstances. All of the participants talked about major events or frequent occurrences in their life that influenced or triggered their depression in a major way. Lee was able to trace all her discontent to two main external triggers in her life: “I would have the worst story to try and type out, because everything always goes back to two key things, right? Like what happened when I was 14 and then my experiences with depression when I was a child and just didn't have the language to go see a counsellor” (October 15, 2014). As mentioned, Kate also experienced a traumatic event in her life. She explained that:

I know that the cause of my depression or the trigger for my depression was the accident. And I guess everyone has their own cause. Maybe like an abusive parent or something like that. It just makes sense that maybe there is a cause. But I mean, again, maybe that is a little ignorance saying that there must be a cause for it when it can just sort of happen.

(October 5, 2014)

These examples of events in the participants' environment or life around them triggered symptoms of depression. Triggers for depression came in various forms for the participants, such as one seemingly harmless incident Alison had with her family:

It maybe started, or seriously started, when I noticed it one time when my mom and my sister were snuggling at camp. And they were like, "Oh, we are cuddling and it's so great!" And then I was like "Can I join?" And my sister was like "No, you are not wanted". And she was kidding, but I went and cried. And they were like "Oh, are you okay?" And I was like "No, I don't know why I'm crying". (October 3, 2014)

Others, such as Rachel and Georgia, had troubles within their family and life at home which caused them to feel depressed.

Influences from the environment, such as traumatic life events or external stimuli, appear to be one of the greatest factors that may influence someone with depression. Events like sexual assault and fatal car accidents have continued to exacerbate the mental state of some participants for years after they had occurred, and were very difficult to find relief from. These events occurred only once, but appeared to impact the participants quite severely. Three participants talked about external factors that occurred on a consistent basis, such as family, relationships, or other health problems that triggered their depression. In both cases, the participants had little control over the occurrence or outcome of these incidents, yet were impacted so profoundly.

Quite a number of studies in the literature show similar findings of traumatic events linked to the causation of depression symptoms (Horesh, Klomek, & Apter, 2008; Karp, 1994; K. Kim, 2012). Since there is no way to anticipate these incidents, individuals who experience depression as a result will require versatile coping methods to make for a less detrimental experience.

During the interviews, participants were asked about how online social media plays a factor in their lives, and if it relates to their mood. All of the participants except Lee expressed a disinterest in using Facebook. When asked about it, Mitchell replied, “I’m not a firm believer in online social media. I think it’s a mess and a waste of time” (July 14, 2014). Others, like Kate, just used it to keep in touch with people and didn’t really interact: “I don’t ‘like’ people’s things. I just go on it to keep in contact with people. . . I won’t post statuses or funny pictures or jokes or anything like that” (October 5, 2014). The other participants who expressed a disinterest in using Facebook gave similar or nearly identical responses; they used it for contacting others but felt reluctant to interact themselves. Such a pattern suggests the idea that there is an element of isolation associated with depression even in a digital world, and that depressed individuals are reluctant to interact with others through online social networking sites. Depressed individuals tending towards isolation, was a finding in this study, as well as the literature (Chen & Lee, 2013; Joiner, Coyne, & Blalock, 1999). If a lack of online interaction is observed for a youth, it may be a possible behaviour that can help identify someone who is depressed.

On the other hand, some expressed an advantage from using online social media websites like Tumblr (an electronic media sharing platform) described it as a positive thing. Amanda talked about the benefits she finds in using it to interact with other depressed people:

I’m on Tumblr every day, because to me, that is a group of like-minded people. I mean, it’s not as much of an online social network since you don’t talk to people as much or

reply like you would in Twitter or Facebook. But I feel that there is a bigger community to realize and connect with. There are a lot of people out there. (October 6, 2014)

Alison expressed similar thoughts about the website:

It probably makes me feel less alone, because I know that there are so many people out there now. Everyone on Tumblr is very accepting about stuff and they are very open about everything, so that makes it easier to make it feel like it's not just me. (October 3, 2014)

I think this particular site (Tumblr) was positive as it acted more so as a vessel to connect those with similar interests and experiences, but did not require them to interact in a conventionally “social” way. Having the ability to share interests, ideas, and see that a large number of other individuals deal with depression was a positive thing for Amanda and Alison. Being aware of others who struggle with depression can be beneficial, and we have seen here that online social media can be used as a method to provide that.

Mitchell identified another positive trait that online social media has, which is its ability to spread information: “Everyone's all pro-awareness for whatever cause pops up; so whether it's gay rights or mental issues or cancer awareness, that kind of stuff. So I think online social media could be a very good vessel for awareness” (July 14, 2014).

But the spread of information was also found to trigger symptoms of depression for some participants. Lee had described one instance where she was confronted over Facebook by the individual who had sexually assaulted her, which triggered subsequent feelings of anxiety.

Alison described one instance where Facebook indirectly influenced her mood:

I think definitely with that issue of not having friends, which was something that I sometimes was upset about. When I was not feeling good, seeing what other people were

doing, especially when I knew that they were all going somewhere and they didn't invite me, because A, they didn't need a ride or B, who knows what, that didn't feel good.

(October 3, 2014)

For Alison and Lee, the use of online social media had a slight effect on their mood at certain times. This occurred when they were exposed to information over their online social networking sites that made them feel sad. As noted by Becker, Alzahabi, and Hopwood (2013), the type of media used, the method of its usage, and the personality of the user are all important factors when relating social functioning to social networking. Those who suffer from depression should then be conscious about how online social media may affect them, and decide how to act accordingly as a result.

Extraneous outside factors which appeared difficult to control was seen here to be a factor in how the experience of depression is influenced. Events in the life of a youth and the way they mediate themselves with the world around them influenced feelings and perceptions. We also saw how these responses displayed a mixture of negative and positive experiences of depression in association with online social media. These examples of environmental circumstances appeared to be some of the most detrimental and key aspects of an experience, and showed how much of a role they can play with the individual.

Family. To some extent, all of the participants talked about their family in relation to their experiences with depression. For some, family was a means of support. Alison claimed, –My mom has said a lot of the right things that I needed to hear” (October 3, 2014). Mitchell’s family indirectly helped him acknowledge he had depression: –The biggest thing for me, which probably tipped me off along the lines on figuring out if I have depression, was that I became very irritable with mostly family” (July 14, 2014). Family acted as an external support for the

participants with depression because they provided encouragement, care, and helped to acknowledge the presence of the depression; having such support led to treatment methods such as counselling, medication, or other healthcare options.

However, there were instances where family members were not supportive, like the case of Georgia's stepmom; Georgia explained that she had overdosed on a medication and needed to go to the hospital:

She wasn't worried. She said, —You'll be fine, go back to sleep.” And anyways, I went back downstairs after I called poison control, and said, —This is what's happening.” And she just said —You'll be fine . . . if you really want to go to a hospital, then you can drive yourself.” And she threw the keys at me. And that's what I did. (October 7, 2014)

This appeared to be an event of great significance in Georgia's life, as she spoke very quietly while telling the story. It was evident that she cared to some extent about what her stepmother thought and how she cared for her, and the reaction she received did not help the situation.

Another unit of meaning related to family was the lack of understanding which some family members had towards depression. Alison described her family's perceptions:

. . . my dad and my sister don't really get it sometimes. Like, [sister's name] is like —Maybe you're just having a bad day?”, and I say, —[sister's name], it's over time. I'm not having 17 bad days in a row.” And she's like —Oh”. And my dad is like —Just go sit in the sun for a while”. And I'm like, —well, that might help for a little bit. But that wouldn't help for ever”. (October 3, 2014)

In Georgia's case, the lack of understanding about depression fostered stigmatizing attitudes within the family towards treatment of depression. When asked where she learned to perceive herself as weak for taking pills, she replied,

Probably my dad. He's never had . . . like depression just hasn't been okay. And like stuff that my sister says: ~~do~~ you want to be someone that has to take a pill every day for the rest of their life?" And, ~~you~~ know, you're going to get addicted to this pill. Pills are easy to get addicted to." Or, ~~you're~~ going to have a start taking more of them, or a new stronger pill until eventually you aren't you anymore." Or, ~~you're~~ just killing your kidneys because you are taking just too much medication." A big part of it for me was, like, you are really depressed when you have to take medication for it. Which is sad and I hate that I think that, because I know it's not true. I don't want to have to take medication for it. So if I can get on with my day and not have to take it, then that's great for me.

(October 7, 2014)

Kate found that her family connected depression with suicide: ~~But~~ they were just so worried that they were going to the worst possible idea that I would kill myself. But I wouldn't. But that was just changing their complete outlook on depression" (October 5, 2014). Kate then described how this worry made her start counselling and tackle her problems. These examples of false or detrimental ideas that family members have made the participants feel worried and stressed. How the important adults in their life perceived them mattered a great deal to them, and the ideology of these adults even seemed to be adopted by participants themselves at times.

Rachel was afraid of how her mother would feel if her teacher revealed that she was depressed:

So she told me that if I didn't tell my mom, then she would have to. And that made me really, really scared. And I didn't want my mom getting upset at the fact that I really looked up to this other adult female figure because I know my mom tries really hard and

family is very important to her. And I didn't want her to think that I looked up to this woman as a mom instead of my actual mom. (October 3, 2014)

Once Rachel told her mother about her depression, she found that she was very supportive and helped her pursue treatment options.

Each one of the participants also talked about one of their family members who suffered from a mental health issue, such as anxiety, depression, bipolar disorder, and so on. None of them described the situation within the family as being a prominently addressed issue, and there was an element of distancing between that family member and the rest of the family, in most cases. For example, Amanda described her family situation:

My mom has two brothers, but one passed away and one is really bad at keeping in touch with the family. He has bipolar, and he doesn't like being . . . whenever he is with the family he is told to take meds. He stays away. (October 6, 2014)

Many of the effects regarding family also had to deal with perceptions that the family members had. These perceptions influenced the participants' own thoughts and actions, such as false ideas about medication or worry about what others thought. From the course of conducting the interviews, I gained a sense of how important family and family perceptions are for the participants. This was even evident due to the nature of how much time in the interview was spent talking about family. For Rachel, Mitchell, Kate, and Alison, having the presence and support of family was key in bridging the gaps towards finding treatment and relief of depression. But, the ideology of their family members hindered the communication between the two parties and created difficulties.

