The Social Experiences of Depression among Lakehead University Students

Master's Thesis

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Appendix

Abstract

While depression is known to be prevalent among university students (Ibrahim et al. 2013), there has been little research on how students deal with this in day-to-day life. Drawing on 21 semi-structured interviews with university students who have a medical or self-diagnosis of depression, this qualitative study aims to explore the social experiences with the condition. This study has four main objectives: to learn if university students with depression experience stigma and the impacts of this experience, if and how they decide to open up to people about their depression, how depression impacts their daily lives, and how media depictions of depression impact student comprehension of their own depression. Schutz's (1967) and Berger and Luckmann's (1966) notion of "typifications" is used to explore how students encounter and interpret mass media representations of depression. The mass media was considered influential in shaping peer understandings of depression and in turn their relationships with others. I draw on Goffman's (1963) theory of stigma to understand how students decide whether to conceal their depression from others or disclose it in order to receive support. I conclude by discussing the implications for understanding the impact of depression in everyday life as well as policy recommendations for student services.

Introduction

Depression is perhaps one of the most—if not *the* most—publicly known *mental disorders* (or categories of mental illness affecting mental health) in society today. It is such a well-known mental disorder that it has been the topic of countless books, films, syndicated television programs, daily radio and television talk shows, and so on. It is common to hear people casually state, "I'm depressed" or "I have depression" or "that's depressing," when having a bad day or when commenting on an unfortunate event. Depression has indeed entered the popular culture lexicon and has become a common source of conversation in the public discourse.

Previously referred to as *melancholia*, depression is now known as clinical depression, major depression, or simply "depression" (Cockerham 2017). Depression has a long history, with similar conditions being described at least as far back as the classical eras of Greek and Persian antiquity (Radden 2003). It was in the twentieth century, however, that depression came under close research scrutiny from psychiatry and, later, by the social and health sciences (Kent 2003). During this period, depression was theorized and critiqued, defined and redefined many times over, and eventually came to be recognized as the condition we know it to be today.

What many people commonly know about depression is that it characterized by sadness, loss of interest or pleasure, poor concentration, disturbed sleep, and, at its worst, depression can lead to suicide. Perhaps less known is that people with depression may also have multiple physical complaints with no apparent cause, it can be long-lasting or recurrent, and it can substantially impair people's ability to function at work or school and to cope with daily life. Additionally, prevention programs have been shown to reduce depression both for children and adults and there are also effective treatments for depression including talking therapies, such as cognitive behaviour therapy or psychotherapy, and antidepressants (Wijnhoven et al. 2014; Young, Mufson and Davies 2006; Dias et al. 2019).

What many people do not realize is that depression is not simply a condition that afflicts a few individuals in society, but that it now constitutes a public health epidemic, affecting not only morbidity but also societal and economic prosperity. Globally, an estimated 264 million (or approx. 4% of the world) people are affected by depression (GBD 2018, WHO 2017). More women than men are affected by depression (Albert 2015, WHO 2017) and it occurs in all age groups, though it is more common in late adolescence and early adulthood (15-24 years) and in older adulthood (55+ years) (WHO 2017).

Both quantitative and qualitative sociologists have examined depression. Quantitative sociologists explore depression through a macro approach with an emphasis on the rate of depression among different social groups, considering the effect of gender differences (Hopcroft and Bradley 2007) or age (Falci and McNeely 2009). Qualitative sociologists have examined depression through a micro approach to understand the meanings of depression through lived experience using a symbolic interactionist approach (e.g., Karp 2017) and the social, cultural, and historical norms attributed to depression diagnosis using a social constructionist framework (e.g., Horwitz 2011). These studies are vital for moving beyond a dry understanding of depression in the abstract and connecting to the emotions and real-life experiences of those struggling with the condition. Indeed, these studies are largely responsible for inspiring my interpretative approach to the subject here. While these studies are beneficial to understand the sociology of depression, not much is known about how university students experience and negotiate depression in their everyday lives. As depression prevalently occurs during late adolescence into early adulthood (WHO 2017), which is the age when those with the condition must learn to navigate it socially. Little is known about how stigma is experienced and the disclosure practices university students with depression use. Finally, it is unclear how people with depression interpret media images of depression and whether these inform their understanding of the condition.

Drawing on symbolic interactionism and related perspectives, I designed a qualitative study to explore the social experience of depression among university students who possess either a medical or self-diagnosis. I conducted 21 semi-structured interviews with participants using a purposive sampling approach. My analysis drew on Goffman's (1963) theory of stigma to understand how students decided to disclose or conceal their condition to others. I drew on Berger and Luckmann's (1966) and Schutz's (1967) phenomenology to understand how typifications or generalized images of depression in the mass media were encountered and negotiated with others. While mass media images of depression were not accepted wholesale, they were important in shaping how individuals and their loved ones perceived depression, whether or not to disclose the condition, or how to negotiate their relationships.

SOCIOLOGICAL PERSPECTIVES ON DEPRESSION

In North America, mental disorders are diagnosed by medical professionals and psychiatrists using *The Diagnostic and Statistical Manual of Mental Disorders* (or DSM). According to the most recent edition, *DSM-5*, in order to be prescribed the diagnosis of 'Major Depressive Disorder' an individual must have at least five symptoms for two weeks or more, where "one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure" (American Psychiatric Association 2013:160). Other common symptoms associated with the condition are tiredness, suicidal thoughts, lack of self-worth, and fluctuation in weight (p. 161). From a sociological perspective, however, despite the fact that being diagnosed with depression is an individual encounter in a clinical setting, much of one's understanding and experience of this disorder is a social process and should also be studied using a social lens.

Since at least the 1950s numerous sociologists have examined mental illness in general and mental disorders in particular, though depression itself has been a popular topic of research. Much of what they have explored is the role that social interaction plays in people's understanding of mental illness and specific mental disorders. Most sociological studies focused on the experience of mental illness during the time of the *DSM-III* (1980) and *DSM-IV* (1994), a period when depression was defined and diagnosed differently than it is presently. From a sociological perspective, it is less clear what it means for individuals to live with a mental disorder like depression today. Of particular interest to sociologists is how key social groups, such as university students, who have largely come of age during the time of the DSM-5 (2013), identify and experience depression in the contemporary era.

University students present an interesting case study for studying depression because they are inundated by mass media content on a daily basis, whether it is through social media, television, billboards, or smart phone alerts and updates. However, it is unclear if and how students with depression are impacted by mass media representations of depression. Depression has become a common topic in mass media to the extent that, arguably, the condition has taken on a life of its own. It is commonplace for celebrities like Jim Carrey and Demi Lovato to share their experiences with depression or, in the case of celebrities like Robin Williams, to be the subject of reportage about the dire consequences of untreated depression. One benefit of celebrities' decisions to disclose their depression to the public is that this has opened up the conversation on mental illness to wider and more general audiences. A conversation that historically would have been swept under the rug is now increasingly part of the public sphere.

The mass media has also represented what it means to have depression and other mood disorders through visual mediums like film and television. Consider the following films, for example: *The Perks of Being a Wallflower (2012), 13 Reasons Why (2017), Little Miss Sunshine (2006), The Hours (2002), Joker (2019), Still Alice (2014),* and *Silver Linings Playbook (2012)*. All these films were critically acclaimed box office successes that, for better or worse, shed light on depressive disorders through their use of drama, comedy, cinematography, editing, and storyline.

The mass media has also represented the relationship of depression to suicide. Correspondingly, there has been public debate about whether these depictions could be harmful. Bydlowska (2019) argues that the 'romanticization' and 'glamorization' of suicide in the mass media must end. She describes how the mass media emphasizes the extravagant life of famous people who decided to commit suicide such as Sylvia Plath and Kurt Cobain, which distracts from the truth of suicide. Instead, the mass media should prioritize awareness and education about mental illness.

In Ontario alone, approximately fifteen percent of university students reported struggling with depression in 2016 (Glauser 2017), arguably constituting both a social problem and public health issue. Concern over this public health issue is evident in the widespread news articles that have discussed the rise of depression among university students and the increased need for support services (McKenzie-Sutter 2020; Treleaven 2020). Discussions of depression have led to disputes within secondary and post-secondary institutions about how mental illness should be addressed, whether by increased awareness, development and expansion of services, or all the above (Nasser 2019; Thom 2018). However, these sources have directed attention towards the rise and treatment of mental illness in the school system while the experiences of students is left out.

Many disciplines ranging from the social and health sciences to the biomedical sciences have researched depression among university students. Oliffe et al. (2010) examined male post-secondary students experience with depression. One key finding of the study is that student perceptions and experiences of depression were understood in relation to the “unmanly” attributes of the condition. Social stigma as it relates to mental health has been widely explored (Wada et al. 2019) as well as specifically among male students with depression (Oliffe et al. 2010). Several studies have also explored media representations of depression (Bengs et al. 2008; Rowe et al. 2003). Previous research has examined how youth with a mental illness (Nesi et al. 2020) and university students without a mental illness understand media representations of psychiatric conditions (Quintero Johnson and Riles 2018). All these studies make stride towards understanding depression among university students; the present study will further contribute to this body of literature with a specific focus on interpretations of depression in media as well as the experience of depression-related stigma using a sample of Lakehead University students.

THE PRESENT STUDY

My MA thesis research makes a unique contribution to the sociology of depression as it examines how students with depression understand stigma as well as how mass media representations of depression are experienced by the students. The way university students understood their condition largely corresponded to how they perceived society to treat and understand depression. In other words, how participants understood their depression was influenced by the social norms and values associated with the condition.

I became interested in the social experience of depression for many reasons. First, I am interested in topics that are considered taboo, delicate, or socially unacceptable, particularly when people talk about their own experiences. I believe it is crucial to understand why certain topics are swept under the rug or left to be *The Elephant in the Room* (Zerubavel 2007), in social encounters. When topics are not openly addressed, people struggling with a stigmatized condition may feel afraid to receive help or seek support. When a person does not receive help for a medical condition, their symptoms may become worse as time goes on. Second, I am interested in how physical health and mental health are often treated differently, both medically and in social discourse. Third, I have struggled with depression in the past. Fourth, I wanted to examine the lived experience of depression among university students, to understand what it means for people to have depression in their own words. Finally, I think it is vital to recognize not only the psychological symptoms of depression but the social values and norms attached to the condition as this makes up the "social baggage" that informs both public perception and people's experience of the disorder. From a sociological perspective, while individuals with depression may experience psychological symptoms, the social values they ascribe to their condition and whether or not they chose to disclose it all have a social basis.

This study has four objectives. First, it examines if university students with depression have experienced stigma and, if so, how they believe their perception of stigma has impacted their mental health and comprehension of depression. Second, it explores the decision of university students to openly disclose or hide their depression from people in their personal lives or from people in the university context. Third, it explores if and how the experience of depression has impacted their daily lives and their perception of events. Fourth, it explores students' perceptions of how mass media sources (e.g., films, online sources, newspapers) depict depression and which sources they draw from most to understand their own depression and the stigma surrounding it.

The thesis is organized as follows. Chapter 1 provides a short literature review to contextualize how depression has been examined by different academic disciplines. I begin by examining how psychiatry and the health sciences have approached depression, which segues into how sociologists have understood the condition. To conclude, I discuss how the sociology of depression relates to the present study. Chapter 2 examines the methodological approach I took in order to conduct this study. This chapter discusses sampling and recruitment strategies, the interview method, methodological challenges, and my personal reflections on the study. In Chapter 3, I introduce the data findings by discussing participants perceptions of how the mass media depicts depression. To support these findings, I use Schutz's (1967) and Berger and Luckmann's (1966) notion of typifications to better understand how participants perceived stereotypical depressive characters. In Chapter 4, I use Goffman's (1963) theory of stigma and notion of 'passing' to understand students' experiences with stigma and disclosure practices. The thesis concludes by addressing the broader sociological implications of the research, the study's limitations and directions for future research.

Chapter 1. Literature Review

This chapter reviews three disciplinary approaches to the study of depression: the psychiatric approach, the health and public health sciences approach, and the sociological approach. By necessity, this review cannot be exhaustive of the research on depression but rather is intended to provide a basic understanding of the different ways that the medical, public health, and social sciences understand the condition. The following research questions guided this review: 1) how depression has been defined and studied historically, 2) how depression is currently defined and researched, 3) what assumptions underlie the different disciplinary definitions of depression, 4) the key insights about depression that each disciplinary approach offers, and 5) how various studies have approached depression among university students.

1.1 PSYCHIATRIC ACCOUNTS OF DEPRESSION

Psychiatry is a branch of medicine that focuses on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders (Cockerham 2017; American Psychiatric Association 2013). Psychiatrists are trained as medical doctors and work to diagnose and treat mental disorders like depression, most often using pharmaceuticals and behavioral therapy.

The psychiatric approach to understanding depression draws heavily on biomedical science and the "medical model" of illness, which believes that mental disorders are the result of physiological factors that affect the structure and functioning of the brain (Cockerham 2017). Psychiatrists see depression as an individual-level affliction whose symptoms can be identified using medical observation and treated using biomedical interventions.

Since the 1970s depression has been a part of the lexicon of popular culture and is loosely, if not erroneously, equated with "sadness" (Philip 2009). However, from a psychiatric perspective depression is a considerably more nuanced condition that is not reducible to sorrow, unhappiness, or low spirits. According to the Canadian Association for Mental Health (CAMH 2021),

> Clinical depression is a complex mood disorder caused by various factors, including genetic predisposition, personality, stress and brain chemistry. Treatments include psychoeducation, psychotherapy, pharmacotherapy and brain stimulation therapies (electroconvulsive therapy, transcranial magnetic stimulation and magnetic seizure therapy).

Psychiatric research on depression has illuminated the complexity of the condition. According to the CAMH (2021) there are four common types of depression which can occur based on life events or environment: postpartum depression, dysthymia, seasonal affective disorder, and depression with psychosis. An important focus of psychiatric research is the relationship between depression and gender differences. For example, research consistently finds that females are more likely than males to struggle with depression, a finding that is attributed to hormonal factors. In contrast, males with depression are more likely to struggle with anger. From a sociological perspective it could be argued that patriarchy accounts for the distinction between men's and women's depression as women have historically been mistreated, dismissed, and incorrectly labeled as mentally ill.

Historically, psychiatry used different diagnostic tools and forms of measurement in order to study and understand depression. The Rorschach measurement is one tool implemented to understand depression (Bills 1954). The objective of the test is to examine the difference between an individual's self-interpretation and their ideal self (p.135). According to the Rorschach measurement, the hypothesis was that individuals with depression would have a significant difference between their self-interpretation and ideal self. Another measurement used to understand depression is the Bender-Gestalt Test (Tucker and Spielberg 1958). The objective of the Bender-Gestalt Test is to understand the difference between participants with and without depression (p.56). To understand whether participants had depression they used a 27-item check list and standardized clinical records. This study consists of 36 men that were separated into two groups according to participants who did not have depression and participants with depression. Participants in the study struggled with character disorder, psychosis, and psychoneurosis. One finding of the study is that participants in the depression category struggled with distortions which was not apparent among participants without depression. These early efforts to identify and measure depression were instrumental in shaping the biomedical clinical focus of psychiatry to the present.

Perhaps the most important and well-known diagnostic tool used in psychiatry to define or diagnose an individual with depression is the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is a product of twentieth century psychiatric research and medical practice. As a text, the DSM is a historical document that has undergone several versions as the science of mental health has advanced. The DSM was originally created in 1952 and the most recent fifth edition was published in 2013 (Grande 2019). As such, the definition of depression has shifted as psychiatrists have learned more about the condition. According to the DSM I, the earliest version to contain an entry on depression, the condition was classified as a psychotic disorder requiring treatment through hospitalization (Horwitz 2011:42). Some common symptoms associated with this severe mental disorder include: delusions, distortions, and hallucinations.

By contrast, according to the most recent edition of the DSM, or the DSM-5, in order to be given the diagnosis of ‘Major Depressive Disorder’ an individual must meet the following criteria:

> Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. (American Psychiatric Association 2013:160)

Other common symptoms include: fluctuation in weight, suicidal thoughts, tiredness, and lack of self-worth (p. 161). In the United States alone, there is a noticeable gender difference (p. 165). Starting in young adulthood, women are 1.5 to 3 times more likely to struggle with depression than men. Over time it can be seen how the definition of depression and ways of researching the condition have changed along with the social norms connected to the condition. At the time of the DSM I, patients with depression (as well as other psychiatric conditions) lived in mental institutions where medical professionals identified the condition through a handful of general symptoms. Currently, or at the time of the DSM-5, individuals with depression live 'normal' lives with medication and therapy, and they must meet specific criteria in order to receive a medical diagnosis. Looking back socio-historically, it is clear that medical knowledge and treatment of mental illness does not simply evolve in response to biomedical advancements but also with changes in culture that impact social norms and values.

One area of psychiatric research is the prevalence of depression among post-secondary students. Ibrahim et al. (2013) for example conducted a meta-analysis that examined the prevalence of depression among undergraduate students by evaluating 24 articles on this topic published between 1990 and 2010. The articles either focused on undergraduate students from a wide range of disciplines or medical students. The authors found that undergraduate students had higher average prevalence rates of depression (35.6%) than medical students (25.6%), most significantly, the prevalence rate of depression is approximately three times higher among students than the general population of the United States (p. 394). These findings are important as they explore depression by addressing the heightened prevalence of depression among university students. Given that depression disproportionately effects university student, I decided to focus on this population for the present study.

1.2 THE HEALTH SCIENCES APPROACH TO DEPRESSION

The health and public health sciences is a branch of applied science research that deals with human and animal health with the goal of understanding and improving health at the population level. This field consists of a conglomeration of specialities including public health, epidemiology, gerontology, kinesiology, nutrition, and several specialities in psychology. Disciplines in this field draw upon knowledge and undertake research that might be thought of as situated between the biomedical and social sciences.

The World Health Organization (or WHO) explores depression through a population health and social justice-oriented approach often used by the health sciences. According to the WHO (2020),

> Depression is a common illness worldwide, with more than 264 million people affected. Depression is different from usual mood fluctuations and short-lived emotional responses to challenges in everyday life. Especially when long-lasting and with moderate or severe intensity, depression may become a serious health condition. It can cause the affected person to suffer greatly and function poorly at work, at school and in the family. At its worst, depression can lead to suicide.

From this description it is clear that depression is a global health concern that can impact not only one's mental health but also their social environment. The geographic location in which an individual lives also impacts their ability to receive mental health resources. Approximately 76-85% of people in developing countries cannot get help for their condition. Likewise, throughout the world individuals from all socio-economic backgrounds are frequently improperly diagnosed with another condition when struggling with depression. Thus, the focus of this line of research and knowledge base about depression is not the individual-level but population scale.

The International Classification of Diseases (or ICD) is another manual that is used by mental health professionals. The ICD is used globally but is less common in the United States where the DSM is more prevalent (Grande 2019). The ICD was created in 1893 but was originally named 'The International List of Causes of Death' until it was later renamed in 1900. However, the focus on mortality and illness was not implemented in the manual until the ICD-6. The most recent edition of the manual is the ICD-11, which was published in 2018. There are several similarities between the ICD and the DSM as they each examine different mental illnesses and are used as a diagnostic tool, though there are a few notable differences. Both manuals include mental disorders that the other does not mention. For instance, the ICD-11 includes prolonged grief disorder, gaming disorder, and complex PTSD, while the DSM-5 examines disruptive mood dysregulation disorder and a broad range of personality disorders. Likewise, one structural difference between the two manuals is that while the DSM is focused completely on mental disorders, the ICD examines all medical conditions and has only one section tailored to mental disorders. The main difference between the two manuals is that the DSM has specific criteria that regulate who can have a disorder, whereas the ICD focuses more on guidelines and is largely up to clinical interpretation. These differences demonstrate that the identification and classification of mental disorders is not a universally agreed upon or precise science.

As the prevalence of diagnosed depression has increased in recent decades (Klerman and Weissman 1989; Lepine and Briley 2011), the public health impact of depression has become an important area of population-level health science research. Cassano and Fava (2002:849) examine how depression has become a public health concern with an emphasis on its treatment in primary care settings. One concern they present is that even though over ten percent of patients have depression, many are not identified as struggling with the condition. One reason that under-diagnosis occurs is because patients may overemphasize the physical symptoms of their depression instead of their psychological pain due to fear of stigma (p. 850). In contrast, Patel et al. (2007:1302) examines youth mental health (12-24 years old) through a population-based model. Some common risk factors for developing a mental disorder include: having a parent with a mental illness, living in poverty, and experiencing child abuse (p. 1304). Both studies shine light on depression as a growing problem at a population level, and not limited to a few individuals suffering from physiological ailments.

Recent health science studies examining depression among post-secondary students focus on the impact of economic and social environments as a contributing factor to the disorder. Umeda et al. (2021:1) examines the impact of food insecurity among post-secondary students by considering the potential association with depression and pain, in contrast to students who did not encounter food insecurity. To do this, one hundred and seventy-six post-secondary students in the United States were asked to do a couple different questionnaires (pp. 1-2). Students who struggled with food insecurity were more likely to report having depression and encounter pain interference (p. 6).

Davies et al. (2016:1) examines post-secondary students' knowledge of and ability to help their friends struggling with depression according to the participant's major, gender, and the gender of the individual with depression shown in a video vignette. To do this, 483 students were asked to complete an online survey where they were quasi-randomly selected to watch a short film clip, followed by a question of what they would do to assist said person. Students in majors that are deemed to be knowledgeable on mental illness such as nursing, social work, psychology, and sociology were recognized throughout the study (p. 5). One concerning finding of their research is that many students did not feel able to assist other students with depression:

> Although the majority of students (64%) would provide support and information to a fellow student, less than 2 % would assess risk of harm. Furthermore, only 13% of students felt very confident about helping a friend with symptoms of depression and nearly 40% expressed no confidence or only slight confidence. As predicted, students undertaking courses with mental health-related curricula has higher MHFA scores and increased self-confidence to help a friend, suggesting that they were better placed to help other students who had mental health issues. (p. 7)

These are important studies on university students that take a population approach to health. They tell us that depression is not merely something experienced by people born with mental disorders but that social and environmental factors are also implicated.

1.3 SOCIOLOGICAL UNDERSTANDINGS OF DEPRESSION

In contrast to the individual physiological focus on depression by psychiatry and the population behavioural approach to depression by the health sciences, sociologists tend to examine the social factors that impact how individuals with depression understand their condition and live their daily lives. While many sociologists have studied mental illnesses, relatively few have specifically examined depression from a sociological perspective. Among those who have, three key theoretical frameworks have been used to make sense of the condition: medicalization, social constructionism, and symbolic interactionism.

1.3.1 Medicalization of Depression

Sociologist Peter Conrad (2007) is famous for his central role in developing the medicalization framework for exploring the social causes of illness. Medicalization is a process whereby social problems once considered to be outside of medical jurisdiction have shifted to become understood through a medical lens (e.g., defined in medical terms, treated with pharmaceutical solutions) (p. 4). Conrad states,

> Although medicalization occurs primarily with deviance and “normal life events,” it cuts a wide swath through our society and encompasses broad areas of human life. Among other categories, the medicalization of deviance includes alcoholism, mental disorders, opiate addictions, eating disorders, sexual and gender difference, sexual dysfunction, learning disabilities, and child and sexual abuse. It also has spawned numerous new categories, from ADHD to PMS to PTSD to CFS. Behaviours that were once defined as immoral, sinful, or criminal have been given medical meaning, moving them from badness to sickness. Certain common life processes have been medicalized as well, including anxiety and mood, menstruation, birth control, infertility, childbirth, menopause, aging, and death. (p. 6)

According to Conrad, there are three main components that led to the increase of medicalization starting in the 1970s (p. 8). One major component is the medical authority of doctors to define social problems as medical conditions (e.g., redefining excessive alcohol consumption as alcoholism). A second component is the influence of special interest groups and social movements whereby lay people fought for a social problem to be considered a medical condition (e.g., Gulf War Syndrome, fibromyalgia). A third component is how professionals have fought for certain issues to become medical in order to have power over medical treatment (e.g., alcoholism, depression) (p. 9). Another major component that has become apparent as time has progressed is the growth of the pharmaceutical industry and its influence over medicine (p. 17). For example, Prozac has become a widely prescribed medication that is used to help people with depression (p. 61). One reason Prozac became popular when it was created in 1987 was due to pharmaceutical companies paying for the drug to be advertised to the public through radio announcements, newspapers, and television.

Sociologist have used the medicalization theoretic framework to study social aspects of depression empirically. Clarke and Gawley (2009:91) examine how magazines represented depression in the United States and Canada between 1980-2005. The study finds that throughout the 1980s depression was believed to be caused from multiple factors but most common were negative life events such as the death of a family member (p. 95). In that time frame, depression was just starting to be recognized as being caused by genetics or chemical imbalances in the body (p. 96). As such, from the 1990s forward, depression began to be viewed in medical terms. Likewise, by the 1990s the medicalization of depression became further popularized throughout magazines, since the recommendation to help depression was to go to their doctor to enroll in therapy or get medication (p. 97).

Thomas-MacLean and Stoppard (2004) examine how ways that primary care physicians understand, define and treat patients with depression often goes against their understanding of the social context of depression. For instance, some female physicians in the study recognize the social context of their female patients' depression such as gender inequality and lack of childcare services, but focused on the medicalized context of depression by encouraging their patients to recognize their own problems (p. 284). In addition, primary care physicians describe depression as both a "normal" and medical problem (pp. 285-286). The authors argue that this is contradictory as,

> In order for physicians to treat their depressed patients, especially with medication, there must be something demonstrably 'wrong' with them. If depression were viewed as a normal, or understandable, response to particular social circumstances, it would call for changes within the institution of medicine. (p. 286)

While not denying the biomedical realities of depression, this study helps inform a sociological understanding of depression as medical professionals are recognizing that the medical model approach which informs their careers does not take into account the social problems their clients encounter when struggling with depression.

1.3.2 The Social Construction of Depression

Peter Berger and Thomas Luckmann (1966) are influential for their work on social constructionism. They argue that human knowledge and reality are based largely on how society equally constructs and shares in the meaning-making activities and processes that organize how we understand the world. Sociologist Allan Horwitz (2011:41) used the social constructionist approach to examine depression as follows:

> The social construction of depression illustrates how social and cultural processes can have fundamental influences over diagnostic processes even in the absence of struggles among forces external to the mental health professions. It also indicates how diagnoses themselves can have major professional, economic, political, and social consequences.

Horwitz explores the creation of major depression in the DSM-III, which he argues astronomically increased the rate of diagnosis of the disorder (p. 42). This shift in definition was made because psychiatrists wanted medical dominance over the condition. He points out that the first and second editions of the DSM examined the underlying unconscious mechanisms of depression without certain guidelines or criteria being established (p. 45). As a result, a major critique of the early DSM editions was the inability to diagnose individuals in a consistent manner. This meant that other professions, such as social workers and counsellors, felt they could do the same diagnostic work of psychiatry. This resulted in competition among professions for the ability to diagnose and treat depression. Eventually a clear-cut psychiatric definition of major depression appeared in the DSM-III, though this coincided with a rise in major depression diagnoses. Horwitz argues this is problematic because the new definition of major depression is based on the Feighner criteria, which has little empirical evidence as only one of the five publications in that study showed reputable evidence for the change in guidelines (p. 44). Likewise, what once required one month to receive a major depression diagnosis in the DSM-II shifted to two weeks in the DSM-III (p. 46). In short, Horwitz shows how social factors like social values and economic competition are more influential than so-called objective science in producing our contemporary medical understanding of depression.

In a related study, Horwitz and Wakefield (2007) argue that the DSM-IV does not differentiate between ‘normal sadness’ and ‘depression’ as a mental disorder. Moreover, they examine how the diagnosis of ‘major depressive disorder’ in the DSM-IV does not exclude forms of normal sadness aside from the death of a loved one (p. 8). They deem this to be problematic since there are many normal reasons that an individual could experience the symptoms of a major depressive disorder but not have the mental illness (p. 9). Horwitz and Wakefield argue that this lack of differentiation between normal sadness and depression has led to the misidentification of the latter, and an increase of the depression diagnosis throughout the population (p. 6). In short, Horwitz and Wakefield examine how the definition of depression in the DSM-IV informs societal knowledge and treatment towards the condition by which the emotion ‘sadness’ and the condition ‘depression’ are no longer distinct.

1.3.3 Symbolic Interactionist Approaches to Depression

Sociologists interested in the meaning-making and social interactional aspects of mental illnesses like depression have frequently drawn from symbolic interactionism. According to Herbert Blumer (1969: 78-79),

> The term “symbolic interaction” refers, of course, to the peculiar and distinctive character of interaction as it takes place between human beings. The peculiarity consists in the fact that human beings interpret or “define” each other’s actions instead of merely reacting to each other’s actions. Their “response” is not made directly to the actions of one another but instead is based on the meaning which they attach to such actions. Thus, human interaction is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another’s actions.

Sociologist David Karp (2017) applied this approach in one of the few full length sociological books on depression (originally published in 1996), in which he conducted interviews with individuals who had a medical diagnosis of depression. He argues that symbolic interactionism is imperative because it examines how the meanings and symbols humans associate with their reality are not permanent but are constantly recreated through each individual's interpretation and corresponding reaction (p. 70). This theoretical approach is vital to comprehend the main question of the study "how depressed individuals make sense of an intrinsically ambiguous and seemingly intractable life condition" (p. 71). Karp's study examines peoples' experience dealing with depression including medication, identity formation or "identity turning points," how one expresses in words their understanding of depression, and how the condition of depression impacts family and friends. One theme is how depression can create disconnection from loved ones. Karp states,

> Establishing human connection is plainly linked with empathy. Social psychologists would say that we remain apart from others who will not or cannot "role-take" with us; who are unable to put themselves in our place and see the world as we do. All role-taking, of course, is imprecise because we can never actually be another person; we can only try to put ourselves in another's place and imagine how he or she is seeing and experiencing things. We all necessarily make distinctions among people in terms of their capacity to appreciate our inner life. Thus, the decision to keep the pain of depression private casts others into the status of strangers, persons who are near and distant at the same time. They may be proximate in an immediate physical way, but they are perceived as distant because we do not share with them the perceptions and emotions that most centrally define our experience of the world. Since depression utterly dominates one's "lived world," keeping it secret dramatically distances sufferers from everyone, including family and friends with whom they might have a significant volume of daily conversation. (pp. 106-107)

Here Karp is making a point in recognizing that people made the choice to hide their depression which in the end made them feel more alone based on this decision. This is important because Karp emphasizes how depression can make individuals want to isolate and societal norms can also lead to non-disclosure, but isolating makes an individual's depression worse when what they need most is connection.

Karp also examines how individuals with depression often use metaphors as a way to describe their experiences. For example, a significant number of participants described their experience using the words “suffocating” and “drowning” (p. 93). Participants would also discuss different colours as a way to explain their emotions such as “blackness” (p. 95). Karp argues that these metaphors are an important way to understand what participants are going through as it was often based on the harder periods of their depression.

Finally, Karp explores how people with depression understand the biomedical meanings of their illness and begin to accept medication as the solution. Karp states,

> …the decision to embark on a course of drug taking is not a simple matter of unthinkingly following a doctor’s orders. In fact, a patient’s willingness to begin a drug regimen and stick with it involves an extensive interpretive process that includes consideration of such issues as the connection between drug use and illness self-definitions, the meanings of drug side effects, attitudes toward physicians, evaluations of professional expertise, and ambiguity about the causes of one’s problem. (p. 172)

Despite the diversity of experience, many people encountered a four-stage process when taking medication for their depression: “resistance”, “trial commitment”, “conversion”, and “disenchantment” (p. 181). In the first stage, people with depression encountered feelings of ambivalence towards medication and were “resistant” towards this change. In the second stage, people began trying out an anti-depressant medication which shifted their orientation towards their condition to a biochemical approach. In the third stage, whether people have a positive or negative experience with medication, they fully accept or are “converts” to viewing their condition under biochemical terms. In the last stage, some people come to a point where the medication is not effective or they encounter negative side-effects and become “disenchanted” and want to deal with their depression without pharmaceuticals. This is important because it examines the multiple stages and meanings individuals go through in coming to identify their condition as requiring medication.

1.4 CONCLUSION

In summary, it is evident that psychology, the health sciences, and sociology explore depression differently. Psychology focuses on the individual requirements of people with depression as well as common diagnostic methods and gender differences. Health sciences examine the larger population health impact of the condition and inequalities that exist between different social groups and across regions or across different nations. Sociology examines depression with reference to the influence of social norms, values, the social construction of the disease, and how all of these, influence how people with depression are treated in medical and social contexts. These concepts are also important in influencing how people with depression perceive themselves. Medicalization studies focus on how depression shifted away from being considered a non-medical social problem to a medical condition in need of diagnosis and medical treatment (Conrad 2007). Horwitz and Wakefield (2007) and Horwitz (2011) explore how the social construction of depression has culminated with the novel definition of major depression in the DSM-III and the DSM-IV that has led to an increase in the diagnosis. Finally, Karp's (2017) study of depression used symbolic interactionism to examine the lived experience of individuals with a medical diagnosis of depression and the multiple forms of meaning-making that takes place.

Karp's (2017) study has been most influential in my own research because it also examines people's experience living with depression. One similarity that emerged between both of our studies is that depression brings forward disconnection from loved ones. The participants in my study chose not to disclose to family or friends because they had experienced or were afraid of receiving negative stigmatic messages. However, while Karp's sample examines adults with a medical diagnosis of depression, my sample draws on Lakehead University students with a medical diagnosis or a self-diagnosis of depression. Another difference between our work is my study examines students' experience with stigma and how they perceive media depictions of depression.

Karp (2009) spoke more in-depth about his study on depression in *Ethnographies Revisited: Constructing Theory in the Field.* Data collection and analysis involves understanding how new themes that seem unexpected, merge together as he refers to Chapter 4 on "The Meanings of Medication":

> I was struck by how closely the stages of religious conversion described in the literature paralleled the commitment process to medications. While there is no absolute equation between the two processes, it is nevertheless plain that "commitment" and "conversion" assume common forms in quite different social arenas. The notion of a conversion process provided a novel way to look at the medication experience over time, even for those who felt deeply uncertain about the efficacy of psychiatric drugs. Thus, I made a choice for ordering my medication data that could never have been envisioned at the outset of my work. (p. 43)

I experienced a similar dilemma when understanding students experience with stigma. When approaching stigma my understanding was based on Goffman's (1963) use of the term. However, the themes presented did not always fall into those categories. To briefly explain, students with depression were told that they chose to act or feel the way they did. This was odd to me as illnesses are not generally thought to be based on free will or a desired quality. Nonetheless, I described students' stigmatic experiences with others under this framework.