Difficulties between a depressed child and the parent can create strained relationships, as observed by Draucker (2005). This was found to be due to mismatched emotions, incomplete

understandings of the mental illness, and unwillingness to talk to one another: a similar context to Georgia's experience. Other studies support this, and have identified psychiatric illnesses as a potential source of strain on families (Phelan, Bromet, & Link, 1998). Youth who experience depression may also feel a similar strain on themselves, as they would not want to be a member of the family to be singled out due to mental illness. A variety of outcomes could arise from this, such as a reluctance to communicate or ask for help in alleviation of symptoms. Family could act as a support for those suffering from depression if mutual understanding and care exists.

We have seen here that family can have a twofold effect of positive and negative attributes towards the interactions with depressed individuals. Many internal perceptions of the participants were influenced by family members, which resulted in different ways that they think about their mental illness. On the other hand, there were positive support mechanisms which family could provide.

External perceptions. What other individuals thought about those with depression (or what depressed individuals perceived others to have thought) was a major piece of meaning that reoccurred throughout the interviews. Negative perceptions or judgments of others is known as stigmatization and were detrimental in accounts that participants gave during the interviews. For example, Georgia stated, "A lot of people, I think they don't want people to know that they suffer from any kind of illness. Or that they need to talk to someone about it" (October 7, 2014).

During high school, some participants talked about the negativity that existed. Mitchell described his impressions by saying, "Well, I think there is, less so now, but especially through high school, and earlier than that, there is a huge social stigmatism [sic] attached to depression" (July 14, 2014). Amanda described the ideology in high school, by saying, "I think that the majority of other people think that mental illness means that you are crazy. Again, the One Flew

over the Cuckoo's Nest‘ type of extreme. There's no middle ground” (October 6, 2014). She continued talking about a classmate in university:

To her, again, mental illness meant that you couldn't function and that you belonged in a psych-ward‘ type thing. And that's also like other people who haven't been exposed to it. That seems to be the thought that at least I get from it, what they‘re thinking. (October 6, 2014)

Review of the DSM-V (2013) reveals that depressive disorders exist in many forms and to varying degrees, and that Amanda’s perceptions of what others think would be inaccurate. Awareness of the wide array of depressive disorders and severity would certainly help in fostering a correct understanding about depression.

In both of these instances illustrated by Amanda, there was found to be actual stigmatization and perceived stigmatization, in the sense that perceived stigmatization is only thought to be present and may not exist. In this case, the actual stigmatization has physical evidence of existence while the latter is presumed to exist by the depressed individual. Corrigan (2004) found similar categorizations, where actual stigma was termed “public stigma”, and perceived stigma was termed “self-stigma”. Relating this back to the designation of externally and internally guided experiences, public stigma would be an externally guided experience and self-stigma would be an internally guided experience. Therefore, it might be more useful to consider stigma, as a whole, as a mutually guided experience. As a consequence of this, stigma can then be considered as an experiential aspect that impacts someone with depression on two fronts: internally and externally.

However, can there be a relation between public stigma and self-stigma? We can use an example for discussion; Mitchell had trouble talking about his depression, and he explained:

If there was more awareness in society about depression at the time, I would have been more inclined to be open about it. Through high school, my parents had approached me and asked me if I was depressed at one point. And I just brushed it off and swept it under the rug and chalked it up to a bad day. So, I did turn a blind eye to it because of the social stigmatism [sic] attached to it at the time. So if there was more awareness of it in society, then it would have been a lot easier to confront it a lot earlier. (July 14, 2014)

This opinion suggests a decrease in public stigma could cause a decrease in self-stigma, and individuals could feel less stigmatized if the society around them was evidently less stigmatizing itself. Evidence of this relationship was found by Vogel, Wade, and Hackler (2007), where an individual's willingness to seek counselling ~~was~~ fully mediated by self-stigma and attitudes" (p. 40). It is critical to emphasize that self-stigma appears to be a dominant factor in the experience of depression, where perceptions of self can be influenced by the perceived impressions of the outside world. Environments that are socially accepting of those with depression could reduce the public stigma and subsequent self-stigma as a result.

The actual and perceived impressions of others have led to difficulties associated with the communication regarding their mental illness. For example, Georgia also experienced difficulties talking about what she was going through in middle school because she feared what other people and her family members thought:

Grades seven and eight, nobody ever knew. And I think a lot of it was... I didn't want someone to . . . my family, like, they would hear about someone cutting themselves and they would say it's just for attention. And people at school would say that too. And there was no one to go to. I would rather do it and have no one know than have someone think

that I was just doing it for attention, because I knew that response would just make it worse. (October 7, 2014)

On the whole, external perceptions could be viewed as something that presents a negative impact on the experience of depression, since the participants elaborated on the detrimental views of others. Participants felt that depression is something that is not and should not be advertised by someone who is experiencing it, as it could potentially cause others to think differently of them. What I then saw as a consequence for Mitchell and Georgia was a reluctance to talk about their issues with depression because it was not seen as socially acceptable by others. These feelings were commonly found in the literature (Corrigan, 2004; Dinos et al., 2004; Martin, 2010) as well as in the interpretations of the findings within the theme of family. This further supports the conclusion that these family perceptions were particularly meaningful to the participants. Such a barrier would likely be an obstruction to accessible treatment methods, relationships with others, or other positive mechanisms which may have proven to be helpful.

This prevailing notion or idea that depression should be hidden and kept to oneself was a theme that I noticed in multiple findings. Even in a class setting where depression was studied, this was the case as described by Kate: ~~But~~ in that class, that's basically just what we learned: depression is a basic being sad and keeping to yourself" (October 5, 2014).

It can evidently be seen in this section that there are some issues with how the individuals themselves perceive the thoughts of others and how the actions of others can be detrimental to finding resolution in the experience of depression. External perceptions also appeared to be apparent in the school environment which hindered leads for the participants finding help from avenues around them that could have been available.

Mutually guided experiences. Mutually guided experiences are experiences that involve aspects of internally and externally guided experiences; they are directed by both the people and events surrounding the individual with depression, as well as by the thoughts and feelings that the individual carries alongside these external stimuli. Each may have an influence on the other, and work together to govern the experience as a whole. The categories of description that reflected this construct were positive processes, relationships, school interactions, and accessibility.

Positive Processes. The theme of positive processes could be thought of as any measure that was taken or experienced, which aided or was intended to aid the individual in dealing with their depression. Throughout the interviews, the participants talked about many different things such as communicating, self-reflection, mental health resources, counselling, and personal connections that helped them handle or make their experiences with depression easier.

Amanda talked about how communicating was helpful:

It was good to get things off my chest at certain times. I'm not great at talking about stuff a lot. And so that was good because I could actually talk about things that I don't like fully talking about. (October 6, 2014)

Communication was also helpful for Georgia: –Getting things off my chest definitely helps so it doesn't build up. Talking about emotions” (October 7, 2014). She continued by discussing how her talk therapy is helpful: –With the talk therapy right now that I'm doing, I'm learning as to why I think the way I do so I'm not getting mad at myself anymore” (October 7, 2014).

Communication and talk therapy is a widely utilized method (American Psychiatric Association, 2013; Berlim & Turecki, 2007), and its positive attributes were discussed in this study. Amanda and Georgia talked about how they needed to –get things off their chest” to prevent a build-up of

stressful emotions. This phrase is nearly identical to “~~g~~ts it out”, which was a phrase used to describe talk therapy by a participant in a study conducted by Hetherington and Stoppard (2002). Talking with a counsellor or someone within a trusting and positive relationship are possible avenues for such communication; a finding supported by McCarthy, Downes, and Sherman (2008). However, communication must be readily available and timely. Accessibility to professional services like counselling, post-secondary student care, or hospitals is difficult at times (Khawaja et al., 2013; Voelker, 2003). As a result, talking to other people where a positive standing relationship exists may be a more beneficial alternative if all that is needed is a release of thoughts and feelings.

Kate, Rachel, and Georgia all found the process of self-reflection to be a positive skill to have. Written self-reflections were helpful for Kate: “Writing in a journal and stuff like that . . . where you can reflect by yourself and it just really helps” (October 6, 2014). Georgia found resistance to feelings of depression:

Right now, I'm working really hard on catching myself when I'm having negative thoughts about myself. And just reminding myself that it's almost like... it's not me. It's like a second part of my brain that's like feeding all this negativity into me and I have to, like, close the gates, sort of thing like that. Like, it's not allowed in my head. The biggest part is like catching myself, you know? (October 7, 2014)

Rachel claimed that her methods of self-reflection helped her feel comfortable with having depression:

I think a lot about myself and my actions and what I do and why I do it and why I look up the types of people that I look up to. . . I guess I am comfortable with myself because I

know what it feels like to not be comfortable with myself. And I'm comfortable and happy with what I've accomplished and what I have become. (October 3, 2014)

Self-reflection and metacognition regarding one's own mental health was a positive process for Kate, Rachel and Georgia. Thinking and reflecting on their own individual thoughts and thought processes helped them monitor and understand what they were feeling. Such a coping mechanism is practical, affordable, and accessible once a helpful mental perspective and reflective nature is obtained. Mindfulness and self-reflection have already shown to be promising techniques for diminishing and preventing relapse of depression symptoms (Birmaher, 2014; Mason & Hargreaves, 2001). They may also promote resiliency for depression, something that very few research studies have provided answers for (Kim, 2012).

Having and knowing about resources to help with depression was also a good thing. Alison described how they are useful by saying, "If you know ahead of time where these services are, I think it will help a lot more with prevention and things getting worse" (October 3, 2014). Mitchell described knowing about depression to be useful:

The best thing to do would be to somehow prepare students or make them more aware through schooling, as well, of mental illnesses and to address them as early as possible. And try to get them sorted out earlier or sooner than later. (July 14, 2014)

Keeping occupied with work or getting involved in activities to distract themselves away from their depression was a coping mechanism that most all participants shared. Kate explained, "It was just helpful, a bit, to have somewhere to go and everything and have something to do. And have a responsibility" (October 5, 2014). Amanda expressed similar ideas, by saying:

I sometimes force myself to go out. I know that it's easier if I really try. Even if it is just watching movies with my friends, it gets me out of the house, and I am less in my head.