How I understand the sociology of depression is slightly different than the sociologists that I have discussed so far within the literature. My own study examines participants' experiences with depression by focusing on their own accounts with the condition and how they understand what it means to have depression in society. My study was influenced by Karp's (2017) use of symbolic interactionism and Horwitz's (2011) social constructionist perspective but through a slightly different lens. Symbolic interactionism is useful in my study to understand the different symbols and meanings participants ascribe to mass media depictions of depression and who was safe or unsafe to disclose to. Social constructionism is beneficial to understand the social norms, historical values, and cultural symbols participants discussed and internalized when sharing their experience with depression. This approach was beneficial because I tried to understand participants' experiences by taking into account the time period of the study, the historical values encountered among family or friends, the cultural symbols from the media, and the potential threat of stigma they felt they may encounter. I believe it is important to recognize all of these factors in order to comprehend why participants felt the way they did or how they understood the social norms surrounding depression. I believe the sociology of depression should focus on people's lived experience with depression and base the theoretical framework that best describes their knowledge systems.

Chapter 2. Methodology

The previous chapter located my research in relation to the health sciences and sociological literatures on depression. This chapter discusses the qualitative research design of the current study, methodological challenges, and my own personal reflections. I begin by outlining the sampling strategy, interview method, and the analytic approach. I then discuss the challenges that I encountered throughout my research and what I did to overcome them. In particular, I discuss the changes to this study brought about by the COVID-19 pandemic. Lastly, I discuss my role as a researcher and the importance of reflexivity in how I approached my data gathering and analysis.

2.1 RESEARCH DESIGN

Previous studies of depression have frequently employed quantitative research designs. Studies in the health sciences and psychiatry have tended to use various survey methods and questionnaires to study the type and degree of depression among the population in general and students in particular (Umeda et al. 2021; Ibrahim et al. 2013). Sociological studies of depression have similarly drawn on quantitative research designs to study the prevalence of depression among different social groups (Hopcroft and Bradley 2007; Falci and McNeely 2009). These studies have tended to pay particular attention to quantifying peoples' experiences with depression through numbers. Qualitative research designs, by contrast, have tended to focus on people's subjective experience with depression and are more immersed in social theory and textual analysis, frequently drawing on symbolic interactionist (Karp 2017) and social constructionist (Horwitz 2011) approaches when developing research questions and analyzing the findings. This thesis builds on previous studies by employing a qualitative research design that uses in-depth interviews to explore university student experiences with depression. I conducted interviews with 21 students at Lakehead University and one member of the Lakehead University counselling staff, though due to this limited response from counsellors only the data collected from students are included in the findings chapters. This study was approved by the Lakehead University Research Ethics Board #1468192.

2.2 SAMPLING AND RECRUITMENT

Due to the impact of COVID-19, I was forced to modify my sampling and recruitment approach. Originally, I intended to post recruitment flyers around the Thunder Bay campus to recruit an initial group of participants and then rely on a snowball sampling strategy by asking participants to help recruit acquaintances who might also be interested in participating in the study. Unfortunately, this approach became unfeasible due to the implementation of stay-at-home orders and the temporary closure of both Lakehead campuses due to the COVID-19 pandemic. On the advice of one of my committee members, I shifted to an online purposive sampling strategy so that I could target the largest number of students who were most likely to speak to my particular research questions.

When employing a purposive sample, a researcher uses their knowledge to identify a community of potential participants because these individuals fit the profile of the people that they need to reach (Palys 2008). This sampling approach allows a researcher to gain insight from as many angles as possible from the strategically targeted sample. In my case, I reached out to eight different departments within the following four faculties: Health and Behavioural Sciences, Business Administration, Social Sciences and Humanities, and Engineering. By contacting eight different departments, my goal was to open up the study to a diverse range of perspectives. This was achieved by recruiting students with either a medical or self-diagnosis of depression, men and women, and who were enrolled in a variety of disciplines. I contacted departments who I thought would be willing to assist me with recruitment by sending an e-version of my recruitment flyer to their listservs. In addition, I contacted counsellors from both campuses by emailing each campus's general email address for 'Student Health and Wellness.'

The decision to shift to purposive sampling ended up being a successful strategy for several reasons. First, I avoided a lengthy delay in beginning the data collection. Second, my approach was consistent with COVID-19 safety protocols in place at that time. Third, I was able to recruit students at both Lakehead University campuses rather than being limited to the Thunder Bay campus. Fourth, as one of my committee members pointed out, some students might feel uncomfortable participating in a snowball sample by telling their other friends to do the study as it could indirectly identify them as struggling with depression themselves. Indeed, I later learned that while some individuals felt comfortable talking to their friends about the condition, others did not. Fortuitously, although I used a purposive sampling approach, some participants still made referrals to their acquaintances as one participant mentioned that a friend had recommended that they participate in my study.

I received REB approval in September 2020 and immediately started recruiting students and counsellors. All interviews were conducted between October and November 2020. I decided to end data collection in November for reasons of workload manageability. In less than two months, I had done 22 interviews and I realized that the interviews still had to be transcribed and coded. I was concerned that by conducting additional interviews I would be unable to complete the MA program on time. With that in mind, if I still had another year of study, I would have aimed for 30-35 interviews as I feel that I did not reach full data saturation due to the diversity of student experience, a detail that will be discussed in the limitations section of Chapter 5.

To recruit students, I emailed the department chairs and administrative assistants to request that they send my e-flyers to their student listservs. The recruitment email that department chairs sent to students introduced me, described the objectives of my research, and asked people to contact me by email if they were interested in participating in a qualitative interview. The email also notified students that participants would receive a $25 Amazon.ca gift card as an honorarium. The following exclusion criteria were included in the flyer: must be an undergraduate or graduate student, must be enrolled at Lakehead University at either the Thunder Bay or Orillia campus, and must have a medical diagnosis or a self-diagnosis of depression.

Four departments that I contacted agreed to send out my recruitment email along with the attached flyer (1 department declined and the other 3 departments did not respond). On the first day that the recruitment posters were sent out I received 17 emails from interested students. That same night, I contacted my supervisor to set up a meeting as I had originally told the REB that I would only conduct 20 interviews with student participants. Following the meeting, we sent in an amendment to the REB requesting to increase the number of student participants to 40 in order to accommodate the demand. Additionally, one of the main goals of my study was to empower individuals experiencing depression by providing a space to share their experiences and I felt that limiting the amount of students that could share their experience would be inconsistent with that goal. In total, 48 students reached out to me indicating interest in the study. After each student contacted me, I responded with an information letter and the informed consent form. Students were asked to read the documents and contact me if they were still interested in participating in the study. Out of the 48 students that contacted me, 21 ultimately participated in an interview. Although I cannot know for certain what accounted for the 27 students dropping out, I believe it may have been due to a couple different reasons such as academic obligations, COVID-19 stress, or second thoughts about sharing their personal experience with depression.

To recruit counsellors, I contacted ‘Student Health and Wellness’ services using the general emails for Thunder Bay and Orillia campuses (i.e., health@lakeheadu.ca and orluwell@lakeheadu.ca). The recruitment email that I sent out was similar to what students received except for having a different flyer specifically tailored to counselling staff. The recruitment email distributed to counsellors introduced me, described the objectives of the research, and asked people to contact me by email if they were interested in participating in a qualitative interview. The flyer also informed counsellors that their interview would provide supplemental information in order to better understand university students’ experiences with depression. No honorarium was offered to counsellors who decided to partake in the study. The only exclusion criterion was that they be employed as a counsellor at Lakehead University’s ‘Student Health and Wellness Centre.’

Originally, I emailed counsellors on both campuses on the same day that I had sent recruitment emails to students. However, I was contacted by only one counsellor who was willing to be interviewed. In the hope of increasing the low response, I sent a second email to counsellors one month later. Unfortunately, that attempt was unsuccessful. In total, one counsellor agreed to be interviewed and, due to this low turnout, the single interview was not included in the data for this thesis.

2.3 INTERVIEW METHOD

This study uses semi-structured interviews to explore the social experience of depression among Lakehead University students who have either a medical diagnosis of depression or who identify as having depression via self-diagnosis. I decided to interview both medically diagnosed and self-diagnosed students with depression for the following reasons. First, I was interested in hearing the first-hand accounts of students who experience depression. Second, I wanted to better understand the range of experiences with depression that students report. Third, I was curious whether students with a self-diagnosis of depression used the mass media as a resource in determining if they had this condition. This was an important perspective to explore because I recognize that many people self-diagnose medical conditions before deciding to seek a medical diagnosis (Aravena et al. 2020). Further, an important goal of my research was to learn about the multiple perspectives and social experiences of university students living with depression. Fourth, a flexible interview approach enables participants to feel more comfortable to share their personal experiences in a flexible and empowering interview environment. With these goals in mind, I feel that taking an inclusive approach and listening to both social groups' experiences was a logical decision. This conclusion is bolstered by the fact that out of the 21 participants who agreed to be interviewed, 12 had a self-diagnosis of depression while 9 were medically diagnosed (or approximately a 60/40 split).

I decided to use semi-structured questions to ensure thematic consistency during the interviews, while still providing participants some flexibility in how they responded to questions (Bartholomew et al. 2000). Following this approach, the interview guide was organized around three central themes: stigma and disclosure, how depression impacts students' daily lives, and their impressions of media depictions of depression. The semi-structured format meant that participants could openly share their experiences but still structure their input and insights around the key research questions and themes of the study.

I took several precautions to protect participant confidentiality. All audio-recorded interviews and field notes were kept on a password protected device. When interview transcripts were printed, they were safely stored in a locked cabinet at my house. During Zoom interviews, only the invited participant was admitted into the meeting. Further, I am the only person who has access to the transcripts, audio records, and field notes which are kept safe on a password protected device and stored in a locked cabinet. Students were given a pseudonym and throughout the written findings were then identified only by their pseudonym, age, gender, and type of diagnosis. Counsellors were assigned a number (e.g., counsellor one) as an identifying feature. To prevent counsellors from sharing personal information about students, they were reminded in the informed consent form and at the start of the interview not to disclose any identifying information. Finally, any identifying information that was revealed during interviews was omitted in the written findings.

Due to the limitations brought forward by the COVID-19 pandemic, I decided to conduct interviews by phone, email, or Zoom. Of the 21 interviews, 5 were conducted by phone, 11 by Zoom, and 5 by email. Although this was another change to my original plan, I feel there were certain benefits to conducting different types of interviews.

First, although I found each interview approach beneficial for different reasons, my preferred method was using Zoom because of the ability to physically see and hear participants during the interviews as well as record the audio and video of our conversation. This was helpful when speaking to students about their personal and sensitive experiences with depression as being able to physically see their facial responses and body language was useful in deciding how to respond or what question to ask next. However, a downside to the Zoom format was the technological challenges. For instance, on a couple occasions either my screen or the participants screen froze and interrupted the flow of the interview.

Email interviews also had benefits and disadvantages. One unexpected benefit to email interviews was that many people documented their experience as though they were writing in a diary, which tended to be more personal and "deep" than the other interview approaches. One drawback was that email interviews tended to be less detailed and significantly shorter in length. While phone and Zoom interview transcripts tended to be 20-25 pages in length, email interviews were limited to 4-6 pages in length and lacked the substance of the longer transcripts.

Lastly, the phone interview method was my least favourite method of conducting interviews. One benefit to phone interviews was that some participants liked being able to talk out their experiences without having to write it out by email or having to use Zoom. The main disadvantage was that it was harder to read how people were feeling without being able to visually see the expression on their face or body language. One example that stands out occurred during an interview with a female participant whose voice sounded shaky. I was unable to tell if she was crying because I could not visually see her expression. Had the interview been done by Zoom, I believe I would have been better able to read the social cues and determine if I needed to take any action such as suggest a break or offer a counseling referral as per my REB protocol. Another downside to phone interviews is that sometimes the connection was unstable and difficult to hear the participant, or the phone connection would end unexpectedly.

These interview experiences are similar to what Price and Puddephatt (2018) found in their study on long distance interviewing. They argue that similar to media synchronicity theory, different interview platforms have stronger or weaker communication abilities.

> On a spectrum of lean to rich media, email would fall on the lean side, Skype on the rich side, and the telephone somewhere in between. The concept of "synchronicity" refers to the degree of instant feedback available. (p. 196)

These findings are consistent with the outcomes of my own interview experiences. Zoom interviews were the most beneficial to interact and read the social cues of students while providing in-depth analysis (similar to Skype interviews). Phone interviews provided the second longest interviews. Finally, email interviews were the shortest.

2.3.1 Interview Guide

Each interview started with a quick introduction and a brief layout of how the interview would be conducted and some general background questions. The background questions asked participants to provide their age, the type of diagnosis (self or medical), the age they received a medical diagnosis and/or began to self-diagnose with depression, and for how many years they had experienced depression.

The student interview guide was organized around three main sections (see Appendix A). The first section examined if and how university students with depression experienced stigma. Participants were provided with the following short definition of stigma: “Stigma is defined as a social experience where an individual is viewed as different or ‘less than’ due to holding what is deemed to be a negative characteristic.” In this section, I also examined students’ disclosure decisions. In other words, I was interested in whether and how students decide to open up about their depression (i.e., disclose their condition to others) or hide their depression (i.e., non-disclosure). I also wanted to know to whom and in what settings they felt the most or least comfortable opening up about their condition. Finally, I wanted to better understand how the experience of stigma made participants feel and if this experience impacted their decision to disclose.

The second section of the interview guide addressed how depression influenced people’s daily lives. Here, I wanted to explore if and how struggling with depression and cognitive distortions (e.g., negative thoughts like pessimism) impacted how they perceived negative events. Questions centered on whether they felt perceived negative events (at the university or in general) to be “more” negative due to their depression. The final question of this section explored whether struggling with depression impacted their decision to seek or to receive help.

The third section of the interview guide examined if and how university students with depression are influenced by how the mass media depicts depression. This section examined students’ perceptions on how the mass media represents depression and what they found to be positive or negative about the representations. For example, one question asked students if they felt the mass media displays a predominant character with depression to have certain stereotypical traits.

Each interview concluded with a couple of questions where I asked if they had any suggestions on how the university could make receiving mental health help more accessible to students, how COVID-19 may have impacted their depression, and any concluding thoughts that they felt the interview did not address. Interviews lasted between 35-120 minutes, with the majority lasting about one hour.

The interview guide for counsellors was similar to student interviews. The interviews were organized around the same themes of stigma, disclosure, mass media depictions of depression, and how depression impacted students’ everyday lives. The main difference was that while student interviews were focused on their experience with depression, counsellor interviews were based on their expertise working with students that struggle with this condition.

2.4 TRANSCRIPTION AND DATA ANALYSIS

I transcribed all 21 interviews. To differentiate between my voice and the interviewee I would use different symbols at the start of each new person speaking (“I” for interviewer and “P” for participant). Although the transcription process was lengthy and at times tedious, it also had certain benefits. For instance, it helped me identify key themes and important quotations early in the analytic process. Transcription also enabled me to gain a stronger and more comprehensive understanding of the data, which was useful when it came time to identify key themes and useful examples for inclusion in the written findings.

I did not begin coding and data analysis until I had completed the interviews and transcriptions. To analyze the data, I printed out all interview transcripts (which were kept safe in a locked cabinet) and coded them by hand using thematic analysis. Thematic analysis is a qualitative analytic strategy that examines the data for themes that are directly relevant to the research questions (Creswell and Poth 2018:321). In order to code my data, I utilized different colours in order to code different themes and categories. When I started coding my data, I focused on key themes similar to how my interview guide was structured (stigma, disclosure/non-disclosure, depressive frame, stereotypical depictions of depression). I also noted common phrases that people used to express their experience with depression. For example, some people who noted that their depression made them perceive negative events to be even more negative often used the phrase, “It felt like the end of the world.” All of the codes that I noted were kept on a coding sheet. As I got further into the coding process, I would revisit the codes I had identified to determine if they were related to broader themes in the data. For instance, I began with a code on ‘stigmatic experience’ but later recognized that there were common forms of this stigma that people experienced such as being called “lazy.” This theme became a key section in one of my main findings chapters.

Additionally, I wrote corresponding field notes for each interview that also helped me identify various themes. These notes included common statements and perceptions students had brought forward during interviews.

2.5 COVID-19 CHALLENGES

COVID-19 introduced several challenges at the start of the study that I had to address before beginning the research. One challenge is that due to the closure of the university as a result of COVID-19, I decided to move back to my hometown for the second year of my degree. This meant that I did not have physical access to the graduate student office, which had been a beneficial place to focus on writing and exchanging ideas with other graduate students.

A related challenge was having no direct access to the resources at the Chancellor Paterson library. The limited access to library resources altered how I organized my literature review chapter. Originally, I intended to include a sociological discussion of each version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) from the library. My goal was to provide a discourse analysis of how each manual defined depression, how these definitions changed, and if and how these shifts reflected social norms and values around the condition. Unfortunately, the DSMs are "reference only" books and are not allowed to leave the library premises and the early versions were not accessible online. I was unable to resolve this problem and thus I decided to restructure my literature review chapter, excluding the discourse analysis.

Lastly, the structural barriers from the pandemic made it feel more difficult at times to remain motivated to complete my research. Overall, I tried to stay optimistic during this period but it became difficult at times because I did not have the same opportunity to work with colleagues or my supervisor in a face-to-face environment. This was hard for me because I was constantly doing my research online, which at times made me feel disconnected from my work and the university. In the end, I am grateful for the experience of being able to conduct my own research and work with the different people that I have encountered. However, I think we are socialized to have certain expectations for different events that take place throughout our lives and with COVID-19 some of these expectations could not be met. For example, I will not be able to physically attend my graduation. I think my biggest motivational force was hearing students' experiences and wanting to write this study for depression to be better understood and to reduce stigma. Overall, Zoom meetings and emails are helpful to stay connected but did not provide the same sense of connection, community, or support that I felt was beneficial in the first year of my Master's program.