(October 6, 2014)

All participants except Rachel had approached a doctor to find treatment options, with taking medication as the end result. Overall, medication seemed to help the participants. But for some, it appeared to be a trial and error type process to find an antidepressant that worked, such as what Alison experienced:

I have tried three different antidepressants and the first one made me just ridiculously tired . . . and I said “I can't be on this anymore, it's not working.” And then the second one I tried, I tried it for a week and then I had kind of like a freak out. I felt like I had stuff crawling under my skin, and it was really weird. . . The antidepressant that I'm on now seems to be doing most of the work, but I still have to do extras and I think what I'm doing now is really working. (October 3, 2014)

Some medications proved to be ineffective, as seen here in the case of Alison, and created negative experiences. Noting the re-occurring idea of individual differences between people, which manifested itself throughout the study, this idea can also be applied here in the sense that medications have mixed effects for those who suffer from depression.

Alison also talked about how the demeanour of her doctor during appointments was helpful throughout the process:

With my doctor, he kind of just slowed down. It made me realize how serious it was.

When he took the time, I felt really grateful. He didn't make me feel like I didn't have a problem. . . And instead of making me sit up on the stupid bed thing, he made me come

and sit with him. And he was very kind. He didn't brush it off and he didn't try to rush me with him. (October 3, 2014)

I thought that Alison's feedback on how her doctor's positive demeanour within the situation was an interesting detail. Slowing down and making a personal connection with the patient appeared to go a long way in helping Alison feel comfortable with what she was going through. This might have implications for teachers within the education system, who are also busy working professionals. Using this demeanour to interact with students who approach teachers with mental health issues would be a positive mechanism, and could potentially build trust in helping to direct the student towards suitable treatment options from qualified professionals.

Counselling was a subject that came up often during the interviews, and it was found to have negative elements to it even though counselling is generally perceived to be a positive process. Counsellors could act as a supportive body, such as in Kate's case: "I see this counsellor once a week and she is lovely. It has helped so much and I have started pushing myself to participate in activities that I was in before" (October 5, 2014). Mitchell benefitted from the cognitive techniques which counsellors could provide: "The counselling helps in the sense that it made me realize exactly what kind of depression I had. It helped pinpoint my problematic areas that maybe were my stressors, I suppose" (July 14, 2014).

On the other hand, some participants had negative experiences with counselling. Georgia described how her encounters evolved:

I was seeing a counsellor, like all of last year, and I just couldn't get anywhere with her. She just didn't say anything. She would just sit there and look at me blankly. And I just couldn't do it anymore. I didn't even feel good after leaving . . . it was like in the movies,

where she was just like –How does that make you feel?” And I was just like –UUGHHH”! (October 7, 2014)

Rachel had also tried seeing a counsellor, but had no luck:

I didn't feel like talking to a stranger was helping me at all. And I felt like everything she was telling me, all of the advice she was giving me was stuff I already knew. And it just didn't seem worth the time and the money. So I stopped going. And I'm a very interpersonal thinker and I reflect on myself about what I do and why do it. So she was really telling me things about myself that I already knew. And it was frustrating sitting for an hour with a stranger. (October 3, 2014)

Counselling could be seen as a positive process, as it allows for communication, which was already noted to be beneficial. Counselling, as described by the participants, entailed either talk therapy or cognitive restructuring therapy. Georgia and Rachel's experiences with talk therapy lacked a personal connection, as the counsellors were either unresponsive or did not provide meaningful feedback. Studies have shown and discussed strong working relationships between counsellor and counselee to be a commonality in successful practice (Auger, 2005; Shirk & Karver, 2003). Counselling in a conversational approach or format might help this issue, as it can form a personal connection and become differentiated between counselees. Amanda's experiences with cognitive restructuring therapy support this idea:

The person I went to this summer was more of a conversation as opposed to just you telling them all of your problems and get really awkward about everything. And for me, that worked better, because it wasn't solely just me talking (October 6, 2014).

Alison's experiences with her doctor would also support this notion.

Building a personal relationship to carry a conversation on a topic would also benefit from counselees consistently having access to the same counsellor when they book an appointment. These deductions can tie in with the fact of how consistency with counsellors is a necessity. Kate explained,

I saw the same person. And it's good that every time you go in there, you don't see different counsellors. You see the same counsellor, who knows your file, and knows what's going on, and they actually remember stuff that you came in and said last time.

(October 5, 2014)

At the same time, Lee talked about the inconsistency when meeting counsellors as being a problem:

I know so many schools where the guidance counsellor is split between three schools.

Like that's a problem. Or schools that change their guidance counsellors like every second year. And I'm like, that's not okay either. It's exhausting to re-establish rapport with people. (October 15, 2014)

Having a consistent counsellor and someone that the counselled feels comfortable with ties in with the findings on personal connections. Rachel explained, "I think it just really has to do with the type of people. And some people aren't comfortable with some kinds of people and some people are more comfortable with other kinds of people" (October 3, 2014). Such personal connection was suggested to be useful when sharing information. Kate felt that, "Writing it down does not do it justice. So maybe bringing in someone in that wants to talk about it or have someone that has been through it" (October 5, 2014). When asked about positive ways to raise awareness, Lee described her thoughts:

So, having people go into high schools and share their stories, and say that this is my experience and this is how I overcame it. That way, youth feel like there is someone that they can connect with. That way, youth understand that they are not alone, because how many high school aged people feel that they are alone? Like, way too many. And I feel like if you have someone go into high school and talk about it and be like “this is my story”, they would be like “oh, that person is experiencing this too”. (October 15, 2014)

Here, Lee felt that a personal connection with those who are aiding them was important. This helped to eliminate the idea that she was tackling the endeavour on her own. Such an idea ties in with what other participants had said, such as Kate:

It's comforting in a way. It's nice to know that you are not alone; that you're not the only one feeling these feelings and you are not the only one who gets mad and throws papers all over the place just because you're frustrated. It's nice to know it's just not you.

(October 5, 2014)

Knowing that depression is a shared experience and that others are going through the same thing was helpful to the participants while they struggled with depression. We have seen a very similar theme through the connection of online social media, as the online world was a way for individuals to connect and reach the realization that depression is a common problem.

In this section we saw and discussed a number of positive processes that were relevant for the participants. These processes came in different forms and had varying levels of significance to each participant. Furthermore, what worked for some did not necessarily work for others. Some of the most significant and effective processes were self-reflections and having some sort of personal connection with the positive process. In addition to the ideas expressed in

this section, other positive processes arose in other categories of description within the study, making it a prominent area that developed.

Relationships. For this category, relationships may refer to the interaction and connection that the participant had with another person. On the whole, meaningful relationships that were forged with others proved to be a positive contributor to how the participants experienced depression. For instance, Rachel only experienced depression for a brief period of time due to these relationships: “It wasn't a long span of [time] which I had suffered from this, because I was influenced by a lot of positive people” (October 3, 2014). She continued by saying,

And I know that I wouldn't be as successful as I am in my life as I am today if it had not been for [my teacher]. Not just for her, but for other people around me as well who were supportive and understanding. (October 3, 2014)

In a large majority of instances where the participants talked about their relationships with others, the other individual had also experienced some form of depression themselves. This was positive, because a level of understanding existed. Kate explained,

I mean, like, I feel like I talk about it with my sister or my roommate. It makes me feel better because they already know about all of it...so it is nice to talk to people who have been through depression. (October 5, 2014)

The same was true for Amanda during moments when she felt depressed, as she said, “They knew that I was getting too emotional about certain things. So yeah, there is a level of understanding there that is useful because otherwise I would have to talk and explain it” (October 6, 2014). Georgia also talked about being grateful to have understanding friends, as they could help each other find relief in anxious situations. She described a scenario from her university life:

If we go out drinking for example, alcohol is a depressant, right? Generally speaking, someone does get upset at some point. And it started... sometimes it was bad in the beginning. But now, we just kind of learned to be like ~~o~~okay, let's go" rather instead of being ~~no~~, I just want to stay." Like we can relate in that situation, you know? And when we're upset, we could just be like ~~hey~~, I'm upset. I need to go. I can't sit here, I need to go", because we would want them to do the same for us. But, like in first year, when no one knew that I had any kind of depression, like I couldn't say that. You know? I just kept saying I had to go to the bathroom so I could go be sad in my own little corner and be okay. Yeah, we definitely have a good relationship on it for sure. (October 7, 2014)

Adult figures with a knowledge and understanding could also be helpful, such as in Alison's case, —~~M~~ boss is like a second mom to me... she is just a really great person and she has problems as well. She mentioned she has PTSD and stuff so she does understand where I'm coming from with stuff" (October 3, 2014).

At the same time, having friends who weren't directly involved with the participant's depression and served as a friend to help distract was beneficial. Lee talked about some of her friends:

Yeah, they are just fun guys. Good people to help me. I think because of my program and because of what I'm researching, I am constantly surrounded by like... I mean right now I'm doing a paper on rape culture, and I have 10 books with the title rape in my room right now. And those guys are kind of a nice easy relationship where like none of that stuff is going to come up. And you can just go and have a beer and talk about hockey. (October 15, 2014)

In these findings, many of the relationships with others, which were described by the participants, had a positive effect on their experience with depression. Support and influence from peers allowed the participants to cope with the side effects of depression and receive emotional encouragement, whether or not those peers had personally experienced depression. However, a higher degree of understanding can potentially exist if both of the individuals within the relationship have experienced depression, as they both have an idea of what the other could be going through. It seemed as though the participants were more comfortable interacting with these people, and they were helpful in dealing with stressful situations. In the literature, Macdonald et al. (2005) found similar results, in that interacting with others who have a mental illness was easier than with those who did not. A similar idea was also found and previously discussed within the theme of online social networking.