2.6 REFLEXIVTY

Qualitative sociologists frequently take a reflexive approach as they believe it is important to examine how a researcher's past experience and social position can influence the outcome of a study. Finlay (2002:531) states,

> To increase the integrity and trustworthiness of qualitative research, researchers need to evaluate how intersubjective elements influence data collection and analysis. Reflexivity-where researchers engage in explicit, self-aware analysis of their own role-offers one tool for such evaluation.

As a researcher investigating such a sensitive topic as depression, I felt that it was vital to examine how my role as a researcher may have impacted this study.

I began the process of reflexivity early on in my study. The first step was when I asked for my supervisor's advice on whether or not I should inform participants that I have also struggled with depression in the past. My supervisor recommended that I not disclose this information as it might skew how participants responded to different questions. However, he also mentioned that participants may ask me questions after the interview and it was my decision on whether or not I disclose this information. Likewise, Berger (2015:224) noted that there are both benefits and drawbacks to revealing that you have the same experience as your participants, but one drawback is that it can be difficult not to compare or focus on your experience in relation to participants. In the end, I am happy with the decision I made not to disclose my depression to others in the study. However, I will admit that at the end of one interview I did disclose my previous experience with depression. Further, one interesting thing that came up in my study was that despite not revealing my past experience, a few people mentioned how they felt most people did not understand their experience but that I probably did. I found this interesting as it almost made me think that they either assumed I had the condition or that I was relatively knowledgeable on depression. One thing that I am left wondering is how a larger or different participant sample would have responded if I had disclosed my previous experience with depression at the outset, during recruitment.

Of the 21 student participants in my study, only seven were male. Of those seven males, only two wanted to do an interview through Zoom (the approach that I found most useful). I have wondered if as a female researcher my gender impacted which interview method participants chose. Would more of the male participants have decided to meet face-to-face and feel more comfortable doing a Zoom interview if I were male? Would I have gotten more male participants with depression had this been the case? While I cannot know the answer to these questions, I did keep in mind the gender disparity when analysing the data.

As a reflexive researcher, I also had to recognize how my previous experience with depression may impact how I understand the data. One way I tried to limit the chance of this bias is to provide as many different perspectives as possible from participants in my data. Further, because I found every participant’s experience unique, I do not believe my bias had a significant effect. Although I did not have all of the same experiences as participants with depression, I could personally relate to how depression feels very isolating based on it being a stigmatizing topic. I actually believe my past experience was beneficial for a couple of reasons. First, because

I recognized how sensitive the topic was, I tried to make the space an empowering environment for participants, which was helpful. Next, as this topic can often be hard to read and code due to the sadness associated with depression, I believe being motivated to learn about people's varying experiences helped me to complete my research.

Finally, my past experience with depression was one reason that I decided to conduct interviews over surveys. I felt that this was important because interviews provide an environment where people can more freely share their experience as opposed to filling in a circle on a multiple-choice question. I recognized that each individual's experience would be different and that limiting their answers to tailored options would not be beneficial in this context. I also believe the interview space enabled me to encourage an empowering environment for participants to share their experiences to the degree they wanted to, which would be more difficult with survey methods.

To conclude, this chapter has described the methodological design of the study and offered some reflective insights as I look back on the research experience. As a reflexive researcher, my past experience with depression is addressed. By taking a reflexive approach, I was able to examine how this experience may have influenced sample characteristics, interview method, and in reducing bias. My study has drawn upon the existing qualitative sociology studies of depression that paved the way for research on this topic. Where appropriate I have borrowed insights and strategies from these studies but I have also established new ground by exploring university student experiences. A purposive strategy enabled me to effectively sample across the university, while the range of interview approaches necessitated by the COVID-19 pandemic enabled me to try different interview techniques and identify which were most and least effective. The data that I collected both confirms previous studies and establishes new ground in the sociology of depression. These findings are explored in detail in the following two chapters which focus on representations of depression in mass media and the experience of stigma in the context of living with depression.

Chapter 3. The Mass Media and the 'Typifications' of Depression

There are many dimensions of depression to consider when examining research on mass media and mental health. When beginning this study, I wanted to examine whether students drew on mass media in forming their own images of depression. Specifically, I wanted to understand if and how students who self-diagnose draw upon mass media stories and imagery of depression when making their diagnosis. However, this theme was not strongly present in the findings. Instead, what bears out in the findings is that students believe that depictions of depression presented in mass media impact how society perceives their illness. Further, interviews revealed that there are a variety of perceptions on how the mass media constructs depression for public consumption.

In this chapter, I use Schutz's (1967) and Berger and Luckmann's (1966) concept of *typifications* to argue that university students with depression perceive mass media depictions of depression as reflecting common everyday typified stereotypes that influence how their social circles and wider society understand and perceive their illness. While Schutz (1967) and Berger and Luckmann (1966) argue that typifications are created by common everyday people in society I add that the mass media has come to play a role in representing and informing these types. I take a symbolic interactionist approach to understand the multiple meanings participants ascribe to these images as opposed to passive acceptance. I begin by introducing Durkheim's (2001) notion of idealization, followed by a brief discussion of how key sociologists have built upon this theoretical framework. I use this to segue to a presentation of the research findings which illustrate how students with depression perceive the mass media as a positive resource when individuals share their own lived experience with depression. In contrast, students felt it was negative when individuals without the lived experience speak on behalf of people with depression. I explore four common themes in support of the main argument: stereotypical traits, stigmatic perceptions, glamorization and the legitimacy of voice. I conclude with a summary of how these findings contribute to a sociological understanding of depression.

3.1 SOCIAL CONSTRUCTIONS OF DEPRESSION: IDEALIZATION, IDEAL-TYPES, AND TYPIFICATIONS

Émile Durkheim (2001:316) introduced the concept idealization to refer to how all people in a society exist in two worlds: one is the real world and the other is the world constructed by thought, or an ideal world. Durkheim argued that the "ideal" and "sacred" are similar in the sense that the ideal world, like the sacred, is not separate from the "real" world but of the same construction (p. 317). It is only through the collective organization and interaction of social beings in the real world that the ideal concepts are emphasized and become how social life is portrayed and interpreted. As ideals are created by society, they encompass both good and evil morals which are used as rules or guidelines for citizens to follow (p. 316). Durkheim states,

> Society has constructed this new world by constructing itself, because it is society that this new world expresses. So, in the individual as in the group, the capacity to idealize has nothing mysterious about it. It is not a kind of luxury that man might do without but a condition of his existence. He would not be a social being, that is, he would not be a man, if he had not acquired it. (p. 318)

In this quote, Durkheim is arguing that the new world is the "imagined ideal world" which people ritually construct to bolster the moral order and provide ideals to strive for or against. In addition, ideals are created through collective group membership; as each member is united in a common activity, they all feel a sense of "effervescence" or passion which transforms how they understand the world (p. 317). These shared rituals or collective activities create a powerful force where they begin to endow the world with shared meanings and symbols. As these ideals are shared within a society, they also create values, norms, and morals for citizens to follow. Since

Durkheim's seminal writing on this topic, sociologists have continued to advance the idea of idealizations in creative ways.

Randall Collins (2004) examined the importance of interaction rituals through the form of situations. He examined both the importance of emotional energy and interaction ritual chains in his field of work. Collins states,

> A theory of interaction ritual (IR) and interaction ritual chains is above all a theory of situations. It is a theory of momentary encounters among human bodies charged up with emotions and consciousness because they have gone through chains of previous encounters (p. 3).

Once a successful interaction ritual takes place, people experience 'emotional energy' from the interaction in the form of a sense of happiness, strength, and overall motivation to continue belonging to the group (p. 49).

Collins used Durkheim's and Goffman's research on interaction rituals in order to better inform his own study. For example, he examined the theoretical framework of idealizations by Durkheim but examined it through his own formulation of how both Durkheim and Goffman used this framework. Collins argued that Durkheim fit under the framework of subcognitive ritualism as it holds that all thought is created in idealized form and the goal is to better comprehend how these conceptions are brought forward in society (p. 11). Further, he posits that, throughout Durkheim's study of religion, all human understanding is based upon collective group membership (or society) that formulates this knowledge system (pp. 11-12). In contrast, Collins argued that Goffman was a part of functionalist ritualism because his research focused on how individuals interact based on the "functional requirements of the situation" (p. 16), further arguing that Goffman focused on how individuals use 'face work' to align their demeanor to what the situation entails (p. 19). In short, individuals try to portray an idealized version of themselves in different situations in order to uphold different social norms required for the specific situation.

Despite the diversity of how mental illness is represented in the mass media, there tend to be certain prevalent archetypes or constructs of mental illnesses. One tool a sociologist may use to better conceptualize this topic is Max Weber's "ideal types" framework. Weber's ideal types concept refers to the use of logical or rational thought constructs to better understand a topic while recognizing that no ideal type can completely and accurately represent empirical reality (Rosenberg 2016). Ideal types are created by the researcher based on their ability to create thought constructs, their knowledge of historical events, and their experience and data (p. 88). Therefore, ideal types are favorable to sociologists as "dynamic tools to be used in understanding and explaining the generally intended subjective meanings of lived reality, the domain of shared social experiences" (p. 86).

Although Max Weber focused on how sociologists could use ideal types, he also recognized that society as a whole uses these groupings to conceptualize different topics. For instance, VanNatta (2005) examined how staff at a battered women's shelter turned women away from receiving help based on not fitting an 'ideal type' of what a battered woman should look or act like. In other words, staff privileged a particular ideal type of an abused female to decide whom to admit and whom to deny to the program (p. 417). The 'rational' thought constructs that shelter workers used to assess battered women include whether they possessed the following characteristics: low self-esteem, abusive male partner, and followed the rules of the program. Women who were considered 'non-ideal' were in same-sex relationships and disregarded the program policies. In essence, shelter workers believed that women who did not fit the ideal type were not 'real' battered women or deserving of care. This could be extended to how the mass media represents depression as it can lead to assumptions of what a ‘real’ person with depression appears or acts like.

Alfred Schutz (1967) was another sociologist who examined the importance of archetypes in the social world. Schutz was heavily influenced by Weber’s theory of ideal types, though he took a social phenomenological approach to understand human experience. He used the notion of *typifications* to examine how people come to recognize similarities among social objects and communicate this knowledge to others. According to Schutz, typifications are based upon how common everyday individuals utilize language and knowledge to, as a society, understand concepts under the same typified framework (Schutz 1967; Kim and Berard 2009) A simple example would be how most people can recognize and give a name to what a tree is (Kim and Berard 2009:266). “Tree” is a common name that refers to a common object, but the term “tree” still exists within a system of language and cultural ideas that are associated with trees (e.g., birds, fruit, shade, landscaping, pruning, fire hazard, etc.) Importantly, the meaning of the tree changes depending on the context (i.e., a consumer purchasing a Christmas tree vs. a biologist describing a species of tree). Applying Schutz’s concept of typifications, this study begins to move the literature in the direction of examining how the mass media describes depression and whether that informs student understanding of the condition.

Likewise, social constructionists Berger and Luckmann (1966) used the term *typifications* when examining the sociology of knowledge. They acknowledged that Schutz’s research was beneficial to reconstruct the sociology of knowledge despite the analytic framework not being of the sociology of knowledge per se (p. 16). According to Berger and Luckmann, the sociology of knowledge should focus on what is considered real by directing attention towards everyday understandings, since society is built upon this formulation of meaning (p. 15). All of society is socially constructed at some stage yet is reified and seen and experienced as fully objective, non-negotiable reality. They argue this framework is beneficial because every individual takes part in "common-sense" knowledge but only a select few analyze theoretical, philosophical, or scientific constructions of knowledge. In addition, the sociology of knowledge examines the social construction of reality by recognizing not only the construction of knowledge but also how "common-sense" knowledge is collectively formed and intersubjectively shared (pp. 15, 23). Berger and Luckmann state,

> I also know, of course, that the others have a perspective on this common world that is not identical with mine. My "here" is their "there." My "now" does not fully overlap with theirs. My projects differ from and may even conflict with theirs. All the same, I know that I live with them in a common world. Most importantly, I know that there is an ongoing correspondence between *my* meanings and *their* meanings in this world, that we share a common sense about its reality. (p. 23)

Under this framework they examined the typifications every individual uses in anonymous encounters and face-to-face situations (p. 31). Typifications are categories in which people place others, perhaps according to gender, age, culture, personality characteristics, and so on. In turn, people may respond to and act in accordance with these types, or try to resist them. These face-to-face interactions become a form of negotiation where typifications can be altered based on new information presented (p. 31). Further, typifications can lead to assumptions about a larger social group under the same type, such as the example of a man who interprets the mannerisms of a British-English friend based on the man's background, and then apply this assumption to anyone fitting the typification of being English. Typifications are created and enforced through institutions (p.54). Institutions are collectively formed throughout history and change as society progresses. Institutions also set out certain guidelines and expectations for different typified social actors. It is imperative to note that institutions reinforce social norms and values to inform what is appropriate behaviour:

> To say that a segment of human activity has been institutionalized is already to say that this segment of human activity has been subsumed under social control. Additional control mechanisms are required only insofar as the processes of institutionalization are less than completely successful. (p. 55)

This is important as they argue that typifications are not only ways everyday individuals identify and make sense of society but also maintains the authority of institutions to regulate what is socially acceptable or morally problematic. As Schutz (1967) and Berger and Luckmann (1966) illustrate, typifications are important in identifying different types and in the institutional norms informing individuals. Applying these approaches, this study helps move the literature in the direction of examining if mass media typifications of depression inform social understandings on the condition and in what ways are institutional norms and values associated with this.

Sociological research examining the mass media has applied a symbolic interactionist approach to this field of study. For instance, Altheide (2000) argues that the mass media has shifted how identity has traditionally been understood by symbolic interactionists. The mass media depicts identity as a resource or end product in contrast to symbolic interactionists who examine identity as a process that must be understood in relation to the definition of the situation. Seale (2000) argues that health sociologists should be knowledgeable on mass media representations as it can influence people's sense of self and experience:

> As sociologist interested in the experience of illness, and in health care and health policy, we ought to be interested in which stories get told and which are suppressed, and in how members of the media audience (which includes health policy makers and health care providers themselves of course) respond to mediated health messages. (p. 514)

Other fields have also examined the importance of symbolic interactionism in understanding the mass media including consumer studies and information management. Lillqvist, Moisander, and Firat (2017:202) argue that a symbolic interactionist framework is beneficial to understand how social media users actively negotiate meanings as consumers of marketing, as opposed to mindlessly accepting all messages. They emphasized that consumers attempted to "legitimate" or participate in what is positive or negative on marketing practices. Chen, Davison, and Ou (2020) use symbolic interactionism to understand the meanings, interpretations, and responses of customers on the online platform 'WeChat' in relation to a business organization. As these two studies put forward, individuals interpret different meanings and values to various aspects of the mass media. Though I will not be using these studies throughout this research, I do advocate a symbolic interactionist approach in that people place their own meanings and values on media representations of depression as opposed to passively accepting the meanings intended by the producers of the content.

3.2 MASS MEDIA IMAGERY OF MENTAL ILLNESS

Before discussing how university students with depression perceived mass media representations of depression, it is useful to first consider how other mental illnesses are depicted. In particular, how newspapers have represented mental illness. As this study explores student perceptions of mass media depictions of depression through various formats (i.e., films, social media, online sources, newspapers), it is useful to briefly examine how other studies have understood media representations of psychiatric conditions.

Of particular relevance is how PTSD and eating disorders are represented in the mass media and the stereotypical traits connected to these conditions. Houston, Spialek, and Perreault (2016) explored how PTSD was represented in the *The New York Times* between 1950-2012. They found that approximately 49% of articles associated PTSD with being involved in the military (pp. 245-246). In the articles, individuals with PTSD were discussed and given different stereotypical traits depending on whether they had a military background or not (p. 246). For instance, individuals with a military background were described as violent, angry, and involved in drug abuse, whereas individuals without this background were represented as struggling with sorrow and depression. Eating disorders are similarly represented as having specific traits. Saguy and Gruys (2010) examined newspapers in the United States that focused on obesity and eating disorders from 1995 to 2005. A key finding was that while 47% of newspapers represented males with eating disorders, approximately 94% depicted females (p. 240). Additionally, eating disorders were more likely to be perceived as caused by multiple social factors and genetics as opposed to individual fault (p. 242). These insights are useful because they indicate that prevalent mental disorders are often framed under certain assumptions or stereotypes. It is important to note that these attributes can be considered accurate or inaccurate to medical professionals. However, people with the lived experience of PTSD or eating disorders will place their own meaning to these categories and could consider it to be stereotypical or negative.

Research has also examined how depression is represented in newspapers. Rowe et al. (2003:680) examined how depression was depicted in Australian newspapers. In the study they found that, “Of the 49 articles analysed, 45 referred to experts in some way- academics, researchers, politicians, bureaucrats or members of the legal or medical profession” (p. 682). Despite the large number of news articles that spoke about depression, only seven described people’s own experience with depression and, even then, it was often in alignment with experts’ opinions (pp. 682-3). This study suggests that public figures and intellectuals, who may or may not have any lived experience with depression, are more likely to have their voices heard in public discourse about depression and mental health.

These studies provide examples on how the mass media represents mental illness. It is clear from the literature that depression and people with depression are treated as objects of study rather than having their voices be the focus of analysis. It is imperative that students' voices are heard in what these depictions mean to their own perception of depression.

3.3 STEREOTYPICAL TRAITS

When participants discussed their perception towards mass media depictions of depression, they often described common stereotypes. One concern among participants was how these representations could impact how society understands depression. Schutz's (1967) and Berger and Luckmann's (1966) concept of typifications relates to this, as not only do 'types' inform common everyday understandings of attributes but they are based in institutions which inform social knowledge and values. In other words, typifications inform how different types (i.e., people with depression) are understood in relation to other characteristics which are all based on institutional values and norms attributed to people with mental illness.

3.3.1 The Representation of Depression in the Mass Media

I recognized early on that many participants felt the mass media often constructs characters with depression to look, act, and appear in stereotypical ways. In other words, I noticed how students were perceiving the mass media under what Schutz (1967) and Berger and Luckmann (1966) classified as typifications. Many students were able to draw upon various characteristics that the mass media depicts when speaking about depression. Despite the fact that over half of participants felt that the mass media depicts stereotypical depressive characters, participants often reported more general examples of this depiction. One direct example of a stereotypical depressive character was discussed by Felicity, who is 19 years old and has a medical diagnosis of depression. She felt 'Eoyre' from *Winnie the Pooh* was an example of a typified depressive character as he was always depicted as sad and complaining:

> …like they kind of just show the person with depression as kind of like in a way just to be a loser. And they kind of just show them as like- that just like whatever I've noticed from TV and stuff like that, they just kind of show them as a person who nobody really wants to be around who's always whining and complaining. (Felicity, 19 years old)

Another participant discussed how she found the character 'Bella' from the film *New Moon* to fit into this category. Lydia, who is 23 years old and has a medical diagnosis of depression, felt that the character communicates the idea that people with depression are not able to function in their daily activities such as work or school. As a brief background on the film, the main character, Bella, loses her vampire boyfriend Edward at the start of the film because he moves away, at which time she stops doing outside activities aside from school. For Lydia, this film stood out because she remembered how her childhood friends would recount how Bella "shut down" and joke that "you don't want to be like Bella!" Likewise, Darren, who is 24 years old with a self-diagnosis, spoke more broadly on how the depiction of depression is often gendered and feminized.

> I believe the media portrays a depression through female characters or elderly mostly, or even if it is with a male, that male is portrayed as less manly. How often is it that you see a young jock for example portrayed in media with a mental illness? Very rarely. So, it kind of gives this image that only these certain types of people deal with mental illness and it can't be just anybody (Darren, 24 years old).

In short, while Felicity and Lydia noted that depressive characters were perceived negatively among friends and society and that these were not attributes a person would want to be associated with, Darren added that typified depressive characters were often gendered as female and that men were perceived as less manly if they had the condition. It is evident that participants perceived typified depressive characters to depict stereotypical traits, often in a negative light.

Other common depression characteristics that were discussed among participants included being "lazy," "visually sad," "lonely," "pathetic," "unattractive," "a loner" and "always complaining." The following excerpts illustrate how participants perceive depictions of depression in mass media sources.

> I feel like media always has a way of portraying depression and its always the sad and lonely person. I don't know how they interact with others but I know it's not like how I do. I do like to watch those interactions because I feel like it is far from the truth. I have depression and lots of others do to. I don't always act sad and depressed, many of us are very cheerful so we have something to hide behind. The media shows that we are sad and lonely all the time. (Delilah, 19 years old, self-diagnosis)

And,

> Yes, absolutely, it's always showing someone who is either bullied and then goes home and cries themselves to sleep or goes home after a tough day and harms themselves. It is also predominantly showing someone who is visually down and sad and more often then not they look like a train hit them and their home. I think like anything they make someone with depression into a character with typical aspects such as how they act and interact with people which can be very negative as everyone is different. (Connor, 20 years old, self-diagnosis)

And,

> You know I think its typically male and just very um like I said confrontational. Or um also like I've said this a million times but the dark room and kind of ratty looking. Um you know I think there was big thing about looking depressed is how they portray um depressed people like looking disheveled, not washing your hair, and just being kind of unhygienic when that's also not really the case. (Carlie, 23 years old, medical diagnosis)

These characteristics relate back to how Berger and Luckmann (1966) noted that typifications that are applied to one individual can then be applied to a larger social group that has the same typification (pp. 31-32). The implications for this study is that when a character with depression displays the typification of a 'loner' or 'pathetic,' these characteristics can then be applied to any individual that also struggles with depression.

Another type of depressive characteristic that was brought up by a few participants was coming from a poor or traumatic childhood. As one participant notes,

> …like they had to have some sort of like traumatic childhood or like divorce or something. Like it was never just like just somebody like who didn't have all that, with like kind of those problems. Like it's always you had to have some sort of like traumatic past in order to do it. (Brooklyn, 23 years old, medical diagnosis)

Interestingly, this media typification may be based on more than careless stereotypes as there is some empirical support for this. Research examining 2,613 youth who stayed in an adult mental health center in Ontario, Canada finds that approximately thirty percent of the youth had experienced traumatic abuse (Stewart et al. 2015:35-36). While such research may inform mass media constructions of depression, it may also overstate or exacerbate the perceived association between this form of trauma and depression. Repeated representations may also encourage individuals with depression to believe that they do not deserve to have depression if they do not have this background.

It is worth acknowledging that while many participants felt that the mass media constructs negative typifications of what it means to have depression, there were some students that felt neutral on the topic or had no opinion on whether this was the case. A few participants felt that the mass media did not depict a stereotypical depressive character. For instance, Bailey, who is 20 years old and has a self-diagnosis of depression, states:

> Uhh no actually, so now that you mention *This is Us* and then or *13 Reasons Why.* So, like *This is Us* was with a like forty years old man. Umm uhh *13 Reasons Why* is obviously like high school. And then Twitter is everyone- all ages. So, I just I would say no to that. Like I just don't think its uhh specific age they don't act the same because it's so personal to the situation that they are going through so. (Bailey, 20 years old)

Further, while participants varied on whether they felt the mass media had created a predominant stereotypical character with depression, most discussed both the positive and negative aspects of the mass media. For instance, these participants discussed that while the mass media had created some problematic typifications of depression, overall, they felt that media presentations of depression were positive and can "educate" people and reduce stigma.

3.3.2 Exploring How Media Depictions Impact How Individuals Understand Their Own

Depression

While participants varied on the extent to which mass media depictions of depression impacted how they perceived their own depression, many participants felt that these depictions had no impact whatsoever on how they perceived their depression. Participants felt that these depictions were not impactful to their own perception for a variety of reasons. For example, one participant described these representations as unrealistic:

> I don't- I I don't think so, because I just like it just seems so like almost- not fake. I wouldn't say fake. Like they definitely like in shows they play it up and it almost makes it like super unrealistic kind of so it's like you know that would never happen. (Brooklyn, 23 years old).

Similarly, Connor mentioned that he does not easily believe mass media imagery and reporting due to its heavy use of stereotypes. In short, these participants agreed that they took the mass media sources with a grain of salt because of their personal experience and knowledge on the condition.

While many participants felt that the mass media played no role in how they understood their depression, others felt that it did have an impact. While some participants spoke about types of depressive characters directly, others discussed the mass media broadly in their examples. Participants discussed many reasons for why they felt it was positively or negatively impactful. Participants who felt that it had a positive impact drew on how they felt the mass media had an educational or non-stigmatizing component. Consider the following excerpts.

> Yeah. Uhh I would say yes, because I- the media makes it very like 'this is it.' And thanks to like other sources of media sources, like other like reading up and learning that there's a spectrum to these things, that everyone falls behind-behind something. It's assuring to know that my experience may not be like everyone's but doesn't mean that I don't- it doesn't mean I have to like fall between this certain way because everyone experiences it differently. (Julie, 21 years old, self-diagnosis)

And,

> I: Um and then I guess my next question is like has the depiction of depression in the media influenced how you have understood your own depression and like if so, how?
> P: Um that’s kind of about me I realize that I should get help and just that it’s okay to have depression.
> I: Oh okay.
> P: Like you can still be a-a contributing person to society and have depression.
> I: Yeah. Yeah, so that’s-that’s good that’s positive. Um and then like just going off of that like do you think it’s the uh depiction of depression in the media- like do you think it’s influenced how you’ve understood like how you understand stigma associated with mental illness?
> P: Uh yeah, I think their running a lot of those uh things in the media like that it’s okay, because a lot of people like me don’t have the positive um like help from family and that like it’s still a negative stigma. (Lucy, 19 years old, medical diagnosis)

Participants who felt the mass media negatively impacted their perception drew on factors like the perceptions of others:

> I think that really did make a difference in like the way that I view it myself for me because I’m like nobody wants to be around you, you’re always complaining, you’re always sad, you’re always crying. And I think that the media definitely does do a good job at making that like archetype prominent under TV shows and movies. (Felicity, 19 years old)

Other participants felt that media depictions were problematic in the sense that depression is presented in an unrealistic manner, which can have negative implications. For instance, Carlie felt that depression is depicted as though it is short-term which she felt was unrealistic as it does not match her experience of the condition. Further, Darren felt that media depictions influenced him to believe that depression was an “unmanly” condition. In short, while participants reported being both positively and negatively impacted by media depictions of depression, they noted that these messages are significant because they influenced how they understood their depression.

3.4 STIGMATIC PERCEPTIONS

As stereotypical traits have no meaning unless people give them meaning, it is imperative to recognize how media depictions or stereotypes can turn into stigmatic perceptions. One common theme was a concern for how these stereotypical traits can influence how family, friends, and society comprehend their mental illness. As the researcher, it became evident that their concerns were largely based on how media stereotypes can become stigmatic perceptions among individuals in society.

Durkheim (2001) examined idealizations similar to the ‘social fact’ argument not as thoughts created by individuals, but as ideas that are brought forward and enforced collectively and maintained by societal values and norms. The collective representation of the mass media would be placed under this framework. While this analysis is focused on typifications, it is useful to recognize idealizations in the macro collective representation of media. This is important because while stereotypical traits may be perceived as abstract thoughts, they are formed and based on social values and norms and these thoughts can influence people’s understanding on issues like depression and therefore act in stigmatizing ways. As the next chapter discusses students’ experiences with stigma in-depth, I limit my analysis here to how stigmatic perceptions are fueled by avoiding discussing mental illness.

3.4.1 How Media-Based Representations Impact Social Stigma on Depression

One concern that was brought forward by some participants is that the mass media can educate and influence how family members, friends, or society overall understands depression. For instance, Lucy states:

> Yeah, um like use my own family. Like when I say “I’m depressed,” my mom I think she expects me to be like laying in bed all day but I don’t like I happen to get some stuff done.
> I: Yeah, so you feel like almost media depictions almost reflect what people assume of like your experience-
> P: Yep. (Lucy, 19 years old)

This statement explores how one participant felt that her family viewed her depression under the stigmatic assumption of laziness or not being productive. A few participants also felt that the mass media can educate and influence how family members, friends, or society overall understands depression. Consider the following excerpt.

> Well, definitely with the sort of societal stigma we were talking about earlier and the worry about people not understanding. I think the media has a lot to do with that because you know people whether they mean to or not do get a lot of their- learn a lot of things and get a lot of their attitudes towards different things from the media around them. And so, sort of the I don't know, the confusing nature of mental illness in the media definitely contributes to that stigma of sort of worrying that people won't understand. Or worrying that people will treat you differently because you know the-the culture giving them an idea of that-that's not necessarily accurate. (Kaden, 19 years old, self-diagnosis)

In short, participants were concerned that society and the mass media equally influence one another and inform how people with depression are conceptualized. Likewise, participants recognized the potentially harmful impact of some of these stereotypical assumptions.

Another concern was that when the media enforces normalcy surrounding depression, it invalidates people's experience of depression. In other words, participants felt that mass media imagery has inadvertently promoted the mistaken belief that everyone struggles with depression at some level, which in turn can lead to a form of dismissal to those actually struggling with the clinical condition. Consider the following excerpts.

> It-It's not necessarily how the media, it's like how everybody's taking it in. Um it's like they wanna help and so their trying to make a big deal about this now but it ends up just being like "you have it! And you have it! And you have it! And you have it!" So, when like people like really are trying to deal with it then people just sort of go, "well everybody suffers from it." Like I can't even tell you how many times I've heard about that like just heard that statement. (Lydia, 23 years old)

And,

> The media discusses mental illness in a condescending way, whether depression is being discussed in a podcast or depression is represented in a movie. The media tries so hard to destigmatize mental illness they almost make then sound like a good thing. The negativity of these mental illnesses should not be ignored as it makes people with mental illness believe what they are suffering through isn't important. When mental illnesses are depicted in such a broad sense it takes away from the individual experiences of people suffering with depression and it defines depression in a way not everyone with depression

> experiences. The way the media depicts depression is typically inaccurate, because of the inaccuracy it makes people question their feelings and causes doubts about themselves. (Una, 19 years old, medical diagnosis)

Thus, for these participants the stigmatic perception is important not only because is it a form of dismissal towards people with depression but because it makes their condition appear less serious.

3.4.2 Competing Perspectives on The Role and Value of Media Imagery

Another concern that was brought forward by participants was whether individuals are interpreting media depictions of depression as factual or if they are able to recognize the difference between stereotypes and fact. As a side note, I recognize that what is considered 'real' or a 'myth' can be subjective but students views are important because it shapes how they perceive society to understand depression. Misinformed knowledge about depression could have a range of negative repercussions. For instance, Connor felt concerned that if characters with depression are portrayed as outwardly sad then it can lead to the assumption that this is what everyone with depression appears to be.

> For example, you should have learned from me by now that I keep my issues close to my chest so to speak and you wouldn't know from interacting with me that anything was wrong. I don't think they influence me but like I said they upset me as sometimes they for television have to make it obvious that someone is depressed which isn't the case and can result in a lot of people thinking those close to them are doing great, when in reality they want to die every day. (Connor, 20 years old)

Here, Connor is making the point that if media depictions of depression are all taken as factual then it can become easy to dismiss someone not displaying physical cues. In short, participants were concerned this misinformation can impact how individuals understand depression.

Some participants also felt that the mass media did not address mental illness frequently enough, while other participants felt that the mass media too often shied away from the topic. To help address this, it may be useful to explore the sociology of silence. Zerubavel (2010) argued that in order for a topic to remain silent within society it must also be denied to exist in social encounters, and those who do not adhere to these norms are punished:

> What we are socially expected to ignore is often articulated in the form of various *taboos against looking, listening, as well as speaking*. Those who defy or even simply ignore such prohibitions are considered social deviants. As such, they are often targets of social sanctions. (p. 34)

Thus, taboos are considered socially unacceptable topics of discussion. And if an individual decides to break that social rule and speak about the elephant in the room, they can encounter social rejection and mistreatment. Interestingly, participants discussed how they felt the mass media does not address or remains silent about mental illness. The following excerpt demonstrates how one student felt the mass media did not discuss depression as much as it should.

> Yeah, kind of like in TV and film and movies. Cuz I'm- in some of the actors like they try and I find that some shows they'll try and like completely remove mental illness almost. So, they try and influence it as if it's not there, (Sadie, 22 years old, medical diagnosis)

Here, Sadie emphasizes that when depression is not spoken about in the mass media it can encourage the topic to remain ignored.

Others weighed in differently on this issue. Sage, who is 21 years old and has a medical diagnosis of depression felt that she did not see the mass media discussing depression very often as people tend to keep it to themselves. Stetson, who is 20 years old and has a self-diagnosis, felt that depression has been spoken about less due to the current COVID-19 pandemic and also that when it is discussed on a news site it is "just kind of spoken about and forgotten about." Thus, these participants are making the point that silence or not openly addressing depression in the mass media is stigmatizing.

In short, participants felt that the mass media does not address depression enough or at all. Nonetheless, participants felt it was important for the media not to shy away from discussing the topic as this was seen as stigmatic among some participants. The takeaway from these testimonies is that while there is considerable criticism of typified portrayals of depression as negative if not stigmatizing, the silence of depression in mass media is equally if not more problematic.

3.5 GLAMORIZATION

Before getting into a discussion of how university students felt that the mass media "glamorize" depression, I want to begin by discussing how typifications relate to this framework. The glamorization of the mass media also relates to Schutz's (1967) theory of typifications, as many participants recognize that these media archetypes are not only common everyday language categories but create a shared meaning on what it means to have depression. Participants recognized that media typifications have the potential to influence how society understands mental illness and therefore enforce values and attitudes surrounding it.

The word "glamorized" often came up when participants discussed how the mass media depicts depression. To possess glamour is understood to mean "romantic, exciting, and often misleading attractiveness" (Merriam-Webster 2011:181). While the term can be taken as positive or negative, students often felt that how the mass media glamorized depression was unrealistic. They argued that how the media depicted depression was not reflective of their own experience with depression, or overall. Consider the following excerpts about how glamorized depictions of depression can be unrealistic.

> I think it can be glamorized like it doesn't show like the 'day-to-day' circles of living with it. (Lucy, 19 years old)

And,

> Um I think the portrayal like before I had it, I kind of understood it to be this very dramatic experience where you couldn't you know get out of bed for days and you know everything was just terrible and stuff like that it was just lows all the time. Which in-which it is um but I don't know that they really recognize that it's a lot of um up and down. Like you're not just down for months and then suddenly you're better. Like you could be down for a month and then you have you know a week of feeling better but then you're sad again. Um so I don't think they really um portrayed it that way, and I think there's allot of I think not their doing. They're doing a good job of trying to open up a dialogue about it in the media but still I think it gets glamorized a lot, (Carlie, 23 years old)

Here, it is clear that both participants felt that these representations are inaccurate. While Lucy felt that the mass media did not represent the everyday struggles of living with depression, Carlie felt that these depictions inaccurately represent depression as feeling sad on a daily basis.