That being said, relationships with those who have not experienced depression or who have not openly talked about depression could also be positive. For instance, Alison's mother and Rachel's teacher were both instrumental in helping them through the daily struggles with symptoms of depression. Lee also had some "fun guys" to spend time with, which she said allowed her to keep her brain occupied with less stressful thoughts. Therefore, relationships with others can be helpful if the nature of the relationship fulfills the needs that the depressed individual requires.

Overall, having relationships with others appeared to be positive if a level of understanding was developed between the two people. If there was mutual ideology or types of experiences, the participants found it easier to interact and support one another.

School interactions. Findings also showed that school had particular effects on students who experienced depression, both positive and negative. For some participants, school served as

a means of keeping busy or occupied. Kate found that going to university helped for a number of reasons:

It was just helpful, a bit, to have somewhere to go and everything and have something to do. And have a responsibility. Something that I knew I had to go to. Not like these extracurricular activities that I have been doing that make me happy, it's just nice to have something that I know I had to do. It stabilized me. (October 5, 2014)

For some participants, school was also a means for helping them develop self-identity. Georgia explained: "High school was exciting. It was full of new opportunities for me to be a different person. I started to figure out what I wanted to do" (October 7, 2014). She then identified another reason why she enjoyed school: "I think maybe part of it was my escape from home. But it was like an escape everyday" (October 7, 2014). While Rachel was in the process of finding her sense of self and overcoming her depression, she talked about her co-operative education course that helped her along:

I enjoyed the idea of getting to help other people. When I was grade in 11, I got to do my first co-op in the grade nine art room with the art teacher who, we were buddies, and it felt really, really good. And there were a few times when the teacher let me do my own lessons, like facial anatomy. I got to sit there and watch them all like look at each other's faces and compare each other's faces to see if what I said was right. And just watching them all become so astounded by this because they are just grade nines. And I really enjoyed that". (October 3, 2014)

School, both secondary and post-secondary, appeared to be a place that helped keep participants occupied and in a mindset that distracted them from depression. Kate described how the responsibilities of being a university student helped her to divert her focus away from thinking

about how sad she typically was, and provided her with stability. Rachel also benefitted from this idea of responsibility, as she received a number of co-operative education and peer-assistance opportunities to help her develop her sense of self. Her supervising teachers even allowed her to teach classes and hold typical teacher duties such as marking and planning. She received these opportunities shortly after she had been depressed, and she spoke quite frequently in her interview about how they helped her build her passion to become a teacher. Rachel found joy in her responsibilities, which may be another reason why they were so helpful to her. Souma, Rickerson, and Burgstahler (2002) have found that this type of experiential learning for creative students with a psychological disorder to be valuable. These findings suggest that providing depressed students with responsibilities or duties that offer a degree of meaningful development could be beneficial to students if their individual differences surrounding their depression are accounted for.

However, schoolwork could add stress to everyday life, like in the case for Amanda.

When asked if schoolwork affected her stress levels, she replied:

Yeah, sometimes. Not always. I mean, there are times when I can do it and I'm fine. But if I'm already on that edge, sometimes schoolwork can push me over because it's the thinking that I can't do it or if I do it it's going to be terrible. Or that I won't be able to accomplish everything in time, right? But I think that it sometimes mainly focuses on how I am doing when the stress first happens. But for sure, stress never helps. (October 6, 2014)

Academic stress in University was a trigger for depression that almost all of the participants mentioned: social aspects of university, the size of the academic workload, the difficulty in content of such workload, occasionally missing classes due to depression, stigmatization by

classmates, and lack of motivation towards school were problems which were discussed. These external stressors or triggers for depression have the potential to arise suddenly and without warning during an academic career. Stress and perfectionism are traits that other research works have identified to exasperate symptoms of depression (Hysenbegasi et al., 2005; Rice et al., 2006). Therefore, the effects of academic workload could be dependent on the difficulty of the work, the academic ability of the student, and environmental factors surrounding the student at the time.

When asked about relationships between depression and school, Mitchell thought about academic accommodations of schoolwork for those with depression. He shared his thoughts about how classroom accommodations could be created and problems surrounding them:

When assignments get tougher, there were times when I felt like I didn't want to deal with an assignment. Or I didn't want to do these assignments. I didn't want to do anything that day. I guess, ideally, it would have been nice to have the opportunity to have a day extension to accommodate for that or make up for that. And at the same time, I don't think that's very practical, because then what are you teaching the next generation? What are you teaching students? That it's okay to be late on deadlines? Do you know what I mean? It doesn't seem practical to me. When you get into the real world, there are no deadline extensions unless you were able to pull strings and BS a lot of this stuff. But you were never given extensions on the due date. There's no "okay, well you have a mental issue" or even "you're sick, so let's change the due date." You need to make it up somewhere or be able to cope with whatever you're dealing with. So I think if you're giving extensions to students because they had a bad day, or really bad depression day, what kind of life lessons are you teaching them? (July 14, 2014)

The idea of schoolwork stress is an interesting idea when compared with Mitchell's thoughts on school accommodations. To maintain consistency with the Ontario Human Rights Code (2012), learning accommodations are put in place to aid disadvantaged students with disabilities. Mitchell believed that time extensions on assignments would be beneficial for those with depression, but identified them as a measure that could cause problems. He felt that time extensions are not a true reflection of the workplace environment, and that extensions would not promote or foster resiliency. Such an opinion begs the question about what types of classroom accommodations for students with depression would be ethical, practical, and offer opportunities for resiliency. On one hand, depression affects the ability to learn at an optimum level, and can impede memory, speech, thought, social interactions, and overall academic achievement (Crundwell & Killu, 2007). For these reasons, learning accommodations are warranted. According to the literature, Auger (2005) suggests that compromises regarding workload expectations could be made between the student, teacher, and school counsellor that consider both the student's diminished capacity to complete work as well as the teacher's responsibility to ensure the student has a grasp on the required material. Learning accommodations, which a teacher may be able to provide, could alleviate stress associated with schoolwork and soften the negative impact that students may experience in school if such accommodations are created strategically and purposefully.

For Mitchell, the academic work in high school wasn't the problem, but more the social aspects of going to school:

I found the social aspects of high school to be much more, I suppose, challenging. I would assume it would be for most people too. I always said high school was the most

socially traumatizing thing through anyone's life experiences. But, I'd use it as almost an excuse to not go out and be social with people in high school and stuff. (July 14, 2014)

When considering how school impacts individuals with depression, a major factor lies in how teachers interact with students. During the interviews, there were a couple of different opinions on the topic with mixed results. Rachel attributed a lot of her success in finding relief from depression to the support of one of her teachers: “I was lucky enough that there was a person, a teacher, who did notice. She really acknowledged that I had a problem and that what I was doing was not healthy” (October 3, 2014). This interaction proved to be a positive one, as she continued by saying: “That's just what I needed. I just needed somebody to acknowledge me and say “you need help, and I'll help you best I can” (October 3, 2014). Like Rachel, Amanda also felt that teachers could act as a supportive body to students with depression. She expressed this opinion by saying:

I know it's kind of a tough situation, but I think it's important for teachers to maybe pay attention to where students are struggling, and what students are more held back. And just maybe talk to them. I know it's a difficult thing because you don't want to single anyone out for being different or wrong. But I think there are times when it can be seen in some people that they're having difficulties, and instead of just kind of assuming that it's kind of fine. (October 6, 2014)

When asked how teachers could go about doing this, Amanda said:

Maybe it's just more so that they need to make it known that they are available for help when it's needed. And that they can help in any way they can and that they are a safe person to go to that's not going to make judgments. And trying to get them the help they need; whether it's a crisis response centre or counsellor or whatever. (October 6, 2014)

Rachel concluded her thoughts on the relationship between teacher and student by saying:

The biggest adult influence that students have in grade school and high school, aside from their actual parents, are often teachers. So having a strong, capable teacher, who does actually care about students instead of just showing up for their pay check, that really makes a difference. And making students just all feel equal and important. And I think that's the most important thing. (October 3, 2014)

Alison also had some thoughts about the teacher/student relationship regarding depressed individuals, but her opinions were different than those of Rachel and Amanda. She shared her impressions:

I think there needs to be someone who is not your teacher to help you. Unless you are really close with them. For me, if my teacher knew that I was going through something, I wouldn't want that to impact how they saw me or how they treated me in class. Like people could see that something is going on. I don't think it should be someone who has the possibility of treating you differently. (October 3, 2014)

How teachers and students interact with each other comprises much of the way students interpret experiences with school. For students with depression, some of the participants found and believed that teachers could be a support system. In the case of Rachel, her teacher helped her acknowledge that she had a mood problem and needed to find help. Even though it has not been a teacher's formal responsibility to directly help students with depression, they can provide significant positive support. It was also noted that teachers can make a difference simply by acknowledging that some students have a problem. Some of her suggestions were doing little things like monitoring student behaviour and communicating with students. Furthermore, she felt that making students aware that the teacher is a safe and non-judgemental person to talk to would

also make a difference. This resonated with Rachel's statements as well, as she believed having a teacher who cared about their students made all the difference. These descriptions of meaningful teacher interaction propose the notion that the teacher can act as a bridge or mediating body to direct and provide support towards proper healthcare or counselling. Other research has also noted the benefits which teachers may bring forth. Students who believe they have a strong connection with their teacher are more likely to turn to their teacher for emotional or academic support (Fredriksen & Rhodes, 2004; Huberty, 2006). Once such a relationship is forged, the teacher may be able to direct students to proper help, regularly monitor the student's risk level, provide social support, or help create learning accommodations (Auger, 2005; Crundwell & Killu, 2007). Acknowledging this, school systems are currently implementing "*Talking about Mental Illness*" programs (The Canadian Mental Health Association, 2001) and providing teachers with the knowledge and materials (Government of Ontario, 2011) that they may need to work with situations such as those that have been presented in this study by the participants. The ministry of education seeks to support the province's mental health and addictions strategy at a school level by initiating early identification of mental health issues and adding strategies for student support (Center for Addiction and Mental Health, 2016). However, school counsellors are typically perceived by teachers as the best support for students with mental health issues, and some teachers do not feel well equipped to handle these types of situations (Reinke, Stormont, Herman, Puri, & Goel, 2011).