3.5.1 Glamorization and 13 Reasons Why

Another source that was brought up as a form of glamorization was the Netflix Series *13 Reasons Why*. Over a quarter of participants felt the show portrayed depression negatively and expressed concerns that it could impact how other people with a mental illness or society in general understands depression and suicide based on the popularity of the show. In brief, the series is about a teenage girl who experiences various traumatic events throughout her first year at high school, such as being cyber-bullied, stalked, sexually harassed, and raped. In the end, she commits suicide and leaves behind 13 tapes to people who were somehow involved in these negative events and whom she concludes were the "reasons why" she committed suicide.

Participants shared different views on why they found the series to perpetuate a negative portrayal of depression. For instance, Carlie felt that although the show had good intentions, she found that people interpreted the content negatively as it became glamorized among her younger siblings' friends as a cool thing to be an "emo angsty teenager." Further, she found people used the phrase "I'm depressed" in daily conversation as though everyone experiences it. She felt this was offensive and hurtful for people to speak about the condition casually when it was a real and difficult period of her life. Another participant, Connor felt that the show could inadvertently encourage people to commit suicide,

> I'm sure many people will mention 13 Reasons Why as it is very popular and does not hold back in showing the effects of bullying and mental illness. However, it as well as others tend to glamorize the 'they'll miss me when I'm gone' mindset. Which I think can be very bad for people going through particularly difficult times and already contemplating suicide. (Connor, 20 years old)

Not all participants who felt the show wrongfully presented depression used the word "glamorize," though they used similar words to convey the same sentiment. For example, Kaden felt that the show romanticizes depression and suicide and, despite it having beneficial parts, a few notable aspects stood out as harmful. He believed it was problematic because media depictions that are completely unrealistic are more likely to be dismissed by viewers whereas shows that depict some level of truth and accuracy, such as *13 Reasons Why,* are more likely to be accepted and therefore can be harmful. In addition, some participants were concerned about the impact these messages had on people with mental illness. Interestingly, Nesi et al. (2020:3) found similar results when they conducted open-ended responses with 59 youth at a mental hospital in the United States who had viewed one or more episodes of the Netflix series *13 Reasons Why*. In the study, they found that 55.9% felt the show was problematic and triggering, 23.7% believed it was inaccurate, and 16.9% felt that it romanticized suicide (p. 5). Further, 20.3% felt that the show brought forward more social conversation on these taboo subjects. In short, while each participant found the series problematic for different reasons, a common attribute of their arguments was a concern for how these depictions could influence public knowledge and treatment of the condition.

Notably, while the vast majority of participants who brought up the show *13 Reasons Why* felt that it had negative implications, one participant I spoke with took the opposite approach. According to Bailey, the show was beneficial in the sense that it was created to further discuss mental illness as a topic of conversation and therefore it was "something to learn from, not really get hurt by." It is important to note that many participants who felt the series had potentially harmful implications also found that the show had good intentions but that it did not deliver the content in the best way or that people could misconceive the message of the show.

3.6 LEGITIMACY OF VOICE

Next, I want to shift to an analysis of what students perceived to be beneficial or unhelpful when speaking about depression in mass media sources. Notably, students believed it was imperative to hear the lived experience of depression from others as opposed to people speaking about the condition without this background. Interestingly, Rowe et al. (2003) found in their study on the representation of depression in Australian newspapers that the lived-experience was limited in comparison to expert opinion. This study is insightful as many of the participants in my research expressed concern with whose voice takes center-stage in discussions about depression.

Some participants did not appreciate it when people in the media act or speak about depression when they have no experience with the condition. They argued that it was imperative to hear other people's personal experience with depression and less beneficial or accurate hearing the voices of those without any lived experience. The following two excerpts outline how participants felt that people who speak about depression without firsthand knowledge may have good intentions but can never fully grasp the condition.

> Um I think it's inaccurate because like it's coming from people that don't have depression. Like and maybe people are trying to help but its just- as much as they try to

> help, they don’t know what’s happening if they’ve never experienced it before. (Lucy, 19 years old)

And,

> I: Yeah. No, all good. And then like um overall like do you think like the media’s accurate towards mental illness like discussing it or?
> P: I mean I’m sure they try but like they- I imagine most of the people who write it probably don’t have it.
> I: Yeah.
> P: Which I mean you can only understand so much when you don’t have it.
> I: Yeah. Yeah. So, you’d say it’s like more inaccurate almost because of that fact?
> P: Almost yeah. Yeah.
> I: Yeah. Yeah, no that makes sense. Yeah, and then-
> P: Just sure people can tell you about it but it’s a whole different ball game to feel it. (Sadie, 22 years old)

Thus, participants felt that people without the lived experience of depression could not fully comprehend it and therefore should not be speaking on behalf of those with the condition. This sentiment is akin to the disability rights slogan “nothing about us without us” (Charlton 1998) in which the goal of advocacy is to demand inclusion of community voices in policy and public discussions about marginalized groups.

Over a quarter of participants used comparisons as a way to emphasize that mass media sites where people shared their experience with depression was more genuine and authentic than websites, news sites or corporations speaking on behalf of those with the condition. For example, Bailey believes it is much more beneficial to read people’s personal experiences with mental illness on Twitter than reading posts from large corporations discussing depression. Another participant, Brooklyn, found that reading *The Telegraph* news articles were useful but it would have been more positive if it was written by the person who had actually experienced it:

> I: Yeah, no worries. And then like um like do you feel like what you’re reading on like the articles from *Telegraph* like the website- like do you feel like those are accurate?
> P: I I feel like they are but they’re always like edited for length and stuff. So, I sometimes you feel like that’s- like it’s just like worded like any other, like it doesn’t feel as personal. Like you can tell that it’s not written by the like person, so that kind of takes

> away a little bit from it. But um for the most part I think it's it works it gets the message across.
> I: Yeah, like do you feel like um like if it was written by a person that actually experienced it themselves like would it be more accurate or better would you say?
> P: I would say, yeah. I like hearing like actual testimonies in like in their words.
> I: Yeah, do you like have any- sorry.
> P: Oh, I was just going to say I think it just makes it more uh like personal and like you can relate better almost. (Brooklyn, 23 years old)

Similarly, Stetson believes YouTube provides an atmosphere where it feels like the viewer is actually communicating with a real person and it feels more authentic than a short glamorous news clip on television. He also found YouTube videos to be more helpful as they tend to be longer and more detailed when discussing depression than a short news clip about depression. Thus, these participants felt that it was beneficial hearing other people's experience with depression as opposed to reading newspapers or corporations making a statement on a condition they do not have.

Some participants found it beneficial when the mass media depicts individuals who share their own experience with depression. For instance, Kaden felt that the book *The Way of Kings,* was helpful.

> My yeah, my favourite book in the whole world uh *The Way of Kings*. The main character is like very deeply depressed but the book is not about that, I guess. Like it's- I don't know the plot is not built around his illness, it's built around the things he does in spite of it, I guess. Which is a really empowering message for people who have mental health problems. (Kaden, 19 years old)

Likewise, participants felt that it was helpful when social media sites were used to create groups where people can share their experiences with depression:

> But in regards to more specific examples like, well there's one I can actually think of that's very specific. This girl I know made an Instagram page um because she had struggled with um depression and attempted suicide so she was hospitalized and so she made an Instagram page for people to share their stories um so I thought that was helpful. (Bailey, 20 years old)

And,

> …that mental health page I mentioned earlier, like a girl I used to be friends with posted shared her depression story on there- … I guess like for everybody there are some symptoms that are like pretty across the board common like having difficulty getting up in the morning, difficulty getting out of bed and stuff like that. But there is one thing that she said that … that umm she just kind of shut down and she didn't talk to anybody for like days. Like she wouldn't even leave her room. When she just wouldn't even want to go out and stuff like that. And I was like when I had those experiences, I felt like weak for doing it and I was like what's wrong with me? Like why can't I just do simple things that everybody else is doing? And seeing that other people had the same experience made me feel a bit better, I guess. (Felicity, 19 years old)

In short, participants appreciated learning from others' experience with depression through the mass media because it was a non-stigmatizing environment where people shared common stories and emotions that students could identify with. Having this space was important to participants because it made them realize that they were not alone in their battles and that there may be better roads ahead.

3.6.1 Celebrity Voices

Building on the previous sentiments, some participants felt that it was particularly helpful to hear celebrities discuss their experience with mental illness. Participants felt this was beneficial because it was comforting and empowering to see people who they look up to experience the same thing. For example, Sadie noted that celebrities such as Lady Gaga and Katy Perry try to speak about their experience with mental illness in order to make it a more socially acceptable topic of discussion. Moreover, Darren felt that it was helpful when other males share their experience with depression as it is not frequently spoken about by men:

> An example of the depiction of depression in the media that I felt was positive was a few years back when famous male celebrity Ryan Reynolds spoke up about his struggles with mental health in an interview. It was the first time for myself to see that a man on such a big platform was also experiencing similar things that I was. I remember reading of him saying how he was always ashamed of talking about his mental illness and I felt better knowing there was someone I could relate to. (Darren, 24 years old)

Similarly, Nicholas who is 18 years old and has a self-diagnosis of depression felt it was positive when he viewed NBA players such as Kevin Love share his experience with mental illness. Thus, it is clear that students found it beneficial when celebrities shared their experience with depression because they felt less alone. Further, some participants felt that it was important seeing celebrities in that light because it reminded them that they were successful despite having a mental illness.

3.7 DISCUSSION AND CONCLUSION

This chapter began by examining the importance of typifications in how individuals categorize and give meaning to the social world. Berger and Luckmann (1966) and Schutz (1967) concept of typifications was then used to understand how common everyday knowledge systems are brought forward in the mass media and enforced through institutions of what norms and values are associated with having depression. The examination of findings focused on how the mass media represents depression from the perspectives of university students with depression. Although students had multiple perspectives on the topic, four main themes were identified: stereotypical traits, stigmatic perceptions, glamorization, and the legitimacy of voice. A common concern present in each theme was the potential impact that the mass media has on informing public knowledge and values on the condition.

One interesting theme that occurred to me throughout this study was the relevance of C. Wright Mills' observation that "personal troubles" are often "public issues." Mills argued that being able to see personal troubles as societal public issues is crucial because both social and individual factors influence people's experiences, and without acknowledging public issues individuals will see all fault as resting on their own shoulders (Bernhard 2007:123-124). To illustrate this point, Bernhard used the example of gamblers who join group therapy only to recognize for the first time that their personal troubles were actually public issues other individuals also struggled with (p. 126). Likewise, when participants in my own study read or heard celebrities or individuals share their experience on social media, they were able to see their personal trouble as a public issue. Participants described this as positive as it made them feel less alone in their experience.

Throughout this chapter, many participants expressed concern that media representations of depression could impact how friends, family, or society overall understands their condition. This study is limited to interviews with university students with depression. It would be useful for future studies to interview people without depression, to examine their perceptions on media depictions of depression and whether it impacts their knowledge of the condition. This may be beneficial in order to better understand how much the mass media impacts people's knowledge on mental disorders and whether my participants' concerns about media influence are well founded.

Over half of the participants felt that the mass media sources present predominantly stereotypical images of depression. This is important because participants felt the mass media typified characters with depression as unlikeable or as possessing other unattractive features. While participants varied on whether or not these depictions impacted how they understood their own depression, many recognized that depression is a stigmatized condition and these representations only further this knowledge system. The next chapter picks and further explores some of these themes by discussing students' experience with stigma, which at times overlaps with the media depictions examined in this chapter.

Chapter 4. Stigma, Passing, and Disclosure Practices

The notion of stigma is rooted in the sociology of Erving Goffman and has since been explored by many academic disciplines, ranging from the social and health sciences to biomedical research like psychiatry and medicine. It was sociologists, however, who brought forward the importance of stigma as a social phenomenon rooted in cultural processes like norms and values.

This chapter examines the significance of social stigma in the context of depression. I use Goffman's (1963) foundational work on stigma to better understand the social experience of depression among university students. I argue that whether or not participants experienced stigma they were still impacted by the knowledge that depression is looked down upon in society. Further, I argue that some participants who selectively disclosed their depression encountered what I refer to as "suppressed stigma" where they were told by loved ones that they were not permitted to label themselves with depression. I begin the chapter by introducing Goffman's (1963) work on stigma, followed by a brief discussion of how key sociologists have built upon this theoretical framework. Next, I discuss participants experience with stigma, the impact of experienced or perceived stigma, non-disclosure practices, and choosing to gain supports.

4.1 THEORIZING SOCIAL STIGMA AND DEPRESSION

Erving Goffman's book *Stigma* (1963) was a trailblazing work, and, to this day, remains one of the most oft referenced works on the topic. According to Goffman, stigma occurs when an individual is viewed and treated differently based on possessing a socially unacceptable attribute:

> By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances. We construct a stigma-theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences, such as those of social class. (p. 5)

The importance of social stigma is not simply that people are made to feel bad or self-conscious about themselves but that societal norms select and enforce what is considered stigmatic.

For Goffman, stigma is attributed in the context of the relationship between stigmatized and ‘normal’ individuals. Goffman argued that stigmatized individuals are encouraged to act in accordance to or make ‘normal’ individuals feel comfortable around their stigmatic presence. For this to occur, stigmatized individuals must first recognize if they possess a discredited or discreditable attribute. A “discredited” attribute is visually noticeable in social interactions, while a “discreditable” attribute is not as easily recognizable in public settings (p. 4). Individuals who possess a discredited or visible attribute often attempt to manage tension or embarrassment in social interactions with ‘normal’ individuals by pretending their stigmatic characteristic is not present (p. 42). Because the stigma is visible and cannot be easily hidden from public view, ignoring the stigma or acting like it is insignificant is frequently the preferred management strategy. By contrast, those with a discreditable attribute are more likely to manage this information by exercising caution about whom they disclose their stigmatic identity to. Keeping this a secret can become a delicate dance of sorts and can potentially weigh heavily on people’s minds. In Goffman’s words: “To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where” (p. 42). According to Goffman, individuals with depression would have a discreditable characteristic- a condition that is not typically visible but that could potentially be exposed or revealed. Goffman also recognized that while stigmatized individuals often try to hide their attribute, they may also decide to selectively disclose their condition to people they trust. Individuals with a discreditable condition engage in situational disclosure in order to try to obtain support from loved ones although that is not always the outcome (p. 95).

In the book, Goffman argues that stigma can fit into three categories "blemishes of individual character," "abominations of the body," and "tribal stigma" (p. 4). Using this framework, the stigma attributed to depression would fall under the category of "blemishes of individual character." This form of stigma examines personal attributes that are deemed to be socially unacceptable or looked down upon. For instance, Goffman provides the example of individuals who are dishonest or have "domineering or unnatural passions" (p. 4), such as felons, the unemployed, and individuals with a mental illness. People with depression would fit into this category as they possess a mental illness which is perceived to be a negative character trait. One exception to being labeled with a stigma is to be labeled under a "natural framework." In Goffman's (1974) book *Frame Analysis,* he argues that individuals usually fit under a "social framework" where they are perceived as intellectually responsible for their actions. However, individuals can also be placed under a natural framework where they are viewed as being unaccountable for their actions due to biological reasons. Goffman provides the example of children not being held morally responsible or stigmatized for their actions due to age (pp. 188-189).

Sociologist Thomas Scheff (1999) also contributed to the study of stigma, though he explored the concept using a labeling theory framework. Labeling theory posits that individuals whose outward social behaviour is deemed "deviant" are assigned a label by others that become the lens through which they are viewed in social settings. These labels tend to be enduring or difficult to shed, and can negatively affect the identity or sense of self of the "deviant" person. It is important to note that labelling is a social process that is reinforced by many people over time, not simply a one-time action that is internalized.

Scheff provided the example of an individual who was labeled with "insanity" with a mental disorder because they behaved in manner that was in violation of social norms (p. 85). Once the label was applied, all of the person's behaviors were interpreted as consistent with the expectations of someone with mental illness. Further, the labelling process can result in a self-fulfilling prophecy (p. 86). In this stance, the person labeled as "insane" and treated as such, internalized the label and outwardly behaved in ways that were consistent with the newly forged identity. Labeling theory is relevant to stigma because once an individual is labeled, they are placed into a deviant role and are subject to negative societal reactions and judgement (p. 45). In this way, stigma can be seen as a powerfully negative label that can permanently change a person's life and sense of identity. Rosenhan (1973) found similar findings in his study of graduate students who were admitted to a psychiatric ward under the false pretenses of "acting" like they had schizophrenia. After being admitted to the ward, they acted in a "normal" manner but the doctors persisted in treating them as schizophrenic despite this change in behavior. When the students were finally released from the psychiatric ward, they were labeled as schizophrenia "in-remission." This makes the point that once a person is labeled as deviant it becomes difficult to shed the label.

Edwin Lemert and Howard Becker also explored labeling theory and deviance. Lemert posits that individuals can fit into two roles: primary deviance or secondary deviance (Cockerham 2017:123). Primary deviance refers to a person that behaves in an erratic manner but is still considered "normal" due to these actions being regarded as out of the ordinary. Secondary deviance is when a person is defined as deviant because they are known to frequently break social norms and rules. In contrast, Becker argues that deviance "is therefore not a quality of the act a person commits but rather is a consequence of the definition applied to the act by others" (p. 123). According to Becker, deviance is not an innate category but is subject to how individuals respond to different actions, the time period of the act, and the identity of the person (pp. 123-124). These studies are important in recognizing the social values and norms which enforce who and in what circumstances individuals are labeled as deviant.

Graham Scambler and Frederique Paoli (2008:1848) examined the relationship between deviance and stigma by drawing attention to the significance of "shame" and using the example of female sex workers living with HIV. They argued that whereas stigma is an ascribed characteristic that is socially devalued but is not believed to be the individual's fault, deviance is an achieved characteristic based on individual fault that is perceived to be morally wrong (pp. 1849-1850). Put simply, deviance corresponds to blame and sanctioning while stigma aligns with shame and pity (p. 1849). In the case of the HIV+ sex workers, they experienced a particular form of social stigma that blamed them for their illness because the disease resulted from sexual behaviour due to their line of work. Applying these findings to depression, one might be inclined to assume people with depression would experience shame-related depression and not deviance-related depression, though the findings presented in this chapter illuminate ways that some people feel blamed for their depression.

Bruce Link and Jo Phelan (2001) flip the script by exploring how social stigma is enacted on vulnerable people by those in power. The stigmatic process begins when an individual's characteristic is labeled as different (p. 367). Next, the labeled difference is associated with negative stereotypes (p. 368). This difference also is used to segregate the individual using an "us vs them" majority/minority logic (similar to how the Black slave minority (the "them") were treated by the white ruling majority in United States (the "us") prior to the Civil War (p. 370). Next, the stigmatized individual is socially devalued and, as a result, struggles with status loss (e.g., passed over for leadership roles, ignored or spoken over) (p. 371). Similarly, the individual faces various forms of direct and indirect discrimination such as status loss discrimination and structural discrimination (pp. 372-373). Next, the person may be affected by social psychological processes as they are socialized to understand what conditions are stigmatized, which can negatively influence how they understand and interact with people (p. 373). Lastly, for stigma to be enacted it must be enforced by an individual or group who possesses social, political, or economic power (p. 375). They conclude that enacted stigma impacts people's life chances such as their health, occupation, and place of residence.

In this chapter, I use Goffman's (1963) theory of stigma and the notion of "passing" to examine university students experience with depression. Goffman focused on how individuals try to manage tension or information about their stigma by trying to hide or distract from it. Goffman also recognized that individuals with a discreditable condition may elect to selectively disclose their condition. I present findings that show how students with depression both manage information about their stigma and engage in situational disclosure. However, while Goffman viewed the outcome of situational disclosure to be either support or rejection from loved ones, I present findings that show that some students who disclosed their condition were dismissed or told they did not have depression. I argue that this is a form of suppressed stigma, since participants' stigmatized condition was rejected and they were told it was not real. Further, I argue throughout this chapter that whether participants experienced stigma or just had a negative experience opening up about their depression, many participants internalized these beliefs and acted accordingly. I explore four common themes in support of this main argument: the experience of stigma, the impact of experienced and perceived stigma, choosing not to disclose and practices of passing, and choosing to disclose and gain supports.

4.2 THE EXPERIENCE OF STIGMA

Approximately half of the participants' reported experiencing stigma while others were adamant that they had not. I felt it was relevant to include both perspectives because those who felt they had a negative experience often overlapped with the themes of those who had experienced stigma. One common thing a majority of participants agreed upon was that depression is viewed negatively in society. This sentiment is emphasized by the following participant's stigmatic experience:

> Uh yeah, I think it's the biggest reason why I don't tell people. That's like beside the re- like rejection of feeling that but it's just the- it's the like depression is looked down upon and I don't want people to look down upon me for having something I can't control. (Lucy, 19 years old)

Participants' experiences with stigma was diverse and particular to their own individual circumstance. Many of these experiences were based on students who disclosed their depression but then received a judgemental response. Others were indirectly informed that depression was not an appropriate topic of discussion. The majority of the participants' experiences could be placed into four categories: 'illness as a choice', 'play it down', 'deserving to be sick', and 'being lazy.' Nonetheless, all of these experiences are connected because they brought forward the common sentiment about how depression is negatively perceived in society.

4.2.1 Illness as a Choice

One interesting finding that some participants encountered was people who stigmatized their experience by pretending it was not real. As noted previously, Goffman (1963) recognized that stigmatized individuals engage in situational disclosure to receive support or unfortunately rejection. Unlike Goffman's analysis, students encountered suppressed stigma where they were told that they did not have depression. This idea is similar to the concept of 'victim blaming' in the sense that participants were blamed or told it was their own fault for experiencing depression. Capezza and Arriaga (2008:839) provide the following definition of victim blaming:

> When people face extreme hardships, a curious phenomenon is that often they are blamed for the hardships. In the context of domestic violence, one can imagine a situation in which a woman is severely beaten, yet her family asks her what she did to cause this. Such reactions are all too common. Why do people blame victims?

However, in victim blaming the context is generally believed. For instance, a homeless woman is accepted as being homeless but blamed for being in that position. In the case of 'illness as a choice,' participants were in essence told that they did not have depression. In other words, when a participant would discuss their experience with depression to someone else, that person would tell them that "you are choosing to be depressed" or "you are choosing to act depressed." The idea of 'choosing to be sick' or 'illness as a choice' emerged. I felt this was one of the most interesting findings of this study as most people would agree that the pain associated with an illness is not something a person would choose to experience. It would be strange to tell someone diagnosed with rheumatoid arthritis that they have chosen to have this chronic illness and experience this pain. Yet when it comes to depression, it appears that social norm no longer applies. The following excerpts explore participants' stigmatic experiences with illness as a choice. Carlie, who has experienced stigma, has this to say:

> Okay so I've experienced stigma both um kind of in uh the university and outside. So outside it was a lot of people not really understanding what I was going through and maybe thinking I was 'faking it' or just being 'over dramatic' about it um. (Carlie, 23 years old)

Sage shared a specific negative experience where her family felt her experience with depression was her own decision.

> They don't believe that um it's a mental illness. Like I mean like my family for instance, believes that uh depression is a spiritual issue. Because like my one family member is a pastor and they believe that um it's not real and it's not in your head, and that you have

> the ability to be happy if you want to be happy. So technically, they think that the having depression is your choosing not to be happy. (Sage, 21 years old)

Finally, Lucy, had a stigmatic experience when she tried to disclose her depression to a few individuals but they responded back by telling her she was a liar.

It is evident that these three participants did not get a supportive response after they disclosed their condition. Unlike the outcomes Goffman (1963) discussed in situational disclosure, many of the students' loved ones dismissed the idea that they could have depression. These experiences are echoed in a study of employees with a mental illness at a university in Ontario, Canada who were afraid that they would be treated as though their mental illness was their fault if their condition was disclosed at the workplace (Toth and Dewa 2014:736). This fear, they explained, resulted from "being told that they should just 'pull up their socks' and 'get over it'" (p. 736). Goffman (1963) recognized that individuals with stigmatic attributes often try to manage tension or information about their condition but at times they will also decide to selectively disclose their stigma. In this instance, participants were willing to open up but they did not receive a supportive response. This is important because whether participants considered this to be stigma based or not, these responses negatively impacted how they understood their depression.

4.2.2 Playing it Down

A second theme that emerged throughout my research that participants found negative was when they were told either directly or inadvertently that their depression should not be spoken about or to 'play it down.' The theme 'play it down' is similar to the metaphor of 'sweep it under the rug.' In other words, one should not discuss their experience with depression but keep sweeping it under the rug so that no one will see or hear about it. This is illustrated in the following participant's stigmatic experience disclosing her depression:

> When I did want to talk about if I had this mental illness no one would take me seriously and tell me that it wasn't something that I should worry about and that I was perfectly okay, that was normally my parents. And when I talk to my friends about it, they didn't believe it. And it just gave me the idea that I shouldn't talk about it. (Delilah, 19 years old)

Similarly, Felicity had a negative experience when she struggled with depression in her younger years,

> When I was younger it was more people saying like "oh like you're thirteen what do you have to be depressed about?" It's just people always kind of play it down and say it's not a big deal. (Felicity, 19 years old)

Likewise, another participant had a stigmatic experience where she had not disclosed her condition, but felt that her friend's position on depression lead her to make the decision to play it down and not disclose her condition to them:

> But like getting to know more people and I guess maybe it's the stress that they're going through but like a lot of people that I seem to like get to know see it as like a hassle to be around people that are- that have like depression and stuff. And that it like it's draining or like they their dramatic or things like that. And it's-it's hard wanting to talk to them or trying to like properly confide in them because I don't feel like- I feel like 'oh I don't want to be a hassle to them. I don't want to be like that draining person that they don't wanna be around.' So, I find myself allot of the time just kind of like making small talk kind of thing. (Julie, 21 years old)

In addition, Kaden felt that it is encouraged throughout society not to speak about depression unless it is with someone the person is extremely familiar with. In short, it is clear that Julie and Kaden's experience is similar to how Goffman conceptualized stigma. These students decided to manage information or play it down based on the knowledge that depression is looked down upon. Delilah and Felicity encountered this form of stigma following situational disclosure where their loved ones dismissed the seriousness of their depression and told them not to acknowledge their condition.

It is important to note that not receiving validation for their mental illness or being told to ignore it can have negative consequences. Toth and Dewa (2014:736) found that previously experiencing negative stigmatic messages and internalized stigma led individuals to prolong obtaining medical help for their condition. Thus, participants were told either directly or indirectly to dismiss or "sweep" their depression under the rug or they inferred this message indirectly from social norms about depression. The result of these messages is that they felt they should not speak about their depression which is one way stigma is internalized.

4.2.3 Deserving to be Sick

The theme 'deserving to be sick' emerged when I noticed some participants experience stigma in the sense that they were told that they did not deserve to have depression as they came from a good background. For instance, Lucy, had a stigmatic experience where she told her mother she was experiencing suicidal thoughts associated with her depression but was denied to feel that way because of her good background, "Yeah, um I told my mom I was suicidal and she told me that there's nothing to be sad about and I have a good life." Further, another participant who fell into this category is Carlie. She felt that the mass media predominantly depicts characters with depression as having a low-income background and a traumatic childhood. Because she came from a well-off background, she initially found it difficult to recognize herself as having depression. This idea links back to how some participants felt that the mass media depicted characters with depression as having a traumatic background. Likewise, one participant who had experienced stigma shares how she both experienced and internalized the notion of deserving to be sick,

> I: Yeah, like um what do you think kind of made you make the decision to like not open up about your depression? Like to not discuss it? If you feel comfortable sharing.
> P: When I was younger um part of it was ignorance and the concept of like the whole uh like "everybody like there's people in Africa who are starving and dying." And like

> meanwhile, I was getting I was getting to go on trips to Disney and I would have like an iPod or all that back in like 2010. Like all-all that stuff, I had a laptop and like my parents have a very comfortable like were not like my-my parents aren't overly wealthy but very comfortable enough that we could go on a vacation every year. So, it was sort of the whole what could possibly be wrong thing. (Lydia, 23 years old)

In short, participants were told that they did not deserve to have depression from family, the media, or society. It is interesting to think that some diseases and illnesses are considered 'deserved' or 'undeserved' based on the characteristics of the individual. For instance, it would sound strange to say that individuals deserve or do not deserve to have the common cold in the winter. Interestingly, Mosher and Danoff-Burg (2008) conducted research that found individuals were viewed as deserving of lung cancer if they smoked. In this study, they asked participants to listen to an audiotaped interview that consisted of someone struggling with lung cancer but each had a different smoking status and gender (p. 827). In their findings, they noticed how participants that listened to an interview where the individual was a smoker, tended to be outwardly mad due to the perceived control they had over protecting themselves from the condition (p. 836). Thus, while there is some support that people are blamed for or seen to have a right to claim illnesses that are linked to their behaviours (i.e., smokers developing lung cancer), the above findings indicate that this practice may extend to certain mental illnesses like depression.

4.2.4 Just Being "Lazy"

Another form of stigma that some participants reported experiencing was being called 'lazy,' a finding that is reminiscent of mass media constructs of characters with depression presented in the previous chapter. Participants reported being labeled as lazy when, for example, they lacked motivation or had a hard time getting out of bed. Brooklyn, who has experienced stigma stated:

> Um I think the big one is being lazy, I think. You don't have the motivation to do stuff but like like they don't think it's anything else, they just think it's laziness. I don't know that's like my biggest one cuz I haven't been like- like I don't think discriminated like full on after I say I have it or whatever like. But like I don't know. I think people just don't realize and then they just assume your lazy after, and then yeah that's a big one.
> I: Like do you have a specific memory if you feel comfortable sharing of like that occurring where like someone?
> P: It just happened, the only one I can think of now- I'm sure there are others, is just like if I don't feel like getting out of bed or something and my parents will be like you know "get up." That's the only thing I can think of.
> I: Yeah, and then I guess my next question is like how did the experience make you feel where you were called lazy based on?
> P: Oh, um I don't know. Like I-I got it, like I understood why they thought that. But it is frustrating when it's like you can't really control it. (Brooklyn, 23 years old)

Participants often attributed this act of labeling to misunderstandings of depression rather than intentional cruelty. Lydia shared a stigmatic experience where people sometimes misinterpret the tiredness from her condition as laziness,

> Yeah, like they'll just be like "oh well I stayed up til 2, like and I'm fine. Why aren't you fine?" Or if like I don't know like I go to bed early and like sleep for twelve hours say, like people are just like "you just need exercise and sunshine." (Lydia, 23 years old)

Based on the participants' experiences with stigma, it seems that people in their social circles often did not recognize tiredness as a symptom of depression but instead viewed it under the stereotype of laziness. This is important because if individuals with depression internalize the social values that depression is associated with laziness, they may be less likely to disclose their condition or blame themselves for dealing with a symptom they have no control over.

4.3 THE IMPACT OF EXPERIENCED AND PERCEIVED STIGMA

Another theme that emerged in the data was that regardless of whether participants felt they had experienced stigma or just had a negative experience opening up about their depression, many felt that they had not received validation for their pain. Here I discuss two categories. First, I examine the impact of stigma on individuals who felt they had experienced stigma by being dismissed by their social circle. Second, I examine the impact of perceived stigma on participants who, perhaps counter-intuitively, felt they had not directly experienced stigma. My analysis draws on Goffman's (1963) theory of stigma and how individuals with depression manage information about their condition. Both groups experienced feelings of isolation and loneliness, and reported efforts to distance themselves from their condition.

4.3.1 The Repercussions of Stigmatic Experiences

Some participants would try to distance themselves from outwardly appearing to have depression. Darren and Julie each shared how their awareness of depression stigma led them to hide their condition:

> Yes, the knowledge of mental illness being stigmatized has led me to try to hide myself from others about knowing that I suffer from depression. I come off as a confident and social person, however there is more times than not that it's something that bothers me everyday and I have too much pride I guess to show others that since it is seen as many as a weakness. Especially being a male, I feel like it is something that is not common for guys to express to others or know who to talk to about these kinds of things. (Darren, 24 years old)

And,

> Yes, because I thought that depression was like something that was so frowned upon like if you were depressed-like it is the same thing throughout most of my life. I felt like I didn't have it because like I didn't want to be a person that nobody wanted to be around. And uh it seemed like something that was just kind of like more of an attention seeking thing than like a thing that actually people go through because they're not able to actually like process things and-if that makes any sense. (Julie, 21 years old)

Both of these interviewees were not only aware of depression stigma in society but had personally experienced it and sought to avoid reliving the experience. This is important because it illustrates how social stigma directly impacts how individuals understand their condition and whether they decide to obtain help or support.

Some participants struggled with feelings of isolation and loneliness after their disclosure was not met with a positive response. These emotions came up after participants had attempted to obtain support from loved ones about their depression but instead received dismissal or lack of acknowledgement of their condition. Consider the following excerpts.

> Uh it was really hard for me because it came from family members, it came from friends the people that you know you are supposed to rely on so it made me feel really isolated. And I think for you know the first year after like the initial incident that made me depressed it uh was really hard and I actually considered quitting school cuz I just couldn't function at all. (Carlie, 23 years old)

And,

> I: Yeah. Yeah, that makes sense yeah. Like how would you say it made you feel? Like when your like- when you feel like maybe they don't validate or understand what you're going through?
> P: Umm its lonely and it's—it also like sort of like gaslighting in a way like- oh like everybody else says I should be fine. So, why am I not fine? And then you just sort of get angry at yourself for not being fine. (Lydia, 23 years old)

This is important for a few reasons and illustrate the indirect effects of social stigma. First, if individuals do not receive support after disclosing their condition it may make them refrain from doing so in the future. Second, this experience may make them feel like their illness is not as important.

4.3.2 The Repercussions of Perceived Stigma

Some of the students who had not directly experienced stigma but still perceived stigma throughout society made the strategic decision to manage information about their condition by carefully choosing who to disclose to, or simply not disclosing at all. Students felt the perceived stigma associated with depression led them to try to distance themselves away from their condition. For example, Una noted her reasoning behind passing:

> Yes absolutely, I won't take my mental health as seriously as I need to if the world around me tells me it shouldn't be taken seriously at all. It is a lot harder to get help when you are embarrassed about the way you are feeling. (Una, 19 years old)

Similarly, Nicholas, who is 18 years old and has a self-diagnosis of depression, also identifies with not disclosing his depression to others and explains his rationale for passing:

> I feel as if I am not normal because in the media and the way depression is perceived is not positive. As a result, it makes me less open to discussing my mental illness with anyone and pushes me closer to my house. The way I perceive depression is often negative, and that just fuels the fire. If something is harmful, why should I speak of it? But all that does is make it worse in the end. (Nicholas, 18 years old)

This is important because participants felt it was necessary to distance themselves away from their depression because they recognized indirectly that the condition is looked down upon. Further, as the excerpts above illustrate, these messages negatively impacted participants struggling with the condition.