Georgia also shared some thoughts about having a teacher involved in a student's personal life with depression. For herself, she felt that she would not have responded well if a teacher approached her about what she was going through:

There was no helping me in the sense that if somebody had been like –you probably suffer from depression, let me talk to your parents” or –let me help you”. That would've never worked for me. That would have just made things worse. (October 7, 2014)

Even though teacher intervention was found to be successful for some, it may not be the case for others due to the idea of individual differences in relation to depression. As a result, supportive mechanisms, which teachers may attempt to provide, must vary from student to student, and not be regarded as a –one size fits all” approach. Through Alison’s interview, she expressed her opinion about how she would feel somewhat uncomfortable if her teacher knew she was depressed. She feared it might cause them to see her differently, and could affect the way she was treated by this teacher. Alison’s opinion carries a fair amount of self-stigma, in that she believes her teacher would treat her differently, when in reality this may not be the case.

These mixed results from the participants show that teacher intervention towards student depression is not a clear-cut issue. On one hand, having the teacher involved with a student’s experience with depression can be instrumental in helping to find relief from their mental illness. On the other hand, students may not be personally receptive to the idea of teacher intervention. Given that previous findings in this study have shown that proper intervention, communication, encouragement, and destigmatization are all positive contributing factors for those experiencing depression, the rewards associated with helping the student with depression may outweigh and be more significant than the negative factors. Perhaps teacher involvement may be appropriate if there is a strong personal connection between the two; one which is trusting and free of stigma.

Accessibility and awareness. The theme of accessibility and awareness refers to a number of different aspects. Accessibility corresponds to how readily available resources for

treatments for depression were for the participants. Awareness will refer to knowledge or the mobilization of knowledge in relation to depression.

In this category of description, the most dominant idea to appear through coding suggested that a lack of knowledge about depression exists. This finding was also found and previously discussed alongside the themes regarding family members and external perceptions. Kate talked about what she had learned in school:

When you learn about psychology and you learn about depression, they really just don't do it any justice by just saying, "oh yeah, they are just sad and just keep to themselves". It's all based on what I have read in high school or in books. They just really don't do a testament to it on TV or anything like that. (October 5, 2014)

Amanda felt that she could have used more knowledge about depression as well:

I guess I would have liked a class that mainly focused on mental illness or talked about it. It was briefly brushed over in one of my health classes in one of my grades somewhere, but I wish that there was more of a discussion on the effects, and the effects of people around you. And I do remember that at my school in [city], somebody did commit suicide. And the school didn't really explain anything. Depression was still a . . . it happened and it was terrible. But it was never really explained to the students and they were kind of confused that this was a thing. (October 6, 2014)

Both Kate and Amanda felt that the knowledge they obtained about depression before they experienced it was insufficient towards preparing them. There were gaps in how knowledge and understanding about depression was presented to them, and that their classes in school, textbooks, or the way which depression was portrayed by the media did not create an accurate depiction of what depression truly was. A similar finding was uncovered and previously

discussed under the theme of internal perceptions, in that ideas about what depression is are mixed, varied, and inconsistent. Other researchers have found evidence to support this idea that knowledge about depression within this age grouping is disjointed and incomplete in a number of respects (Hartman et al., 2013; Hess et al., 2004; Ruble et al., 2013). These findings support the idea that depression is misunderstood in what it is, how it manifests itself, and how it can be overcome. Such results could suggest two things. One conclusion could be that the current methods for conveying information and teaching others about depression fall short in completing their intended purpose. Another conclusion that could be made is that conveying information on the experience of depression that depicts a true testament of the experience is very difficult to do for those who have not experienced depression themselves. The nature of, feelings, and true experience of depression may not be something that can be easily translated into words or pictures, which is why those who do not have experience with depression find it difficult to understand its true nature. This implication may explain why a lack or difficulty of understanding surrounding depression may exist within those who have not experienced depression themselves.

Lee also felt that the knowledge and ability to convey feelings was a necessity that needed improvement: “I feel like in elementary school, people need to have the language to talk about what they are feeling. . . like there needs to be something in elementary school, where kids can learn what these things are” (October 15, 2014). When asked about how awareness about depression could be spread, Amanda replied,

Through teachers; mainly teachers. They had those posters that you see around school. In high school, there are usually posters up on bulletin boards. Or maybe that was just my high school. They're usually colourful, and I know the high schools that I went to, people

would at least read them because mainly because they didn't want to go to class. But either way, you still read it. (October 6, 2014)

The accessibility to mental health resources was also found to be an area that could use improvement in two regards: increased physical and perceived accessibility. A lack of physical accessibility was expressed by the participants in a number of ways, which referred to resources not being physically available or difficult to find. This was a problem that Lee talked about:

Again, knowing where the resources are. Here [at my university], it's not so bad because it's, like, front and centre. You go into the [university centre] and you'll see it. But, I've been to other campuses and I would never be able to tell you where or how to find their counselling area. Yeah. The thing is just that the availability is a big problem and not just having it randomly available, but strategically and mindfully available so that people are comfortable enough to access these things. (October 15, 2014)

Kate also illustrated a problem with her university's counselling centre:

I mean, like, a big problem there is that they are very busy. They have a lot of students in there. And students who are just learning about it have to wait two weeks for an appointment, and it just sucks. So I think they just need a few more counsellors and stuff like that. (October 5, 2014)

She then went on to describe troubles that her friend was having:

She just says that they never answer her calls. Or that they are never available for her. Or she will have to call WAY in advance for when her prescriptions are running out. Like way in advance, like two weeks before the stuff runs out. I mean, it is a process. (October 5, 2014)

Georgia had a similar experience: –My first appointment, I think was a week [to wait]. And then to book another appointment, sometimes it was like two weeks. And for me, that wasn't enough” (October 7, 2014).

On the other hand, a lack of perceived awareness was also discussed. This referred to the awareness or acknowledgement that resources for treating depression were available. Aids for depression may have physically existed, but participants were unaware of or confused about some aspect of them. For example, when she was asked about mental health services that were available in university, Alison replied, –I am still not aware if there is anything. I'm sure there is, but I haven't looked into it. I haven't seen anything . . . and there isn't anything upstairs” (October 3, 2014). The same was true for Mitchell: –For depression, I never really encountered anything. Unless there was some sort of support group that I was unaware of” (July 14, 2014).

Kate discovered a lack of awareness through her work as a residence assistant:

When I was a [house president] and a [residence assistant], students would come to me and say that they are having troubles with their roommates and everything. And I went and talked to them and everything and referred them to health and counselling, because that is what we are supposed to do. And they didn't know [about health and counselling] (October 5, 2014).

Regarding high school, Alison felt that obtainable assistance for issues with depression was unclear:

At my high school, you would commonly talk to the guidance counsellors, although I don't know if I would be talking to the guidance counsellor who helps me with picking my classes or if they had someone specifically. . . I don't think you see them as people you can go to. (October 3, 2014)

Accessibility to mental health resources in secondary and post-secondary education was found to be hindered as a result of the stigmatism and what fellow classmates might think of them. Lee described a problem in her high school:

Our bulletin board was, like, right in front of where everybody passes to get to their lockers. And that's where our mental health awareness bulletin board was in high school. Even if I wanted to take something from there, I don't think I would have because even in high school, it's still something like, "what will my friends think about me if they see me pulling down the number for the teen-talk phone line?" So I think having resources available [is important], but not to the point that people will be ashamed to take them. (October 15, 2014)

Lee continued by saying,

I think people would be more likely to talk about if they didn't have to worry "what does the person right behind me think about me taking this?" So putting something somewhere that people can more access it more readily. (October 15, 2014)

Awareness about depression and appropriate resources is also an influence on accessibility to resources. If individuals are unaware of the resources or helpful measures that exist, then these resources could be deemed as inaccessible. Therefore, awareness is key, and having physical accessibility to aids is first dependent on the perceived accessibility. Lee spoke to this, as she discussed how health services at post-secondary institutions need to have a presence with students knowing that they exist and where they can be found. This appears to be a real problem, as Mitchell, Kate, and Alison described instances where they themselves or other university students were unaware that student health centres and services were provided at their post-secondary institution. In order for services to be effective, students have to be aware of

them, and the findings have indicated that there are gaps in what students know about student health services that are available to them.

Once mental health information and services are advertised properly and effectively, the next step in being able to treat individuals is to have physical accessibility. This entails having appropriate and timely care for those who need it in accessible locations. Kate mentioned that significant wait times exist in order to receive care at her student wellness centre, which is troublesome when required healthcare is crucial. The document, titled *Open Minds, Healthy Minds* (2011), outlines current strategies being undertaken towards mental healthcare. Analysis of this document revealed that many future initiatives aim to increase physical accessibility of mental health services. The document also discusses how systems need to be streamlined and focussed to aid in this endeavour. Since the document proposes that these services need to be enhanced, this implies that there is an existing deficit in the field, and that a lack of physical accessibility regarding mental health resources in Ontario exists. Triangulating the findings from this study and the document analysis shows that physical accessibility to appropriate mental health services needs to be increased.

Summary

This chapter provided an overview of the findings that were collected for the study. The participants touched on a wide variety of topics, which influenced their experiences, and many of these experiences had elements that were similar to those of other participants. From this, one can conclude that some of the ways youth and adolescents experience depression are shared experiences.

Even though the findings about how university students experience depression were diverse, there were many connections that allowed these experiences to be grouped into themes

and categories. Categories of description could be grouped into three predominant constructs: internally guided experiences, externally guided experiences, and mutually guided experiences. Each of these constructs contained a collection of categories to support the dominant ideas which the construct underscored. Such groupings allowed for connections between experiences to be drawn and discussed, which will be done in the next section.

The Outcome Space

Through the analysis in this chapter and the relationships that were drawn between different categories of description, the following outcome space was constructed (Figure 2):

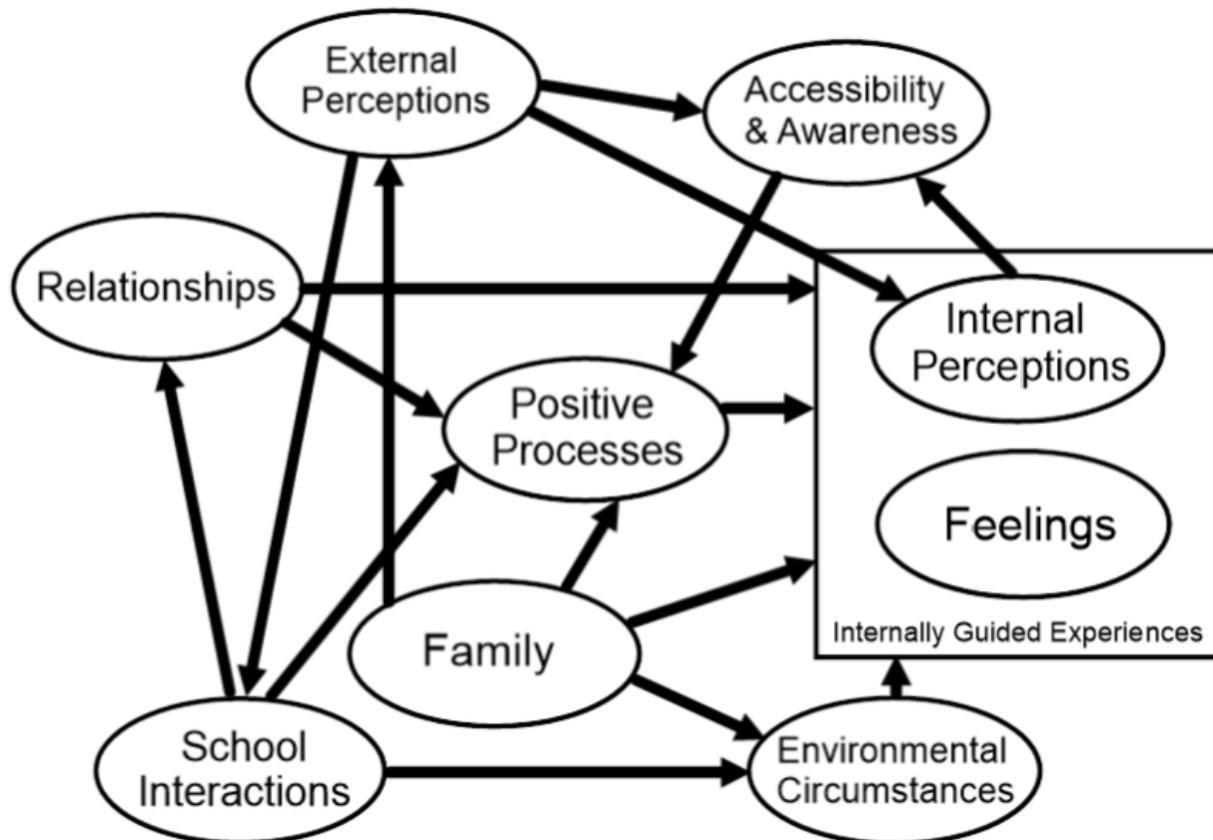


Figure 2. The outcome space of university students' experiences with depression

The outcome space was designed in such a way as to display two main things. The first is to show the variety of categories of description which make up the experience of depression.

Since phenomenography seeks to discover the different ways which someone experiences a phenomenon, this outcome space shows the different topics which arose throughout the course of my research. These different elements of the experience were: feelings, internal perceptions, environmental circumstances, family, positive processes, relationships, school interactions, external perceptions and accessibility and awareness. These categories of description are represented inside the oval bubbles in Figure 2.

The other intended purpose for this particular outcome space was to show the relationships between the categories of description and how they influence one another. By looking at these relationships, I was able to gain a better insight into the phenomenon. For this study, a relationship and resulting arrows in the outcome space were added based on how the participants described one category to be affecting another. For example, if a meaning unit or sub-meaning unit had a connection to a different category of description other than the one it was placed in, an arrow was added in the outcome space. The categories of description are not stand-alone entities for depression; they impact one another. As shown in Figure 2, the arrows depict which categories influenced other ones. For example, school interactions were found to lead to the construction of environmental circumstances, forge relationships, and contribute towards positive processes. Noting these implications allowed the outcome space to be constructed in this fashion.

Central to the human experience about the phenomenon of depression are the feelings and perceptions of the individual themselves. These appeared to be the root of what governed the experience, and the internal mindset of a person governed how they felt, what their attitudes were, how they interacted with others, their work ethic, and how to live with their depression in general. The ideas presented from externally guided experiences and mutually guided

experiences could be traced back in some way or another to result in or be an influence towards a personal thought or feeling. For instance, environmental circumstances could trigger feelings of sadness and exacerbate symptoms of depression. Or, positive school experiences were seen to help some youth build self-identity and gain resiliency towards coping with depression. Because of this central relationship, I have organized internally guided experiences as being a central point to the phenomenon as a whole. This is shown within its own box in Figure 2.

Using internally guided experiences as a central aspect of the experience, externally guided experiences and mutually guided experiences can be thought of as implicating constructs that influence and impact this central element of depression. These external factors could influence how someone experiences the internal factors. These internal factors can be thought of as being closer and more personal to (but not more important than) the experience of depression.

From this outcome space, I will lead a discussion on the major ideas and findings about the experience of depression in the next chapter.

Chapter Five: Discussion of Findings and Conclusions

This chapter will provide a discussion of the findings and interpretations to answer the research questions of the study, as well as focus on the implications for theory, practice, and future research surrounding this thesis. Limitations within the study, personal reflections, and some concluding words are also included.

Restatement of the Problem

The purpose of this study has been to explore past and present experiences of university students with depression. To gather information about this topic and develop an area of focus, the following research questions were used to narrow the scope of the study:

1. How do youth experience depression?
2. How does school affect a student with depression?
3. What factors are instrumental in influencing the illness?

Throughout this chapter, responses to the research questions will be framed through a discussion of the results alongside references to the literature. Connections between the literature and findings will be made to suggest implications for the research.

Discussion of Findings from the Outcome Space

We saw that there were a number of different categories which contributed to positive processes: family, relationships, school interactions, and accessibility and awareness. All of these categories had some positive contribution to the experience of depression in one way or another. In turn, these positive processes could influence the individual for the better. This category was very dominant in comparison to the others simply due to the number of other categories which fed into and influenced this one. Even though most categories had their own negative aspects,

positive processes was found to be dominant enough to be a category on its own because the topic was discussed so often.

Another reason as to why positive processes arose as its own category of description and negative processes did not is because all of the participants who were interviewed and participated in the study are experiencing success with managing their depression while completing university. None of the participants had dropped out of school because of their mental illness and were on the road to finding some positive outcomes and completing their education. This will be further discussed later as a limitation to the study as well.

There were other notable relationships which became apparent as a result of constructing the outcome space. Family, as a category of description, had an influence on four other categories, but did not appear to be greatly influenced itself from other sources. For example, the participants did not discuss in detail how their family situation had changed as a result of depression, but rather how depression was influenced by the family. Such a result suggests that family is an influential aspect of the experience, but not substantially influenced (at least to any degree which the participants discussed). I felt that it was very difficult to determine if family experiences were affected, which could be viewed as a limitation within the study.

Implications for positive outcomes. There were many positive processes identified from the accounts of participants. Self-reflection, conversations, timely accessibility to healthcare, as well as personal and consistent connections with counsellors served as positive mechanisms. Awareness of as many alleviating factors and coping strategies as possible to account for the overarching theme of individual differences across cases of depression was important. Since experiences differ so greatly, counsellors, healthcare workers, family, friends, and teachers, must be aware of methods to help reduce symptoms of depression. A strong conceptualization and

knowledge base about depression by as many people as possible could be a way to overcome this apparent problem.

When asking participants about their conceptions of depression, some individuals presented it as one idea while others thought of it as another. Conceptions of depression appeared to be varied. Multiple ideas about depression existed, which showed that there was not a unified understanding of this mental illness. A review of the literature and findings revealed that there is a general lack of a clear understanding about what depression is and its treatment; more universal understanding of this mental illness could benefit society as a whole (Geddes, 2008; Jorm et al., 2006; Jorm et al., 1997). This was expressed through the participants and the other individuals in their life. A comprehensive overview of what depression is would be helpful to both those who do and do not have experience with depression. Once this is established, conveying such knowledge to those who need it will raise awareness about depression as a whole. Learning about it at an appropriate age would be beneficial, which is why schools are in an ideal position to teach students about depression. Although there are courses in secondary and post-secondary education which touch on the topic, participants regarded them as very minimalistic. Bringing about an enhanced awareness has the benefit of preparing students with the knowledge they need for the future, and educational practitioners would be the ideal bodies to go about doing this because they have the skills to teach effectively, and consistently over multiple years.

Many different attitudes and conceptions about stigmatization were discussed. The idea of stigmatization was discussed in relation to a number of different themes: internal perceptions, external perceptions, family, and accessibility and awareness. For instance, Amanda had a roommate who vocalised her prejudice and hurtful perceptions about those with depression. Or,

Georgia perceived those who take medication for mental illnesses to be weak. Due to the wide number of instances where stigmatization is present and the inherent hindrance which it brings to individuals who are depressed, this implies that a number of different areas must be addressed to combat this problem. Public and personal awareness about depression must continue to be enhanced.

Implications for healthcare practitioners. The information and ideas found here in this thesis may prove to be useful for mental healthcare practitioners when assessing and treating those with depression. First, the accounts given by participants give qualitative accounts of their experience, and represent genuine and personal accounts on the subject. A simple review of the findings narrates what those who suffer from depression experience, and helps to provide information to those who have not suffered from this mental illness. Qualitative data can present a more in-depth and unique representation than quantitative data about how those who struggle with depression progress through it, which could be helpful to counsellors, doctors, or cognitive-behavioural therapy practitioners for instance. Informing those who have not experienced depression is vital, as the majority of the population falls within this group (Canadian Mental Health Association, 2013) and they may not have a knowledge base or understanding to help others in need. This information is applicable to not only professionals in the field, but non-professionals such as family, friends, and teachers if disseminated into appropriate and non-scholarly forms.

Implications for school practitioners. Some of the results found in the study have implications for practicing teachers, administrators, and school counsellors and the education system as a whole. The participants discussed ways in which their teachers were helpful (or could be helpful) regarding their experiences with depression. Offering a supportive relationship

between student and teacher, like in the case of Rachel's caring teacher who showed empathy and concern for her students' well-being, was an instance where school acted as a positive contributor. Or, school could also act as respite when life at home was difficult for the student, like in the case of Georgia who had a wealth of family problems. Solutions and positive contributions from schooling could be made depending on what exasperated the depression. From this, successful supportive measures will depend on each particular student case. The findings showed that school can offer opportunities for success from leadership roles which contribute to self-esteem and personal identity to simply being a space or responsibility to keep students occupied and distracted from depression. Having teachers who may acknowledge these possibilities for meaningful development can be an additional tool for supporting students in addition to assistance provided outside of the classroom.

When asked about what resources or supportive measures were in place at their elementary or secondary schools while they attended, the participants had trouble identifying and elaborating on substantially relevant and helpful sources. One could conclude that this could be a result of possible incorrect implementation by the school system or that very little was done to support the issue at the time when these participants were in grade school. Today, we can see that there are efforts being made towards aiding teachers with issues surrounding mental health. With all of these pieces of information taken into account, the notion that there has been an increase in mental health awareness and support inside the classroom has increased in comparison to previous years.

At the same time, school can also be detrimental to students who suffer from depression. Teacher interactions with depressed students were not endorsed by all participants, which is a significant finding in itself because it shows that teacher interactions must be mindful and take

into account the individual differences of the students; students have their own unique experiences which can be difficult for teachers to know of, interpret, or react to. Students may be concerned about being stigmatized and centred out due to their mental illness in the classroom setting, as negative personal perceptions of students could be perceived to alter the way in which the teacher interacts, teaches, or assesses the student. Or, the student may not be inclined to open up to outside help, such as the case for Georgia when she stated –“That would've never worked for me. That would have just made things worse” (October 7, 2014). Relating this to other findings, it shows that teacher intervention may not always be a successful course of action. But, teachers may be able to provide information on those unique experiences to practitioners who are in a better position to help those individuals. Or, they can offer encouragement towards seeking proper assistance for depression, like in the case with Rachel and her teacher who encouraged her to talk to her parents and counsellors.

In short, the findings of this study regarding suggestions for practicing teachers advises two things: one is that teachers who are cognizant and informed about the situations with students in their classrooms can potentially act appropriately in the best interest of the student to provide a positive outcome. This action could come in a variety of forms, such as communication with the student in an empathetic and concerned manner or negotiation of academic expectations. Such actions will likely be different from student to student. The other conclusion which could be drawn from the findings is that a teacher's role with a depressed student is likely still a subjective matter. It depends very strongly on the student/teacher relationship and whether or not both parties have a mutual understanding and perspective on the issue. As previously discussed, school counsellors are in the ideal position to help students with

mental health problems due to their skillset. In this study, the participants have expressed their thoughts and stories on how a teacher may potentially act in a supportive manner.

Implications for post-secondary institutions. Student healthcare supports which are implemented in post-secondary institutions, like student health and counselling centres, can also benefit from the findings in this work. Considerations for future work and practice can fall into two categories: physical accessibility and perceived accessibility. In terms of physical accessibility, the participants discussed their interactions with student health and counselling at their university, and came to the conclusion that the centres do not have a high enough rate of patient turnover due to various constraints within the organization such as lack of staffing or funding. Help is sometimes not readily available when there is a critical need, and that some centres are physically hard to find. Feasible routes to remedy these issues would help those who experience depression. In terms of perceived accessibility, the consensus among participants was that they were unaware of what sort of health and counselling was available from their university. In some instances, the participants admitted to not being vigilant in finding resources, such as when Alison and Mitchell said they were unaware of the existence of student health services at their university because they had not looked for them. However, any sort of increase in strategic and purposeful advertising of these resources within the university would likely help alleviate this problem that appears to exist.

Implications for online social media education. As a new and emerging topic, the groundwork on links between online social media and depression appears to be in the developing stages. The results found here suggest that there are both positive and negative relations between the two. Online social media can act as a bridge to help those with depression find others who are experiencing the illness, which operated as a source of comfort. But, overuse, misuse, and

misinterpretation of online social media were found to lead to problems. Looking forward, those who educate aspiring social media users need to show that there is potential for negative side effects, and they should be shown how to be mindful and considerate of how they are using this communication tool.

Implications for Further Research

Depression has been widely researched as a mental illness, but there is still work to be done regarding the role of public education in relation to the youth demographic of students. Roles and responsibilities of teachers to students with depression have not been defined aside from the statutes of the law, and have only been defined by the Ontario College of Teachers when a risk of aggression or suicide is present (Ontario College of Teachers, 2015). Moreover, some studies have also identified a need, as expressed by practicing teachers, that they themselves are not well equipped to deal with mental health issues (Heath, Toste, & Beettam, 2006; Reinke et al., 2011). Therefore, policies which are both clearly defined and evidence based, may benefit the endeavours which schools will likely continue to face in the future. It has been suggested that evidence-based intervention strategies for school personnel which are specific to depressed students are non-existent (Crundwell & Killu, 2007), however the Ministry of Education in Ontario does provide information for teachers about students with depression (Government of Ontario, 2013). It is unknown though if such information is utilized and successful in helping students, as initiatives by the ministry are still relatively new. The discussion of a teacher's responsibility regarding students with depression is debatable from many different perspectives. To what degree should teachers become involved and knowledgeable of student issues outside the classroom? What academic responsibilities is the teacher required to hold for the student? Different teachers may have different perspectives on

these questions. Any decision should be supported by research; future research on depression regarding life in schools is still an area that needs further exploration.

The topic of academic accommodations for students who suffer from depression also came up in the study. Psychological illnesses, such as depression or bipolar disorder, still allow the individual to maintain a high degree of functionality in the classroom and the real world, but can create learning disadvantages in the classroom (Hoff, Palermo, Schluchter, Zebracki, & Drotar, 2006; Logan, Simons, Stein, & Chastain, 2008). Upon searching the literature for learning accommodations in the classroom for students with depression, only a few research studies turned up (Crundwell & Killu, 2007; Salzer, Wick, & Rogers, 2008; Souma et al., 2002), but the Ontario Ministry of Education does provide strategies for teachers who have depressed students in their classroom (Government of Ontario, 2013). As previously mentioned, it is unknown how effective these measures are. Furthermore, since this study has shown that there are many individual differences between students who have depression, further differentiation of these strategies could be beneficial to avoid approaches that might work for some but not others. Future research in this field is necessary to discern best practices that will affectively aid, strengthen, and enhance student learning.

The Research Questions Revisited

Taking into account the findings and their discussion as previously presented, the research questions which governed the thesis will be reconsidered and answered in brief:

1. How do youth experience depression? The study uncovered many different ways in which youth (ages 19-25) have experienced depression at different stages of their life. Some of these experiences showed similarities to others found in the literature, while some appeared to be different. As a whole, experiences with depression could be

affected by internal and personal factors, externally mandated factors, or an experience governed by a mixture of internal and external elements. Internally guided experiences included feelings associated with depression and internal thoughts or perceptions. Externally guided experiences included environmental stimuli, family interactions, and external perceptions associated with depression. Experiences which had both internal and external components were the positive processes identified to alleviate depression symptoms, relationships with others, interactions between the student and school, and accessibility and awareness associated with knowledge and treatment of depression.

2. How does school affect a student with depression? The participants of the study discussed different interactions which took place at school, showing that the way in which school influences a student with depression is varied depending on the character of the individual. For the most part, school offered a sense of responsibility and focus for students which could allow their concentration to deviate away from their depressed mindset. Participants described that having work to do or to be in a responsible leadership role was positive for them, and contributed to their self-identity. However, those responsibilities could exacerbate symptoms under various circumstances. None of the participants talked about receiving academic accommodations, but the implications of such accommodations was discussed. Teachers at school could also play an important role in the experience with depression, as a teacher may act as a source of encouragement, support, or guidance for students if a respectful relationship exists. Since teachers are not mental health professionals or might not have any expertise in the field, they can simply act as a

bridge to trained professional supports. Participants in the study expressed their beliefs that teachers can act in this fashion. Yet, there may still be an element of perceived stigmatization between students and teachers, and not all students may respond to these initiatives.

3. What factors are instrumental in influencing the illness? Throughout the interviews, a number of topics came up on entities that influenced the experience of depression for the participants. One of the most commonly discussed areas of their lives which the participants talked about, was their relationship with their family. Specifically, they talked about tensions, stressors, concerns, varying degrees of supportiveness, and how their family viewed them. This created a widespread array of outcomes, from creating distress to providing much needed aid. Relationships with other depressed individuals or those who shared similar views and mindsets to those with depression were positive influential factors. Participants felt solace knowing that others had similar problems or that they were sympathetic to the negative feelings brought on by depression. Traumatic environmental events, such as fatal car accidents or sexual assault, also created feelings of sadness and exasperated depression. Stigmatization, both public stigma and self-stigma, influenced depression in negative ways. It prevented communication with helpful avenues toward treatment options, such as other people or healthcare supports, or the participants perceived views about themselves or views made by others to be negative. Accessibility to resources for mental health problems also had a slight influence, as a lack of awareness surrounding proper knowledge or treatment caused experiences to be prolonged. On the whole, each participant steered the interview towards certain aspects of their life

or focussed their responses on particular things. This shows that everyone had their own element or trigger which influenced their depression more so than other aspects. Identifying each individual's particular influence would be beneficial in altering experiences with depression for the better.

Limitations to the Study

During the research process, there were a few limitations that arose within the study. During the initial search of the literature, some ambiguity arose in relation to the word "youth" and the word "adolescent". For instance, Radloff (1991) used the term youth to describe those between the ages of 18 to 25 while Patel et al. (2007) refer to youth as between the ages of 12 and 24. Or, Gordon et al. (2012) had referred to adolescent years as 12 to 18 while McCarthy et al. (2008) use this term as 13 to 19 years of age. Rice et al. (2006) had designated the university/college age group simply as late adolescence. Some research has also used the term consistently, yet failed to define the specific age designation at all (K. Kim, 2012; Parra et al., 2011). In the literature, the terms youth and adolescent could denote varying age groups depending on who was conducting the study, or in what part of the world the study was conducted. From the lack of consistency, it created problems in trying to merge the literature together and use the two terms, as different studies denoted the terms to different age groups. As a result, the terms were standardized to that of the Canadian definitions. Throughout the rest of the study, careful attention had to be made when using these terms to ensure accuracy and consistency while researching and conveying any findings. Although this may not be deemed as a "limiting" factor through the course of research, it proved to be a cumbersome aspect to navigate around. It limited the amount of information which could be included and excluded to what degree, since age demographics were not clearly defined.

Another limitation arose when identifying the level or form of depression of the participants. According to the Diagnostic and Statistical Manual of Mental disorders, there are a variety of different forms of depression. Because I, the researcher, and my supervisor are not licensed mental health professionals, we were in no position to ask about or screen the participants on their level of depression. Therefore, specific information regarding the participant's medical history was and remains to be unknown aside from what they voluntarily disclosed. However, all participants had some self-declared experiences with depression, and all forms of this mental illness were being investigated. All experiences with depression are relevant to answering the research questions that were posed in the study, regardless of classification as they are all classified under the same section within the DSM-V. Having such information may have helped categorize and draw even more concise relations between experiences, but findings were applicable and significant to the study nonetheless.

There was also a limitation to the study regarding the participant pool. My research included 7 participants who have completed or are still in the process of completing some level of post-secondary education. None of these participants had dropped out of school or were deemed to be "unsuccessful" due to their mental illness. I was not able to find participants for the study who had experienced depression in university but had discontinued their schooling either as a result of depression or not. Having participants with such a background would have enhanced the richness and diversity of the participants, giving the data a more widespread account.

Personal Reflections

Throughout the research process, I found that I learned an extensive amount about depression, and now feel very well versed when it comes to this mental illness. Having a face-to-

face interview with my participants was much more informative than reading literature ever could be, as I could hear the sound of their voice, see facial expressions, and have honest conversations about what they have gone through. Learning was much more meaningful this way. Reflecting on this makes me come to realize that informing others about depression might be most effective if there is a personal connection or embodiment to the experience. Despite how difficult it likely was for my participants to share, they did a wonderful job at articulating instances in their life which may be categorized as some of the most difficult.

Conclusion

This study has provided insight into how a group of university students have experienced depression throughout their life. Through a phenomenographic research approach, a broad array of different experiences were generated and analyzed which lead to the development of an outcome space to depict the different categories of description. These categories were able to provide answers to the research questions, which aimed to understand how youth experience depression, how school affects students with depression, and what influences the illness.

After different elements of the experiences were identified, a discussion into the implications and significance of these findings followed. Links between different ideas in the findings and existing literature were created and then discussed in terms of implications for theory, practice, and future research. The results gathered here may support future actions taken towards developing stronger initiatives towards aiding those who suffer from depression.

Throughout the interview process, it became very clear how strongly someone's life could be influenced by depression. They spoke about events and feelings that appeared to have a profound impact on their daily lives. While some found that coping with their depression has helped them develop as an individual, you could hear the despair and emotion within the voice of

others. Depression impacted many aspects in their life: family, relationships, school, employment, and even just day-to-day well-being. As we have seen here, it is also something that is not completely understood. But there was an overall theme in this thesis that stands to be highlighted: that the participants were hopeful. They were hopeful, optimistic, and stoic regarding the involvement of depression in their life for the future. Hope could be the start of what is needed to forge through what is left for us to figure out about this mental illness. Hope to keep us stepping forward. Hope to keep us mindful. Hope to create a society where depression is less of an issue.

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APPENDICES

Appendix A: Participants Ad

Appendix B: Cover Letter and Consent Form

Appendix C: Interview Guide

Appendix D: Ethics Approval Form

APPENDIX B: COVER LETTER AND CONSENT FORM

Cover Letter

Researcher: Matthew Simko
mdsimko@lakeheadu.ca

Dear Potential Participant,

This letter is an invitation for you to participate in the study entitled, “An Exploration of University Students’ Experiences with Depression”, as part of my masters thesis. I am interested in hearing your personal stories, perceptions, and thoughts about what it is like to live with depression, and what has impacted you. From this, I hope to gain a better understanding of how others are affected by the illness and use these accounts to support mental health research initiatives to provide improved service. This research is supported by the Lakehead University Faculty of Education, Department of Graduate Studies and has been approved by the Lakehead University Research Ethics Board.

Your participation will be voluntary, and you may refuse to participate in any aspect of the study at any time. Furthermore, you have the ability to withdraw from the study at any time. The participants will partake in a recorded interview about their experiences with depression during their life. The length of the interview will be approximately 60 minutes, depending on the degree of response to the questions which the interviewee provides. You may choose not to answer any questions during the interview process. These interviews will be transcribed by the researcher, and the participant will be given a pseudonym to conceal their identity. Participants will have an opportunity to review their transcripts and verify that their views are accurate.

If an incident arises during the interview process where a participant becomes psychologically distressed for some reason, the interview will cease and the participant will be immediately referred to a health counselling centre or crisis response hotline. The participant will also be given this emergency contact information upon completion of the interview.

After the interview, the data will be encrypted and stored by myself for the duration of the study. It will be only stored on an external hard drive, which will be locked within my residence. Once the study is complete, the data will be held in secured storage in the Bora Laskin Building at Lakehead University for a period of 5 years. Participants will have access to their transcripts and the opportunity to verify that their views are clearly and accurately reflected within their accounts after the data has been processed. They will also be sent an executive summary of the results and a copy of the thesis after both are completed.

Confidentiality and/or anonymity will be maintained throughout the research process, and upon its completion. Participants will be assigned pseudonyms, and the transcripts will not be

Student Participation Consent Form

Researcher: Matthew Simko

mdsimko@lakeheadu.ca

This study seeks to understand how university students have experienced depression in their lifetime, and how their schooling has impacted these experiences. The research will be conducted by Matthew Simko, a graduate student in the Master of Education Program and Lakehead University.

I, _____ (please print) have read and understood the cover letter for the study, and voluntarily consent to my participation in the research entitled, “Lived Experiences of University Students with Depression.”

I acknowledge that:

1. I give Matthew Simko permission to digitally record our interview.
2. I am free to withdraw from the study at any time without any consequence, and may choose to not answer particular interview questions.
3. My identity as a research subject will be kept anonymous and confidential in terms of publication/public presentation of the research findings. I must agree to having my identity revealed in order to do so.
4. If the case should arise that I experience psychological discomfort during the interview, it will stop and I will be given contact information for the Student Health and Wellness Centre within Lakehead University, the Thunder Bay Crisis Response Hotline, and Good2Talk (post-secondary student helpline). Potential benefits include a greater perspective about what factors influence students with depression in the region of study.
5. The data provided by participants will be encrypted and securely stored by Matthew Simko for the study’s duration and by Lakehead University for a period of five years after the study is complete.
6. I will be given a pseudonym in the written work to ensure anonymity within the study, and no linking details that would disclose my identity will be revealed. My identity will not be revealed in any published material unless explicit consent is given by myself.
7. I will be emailed a summary of the findings to ensure that my views expressed during the interviews are accurate and satisfactory to myself.
8. Matthew Simko can be reached at (807) 627-9545 and/or mdsimko@lakeheadu.ca. His supervisor, Dr. Karen Reynolds, may be reached at (807) 623-3132 and/or jreynol1@lakeheadu.ca.

Signature: _____ Date: _____

Contact Information: _____

APPENDIX C: INTERVIEW GUIDE

Interview guide

Personal background

1. Briefly describe your family background, including your number of siblings, where you lived, and where you went to school.

Descriptions

1. Could you describe how you have experienced depression in your life?

Impressions

1. Describe your impressions of depression throughout your life? (Prompts: Before? After?)
2. What might have influenced these impressions about depression?
3. How did you first come to acknowledge you had depression? (Prompts: Describe the process? What follow-up came after that?)
4. How do you cope with depression?
5. What do you believe your family and friends think about mental illness?

School

1. How was your life at school affected by your depression? (Prompts: High school? Post-secondary?)
2. What sources of help were there at your school for assisting students with a mental illness? (Prompt: How do you feel they were helpful?)
3. What worked well at your school towards helping others with mental health issues? (Prompt: What could be improved?)

4. How were teachers, councillors, or resources in your school community helpful?

(Prompt: Give an example of a situation)

5. Do you talk to others about your depression? (Prompts: Who? Why? When?)

Online social networking and media

1. What types of online Social Media Networking do you use? Describe how and how often you use them.

2. Describe how these types of social media impacted your experiences with depression.

Relationships

1. Describe your interactions with other people you know that have experienced depression.

Concluding thoughts

1. Looking back, are there any parts of your experience with depression that you would like to change or do differently?

2. Are there any other important aspects of your experiences with depression that we have not already covered?

APPENDIX D: ETHICS APPROVAL FORM



Research Ethics Board
t: (807) 343-8283
research@lakeheadu.ca

May 23, 2014

Principal Investigator: Dr. Judith (Karen) Reynolds
Student Investigator: Matthew Simko
Faculty of Education
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1

Dear Dr. Reynolds and Mr. Simko:

Re: REB Project #: 157 13-14 / Romeo File No: 1463848
Granting Agency: N/A
Granting Agency Project #: N/A

On behalf of the Research Ethics Board, I am pleased to grant ethical approval to your research project titled, "An Exploration of University Students' Experiences with Depression".

Ethics approval is valid until May 23, 2015. Please submit a Request for Renewal form to the Office of Research Services by April 23, 2015 if your research involving human subjects will continue for longer than one year. A Final Report must be submitted promptly upon completion of the project. Research Ethics Board forms are available through the Romeo Research Portal at:

<http://romeo.lakeheadu.ca>

During the course of the study, any modifications to the protocol or forms must not be initiated without prior written approval from the REB. You must promptly notify the REB of any adverse events that may occur.

Best wishes for a successful research project.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard Maundrell".

Dr. Richard Maundrell
Chair, Research Ethics Board

/scw