Students discussed how perceived stigma led them to feel alone and isolated. The following excerpt illustrates the impact of loneliness based on the perceived stigma associated with the condition. Nolan explains his decision to hide his depression when he had not yet experienced stigma.

> Umm I feel like in the- when your quo-when your 'quote on quote' depressed for me it just basically like uhh not opening up. And having to go through all of that and not knowing if people would actually understand or could relate. So, it was mostly just keeping it to myself which made me feel alone too, which probably worsened it. (Nolan, 22 years old)

This is important because when participants felt they needed to hide their depression they then experienced loneliness which made their condition feel more heightened.

4.4 CHOOSING NOT TO DISCLOSE AND PRACTICES TO PASS

Goffman (1963:74) notes that "passing" is one type of non-disclosure practice where an individual tries to hide their stigmatized characteristic and pass as 'normal' if their stigma is able to be hidden. Passing as normal is often chosen as it takes away the differential treatment they would experience if their stigma was noticeable to others. Participants were asked if they ever tried to "pass" at the university or hide their depression and why. As well, participants were encouraged to talk about their decisions to disclose or not disclose depending on the situation. This section examines students' decisions not to disclose their depression and the non-disclosure practices they utilized in the process. Three subthemes are discussed: 'pass at the university and at work,' 'testing,' and 'choosing non-disclosure in case of stigma.'

4.4.1 Passing at The University and at Work

When participants referred to passing at the university, they described a couple of different tactics they would use. Some considered passing at the university to mean not opening up about their depression in this setting. Others mentioned they would try to appear visibly happy when they did not feel that way. Participants discussed in detail how and why they would decide to pass or why they decided not to. Interestingly, both students who decided to disclose or not disclose discussed how professors and students at Lakehead University should be more educated on depression and mental illness in general. Many noted that they often chose to hide their depression at the university because they did not want to be perceived as incapable or have it affect future job opportunities. Carlie states,

> Um how do I deci- I think it's with that it would be I think work oriented or maybe school/work-oriented um just because I don't want them to see me as like incapable of doing things or like I'm not reliable in a way. And I think that's also kind of a stigma that I've noticed around depression is that people aren't- people think that they're not um reliable cuz they you know might flake on uh like going out or they may have a day where they can't do anything. Um so I think it's more uh I don't tell them if its gonna impact how they view me in a professional setting. (Carlie, 23 years old)

Other participants decided to hide their depression because they did not want other students or their friends to be aware of their condition. Nolan, who is 22 years old with a self-diagnosis of depression, had a negative experience where he did not feel comfortable disclosing his struggles with other classmates.

> Yeah. Yeah, so basically like fear of the unknown and also fear being treated differently because during this time I lived on residence so it was like a very crowded setting right. So, I didn't really want everybody- because word kind of spreads around and I didn't want people to look down upon me. And you know with all the negative uh connotations with depression. I just wanted to be seen as a "quote on quote" normal person. (Nolan, 22 years old)

This feeling of worry described above by Carlie and Nolan is supported in research by Wada et al. (2019) on the outlook of mental illness stigma among Canadian post-secondary students. One of the study's main findings was that students viewed the university setting as ability-focused and were concerned that if they admit to struggling with a mental illness, they would be perceived as not as intelligent or capable as students without a mental illness (p. 5). Thus, participants decided to hide their depression in order to prevent their professors from viewing them as less capable or so that their friends would not know about their condition. These decisions were partially made based on the concern that they would be stigmatized if this information were known. Further, some participants felt that it was a sensitive and personal topic that they did not want just anyone to know about.

Some participants chose to try and pass at their workplace due to the perceived stigmas and stereotypes associated with depression. Participants did not want to disclose their depression in the workplace because they felt it would be looked down upon. For example, Lauren, who is 21 years old with a self-diagnosis of depression, did not want to disclose her condition while in a leadership role at her church.

> Um perhaps in the situations I cared more about the ways that they perceived me or perceived it (depression). So, I guess like go back to like the question before of like stigma or that sort of thing. Um and I feel like I had more of a responsibility in those situations I suppose. (Lauren, 21 years old)

Likewise, Winnie, who is 35 years old and has a self-diagnosis of depression, notes her rationale for non-disclosure: "I believe most importantly you don't really show yourself upside down in front of people in a professional workplace.” Other participants decided to hide their depression in the workplace because they felt that they might not be hired if their employers were aware that they had a mental illness. For instance, Sage reported that she would not even consider calling into work for a sick mental health day. Thus, participants felt that the workplace was not a safe place to disclose their condition. This is important because participants perceived employers to have negative preconceived notions about people with depression which are informed by social values on the condition. Interestingly, Toth and Dewa (2014:740) examined how employees with a mental illness often decided whether or not to disclose based upon how other employees and human resources had treated other individuals with a medical condition or on a leave of absence. In addition, some individuals also felt concerned about being fired from their job and were therefore less likely to inform their bosses or supervisors about their condition.

4.4.2 Testing

In order to determine whether or not to open up to people about their depression, some participants stated that they would try to ‘test’ how the person might react first by bringing up someone else who had depression or by allowing the topic to arise naturally. Based on the persons response, they would determine if they felt comfortable disclosing their condition. For instance, Sadie noted how she considered ‘testing’ how people would respond before disclosing her depression,

> Um well I mean if their- you kind of have to feel them and see if their acceptant like kind of bring it in a different way bring it as in like not part of- like not having depression as part of yourself. Like maybe bring it up in conversation about an incident that happened with someone else. (Sadie, 22 years old)

Similarly, Lydia, who has experienced stigma, recounted how while doing a co-op placement she waited for her supervisor to naturally bring up their thoughts on mental illness and based that on whether or not to disclose. In short, participants felt that it was in their best interest to test how the person reacts to mental illness before disclosing their own personal experience with depression.

4.4.3 Choosing Non-Disclosure to Avoid Stigma

Another important theme that emerged among participants was that they reported never experiencing stigma but this was only because they had not disclosed their depression for fear of experiencing stigma. Consider the following excerpts.

> Umm actually I didn’t really experience stigma from the outside world because I was good at like umm I guess “quote on quote” hiding it. Or not really showing it to the world so people couldn’t really tell. (Nolan, 22 years old)

And,

> Have I experienced stigma? No, however I refrained from telling anyone that I had depression due to the fear of being considered a failure or an attention seeker. I knew it would be stigmatized so I didn’t give anyone the opportunity to stigmatize my depression. (Una, 19 years old)

These findings relate to Goffman’s (1963) stigma theory and how individuals with discreditable conditions elect to manage information or hide due to the knowledge of societal stigma. In short, some participants did not want to open up about their condition based on the fear of experiencing stigma. This is vital to recognize as this belief can impact an individual’s decision over whether to seek help.

4.5. CHOOSING TO DISCLOSE AND GAIN SUPPORT

Many participants who discussed their decision to disclose their depression described feeling most comfortable only opening up to certain people. This is reflective of what Goffman (1963) described as situational disclosure, or gleaning where and when it is safe to disclose a stigmatic identity to others. In past sections, we saw how participants’ disclosure often led to the dismissal of their experience and their condition. In the following examples, participants were able to gain support from others they disclosed to, as Goffman had originally considered. The decision of who to disclose to was important because it coincided with whom they chose to seek support from. Up to now I have focused on students' negative or stigmatic experiences, but it is also crucial to highlight that many participants shared positive experiences opening up to people who were supportive and helpful. As each individual's experience is different, they each described a variety of decisions that impacted their decision to disclose. One overarching theme among participants' decisions to disclose was based upon whom they felt they could trust. Participants discussed feeling most comfortable opening up to one or more people or groups: close friends, their significant other, and other people with depression. In contrast, participants felt the least comfortable disclosing their condition to their parents. Some participants also reported disclosing to student accessibility services to receive support, although they mentioned both positive and negative implications of this decision.

Many participants mentioned feeling the most comfortable discussing their experience with close friend(s). They chose to disclose to their friends because they felt they would be trustworthy, supportive, and non-judgmental about their condition. Kaden discusses his experience disclosing to close friends:

> Like I don't know, the friends who know and my girlfriend they are the reason I am comfortable speaking with them is because I don't know. I trust them enough and I know that they are knowledgeable enough and understanding enough not to treat me differently because of that, I guess. (Kaden, 19 years old)

Likewise, Felicity discusses her supportive friend group:

> Oh yeah. Like when I have something going on I like send my friends like fifty texts and I just say like everything in my head and they're totally fine with. Like I feel bad sometimes that I- like sometimes I try not to because I'm like I don't want to bother them

> and like make them read like my long rant every single week. But they've always been okay with it so I feel like that definitely makes a big difference. (Felicity, 19 years old)

In addition, Delilah felt she only opened up to one close friend about her depression as opposed to all of her other friends. In short, participants felt it was beneficial to have friends to speak to about their experience with depression and gain support. This was important to participants because it gave them a space to share their experience knowing they would receive support and acknowledgement of their experience.

Some participants shared that they would disclose their depression to people they were in a romantic relationship with. They chose to disclose to their partner for two main reasons: they felt their significant other would be supportive and that it would be important for them to know if they were going to be in their life long-term. Nicholas decided to fully open up to his partner since they struggle with depression as well. Likewise, Lydia noted that she confides in her boyfriend and close friends: "I mean the first person I talked to was my boyfriend at the time. Um we were just sort of talking but this is before we started dating. Um since then like friends I'm more open with it about." In short, participants seemed to appreciate it when their partner was someone who they could speak to about their depression and obtain support from. Interestingly, Mueller et al. (2006) examined the importance of social support in relation to how people with a mental illness comprehend stigma. They found that if a person with a mental illness receives social support within the first year of their condition, they are less likely to perceive their mental illness as stigmatizing (p. 46).

Some discussed being willing to open up to people who also struggled with depression. They made this decision because they believed that they would understand what they were going through and would not treat them any differently. Brooklyn felt most comfortable disclosing her depression to her siblings who also battled depression,

> Yeah, probably like my-my siblings. Um just cuz I don't know they share all of their experiences and stuff with me and I-I usually I don't know wanna give advice. And so, I usually say like "oh I've gone through the same thing." Or like "this has happened to me." Or "I'm taking this medication." You know like and that usually helps them, so. (Brooklyn, 23 years old)

In short, participants felt that opening up to people who also had depression was helpful because they would be able to grasp what they were going through and could be trusted with that knowledge. Such knowledge might also be helpful for the other person as well.

A significant number of participants discussed feeling uncomfortable when opening up to their parents about their depression. The main reason they brought forward was that they assumed that their parents would not understand what they were going through. Likewise, that they did not want to worry them with their problems. Stetson discussed speaking to his parents briefly about his experience, but found it difficult:

> Uh yeah, I would say simply because in their eyes like I mean you want to be you know a good kid type thing. You want to grow up to impress your parents, you want to be smart and not fail any classes- which I have done now. So, that was tough. And uh and they also just want you to be like the best type person and seeing you in such a shambled state is not good for them either so you kind of have to, you know. It's kinda hard to see a friend or somebody like that so in a tough spot like that, and especially with your parents right. So that's also makes it a little more tough to talk to them. (Stetson, 20 years old)

Felicity also decided not to speak with her parents as they come from a culture that tends not to discuss mental illness. Further, Kaden did not disclose to his parents as he felt they would not understand and potentially treat him differently.

> I don't know it's just a sense that it's not really something most people talk about. And there's uh with family in particular, I don't feel super comfortable discussing it with them cuz I worry their- they're very understanding but maybe not knowledgeable about this kind of thing, I guess. And I worry that talking to them about it would make them like I don't know- I guess treat me differently or not really understand how to approach it. (Kaden, 19 years old)

In short, participants felt uncomfortable speaking to their parents about their depression to varying degrees. This is important because if participants are afraid of disclosing to their family about their condition, they may be less likely to obtain supports or resources due to a fear of stigma. Likewise, hiding one's mental illness from loved ones can lead to feelings of loneliness and isolation, which depression already lends itself to. This concern about different generational perspectives on mental illness is spoken about by Phelan et al. (2000). They conducted a study using the same question originally posed in a 1950 sample, to the "Mental Health Module of the 1996 General Social Survey' to understand if there had been a decrease in mental health related stigma (p. 188). In their findings they noticed that individuals tended to understand more forms of mental disorders but that people who brought up the condition psychosis were two times more likely to characterize mental illness as violent than in the past (p. 197). This study makes apparent how mental illness stigma has remained a problem throughout generations. This is consistent with the current study as participants were concerned that their parents would have stigmatic assumptions about depression based on generational differences.

In contrast to the above, some participants felt comfortable speaking to their family members about their depression. Many of these participants reported past positive disclosure experiences with their parents. Participants also described how their family members would accept them for who they are. Sadie felt the most comfortable speaking to her parents and especially her mom who had also struggled with depression in the past. Likewise, Isaac recounted how for a long time he was afraid to talk to his family about his depression, but recently he did and it was positive and encouraging. Now Isaac feels comfortable speaking to family about his condition. In short, participants who felt comfortable speaking to their parents about their depression discussed how it was a positive support network.

Some participants decided to disclose and gain support from the university's Student

Accessibility Services. While students found this resource beneficial, they also described how the resource was demeaned by other students and professors. Participants felt these accommodations were looked down upon based on the belief that they were getting an unfair advantage in school. For example, Isaac, who is 31 years old and has a medical diagnosis of depression, shares his stigmatic experience,

> Um so I was saying it, it also happens between students. I-I-I remember sitting um with a couple students, maybe 7 or 6, and they were talking and they always complain about or they talk ill about uh people who have special accommodations. Uhh "oh they get more time, they do this, they do that." And I'm like well not everybody reacts to you know stress the same, everybody's different. Some people need help. Some people you know no pressure at all just dirt off the shoulder and your fine during the test and you don't stress. That's I mean-good for you. But others don't react the same and I'm for one I-I-I uhh my anxiety just gets through the roof ah well I do examinations or um yeah. (Isaac, 31 years old)

In contrast, some participants spoke directly about the benefits of using the Student Accessibility Services. Sadie felt that utilizing SAS was not stigmatizing but made her feel less alone as other students with mental illness use the service. While Isaac examined his stigmatic experience in relation to professors and other students, Sadie focused on her positive experience with the SAS service itself.

> Um it well it- it felt like it took a weight off my chest so that like I said before like you don't have to be fighting the battle on your own, you can get help. And they're willing to help. They don't want you to have that much of a struggle though school. They want you to be able to learn and process the information your given without being impacted by mental illness. (Sadie, 22 years old)

It is important to note that all participants spoke positively about the resources and support from the service itself. The participants who were critical of SAS services directed attention towards how professors and students perceived it to be unfair to other students or that students were trying to take unfair advantage by using depression as an excuse. This is important because while students found SAS to be a helpful resource, these negative sentiments could make individuals less likely to reach out for support or they could make individuals feel unwelcomed at university by the limitations of their depression.

DISCUSSION AND CONCLUSION

In this chapter, I have explored student experiences with stigma from a variety of perspectives. One major theme was whether or not participants had experienced stigma or just had a negative experience, they each recognized how societal norms placed less value on people with depression. Further, these norms were internalized and influenced how they interacted with others. Similar to Goffman's (1963) stigma theory, participants tried to hide their depression or manage information about it. Unlike Goffman's analysis on situational disclosure, participants experienced suppressed stigma as loved ones did not acknowledge their depression. I explored students experiences with stigma through four sections: the experience of stigma, the impact of experienced or perceived stigma, choosing not to disclose and passing practices, and choosing to disclose and gain supports.

An interesting thing that my analysis noted is the impact of perceived and experienced stigma on participants was similar to Karp's (2017) study on depression. Karp's study found that individuals with depression struggled with isolation and loneliness which he concluded was due to the combination of depression symptoms and non-disclosure. Karp states,

> As with all feelings and emotions, isolation is experienced in different degrees and hues. Some individuals feel obliged to withdraw from virtually all arenas of social life. Most people though, unless they become hospitalized, struggle through their daily obligations, sometimes heroically maintaining a facade of "normalcy." Others may continue to associate with friends and family while nevertheless feeling disengaged, uncomfortable, marginal, and profoundly alone. Indeed, as everyone knows, sometimes being in the presence of others and ritualistically moving through the motions of interaction can dramatically magnify a sense of loneliness and isolation. (p. 101)

I found this similarity interesting, especially because there are a few differences between our studies. For example, Karp’s study was originally published 25 years ago and all of the participants had a medical diagnosis. My sample focused exclusively on post-secondary students who either identified as having a medical or self-diagnosis of depression. It may be an indication that people with depression still struggle with feelings of isolation and loneliness as a symptom of depression and a side-effect of stigma. Future studies should explore ways to minimize the isolation and loneliness experienced by people with depression.

A new form of stigma that arose in my research occurred when participants would try to disclose their depression to friends and family. When participants attempted to disclose this information, loved ones told them that they were not permitted to have depression. I argue that this is another form of stigma because when a subject is considered taboo it typically is not openly spoken about. When students disclosed their non-visible stigmatic condition, loved ones did not accept their claim to this label. I argue that this is a form of suppressed stigma, as participants’ stigmatized condition was rejected and told it was not real. This is similar to how taboo subjects in the past such as alcoholism were not openly acknowledged and individuals would pretend there was nothing wrong in social encounters. The difference is that, in this instance, students who openly admitted to having depression were sometimes not allowed to label themselves with this stigmatized condition.

Chapter 5. Conclusion

In this thesis, I examined the social experience of depression among Lakehead University students. Participants spoke about their experience with depression from a variety of perspectives. Several students felt that the mass media depicted characters with depression in a negative stereotypical manner. Whether participants felt impacted by these representations or not, they were still concerned that media depictions would influence how society understood or treated their condition. Students found it uplifting or helpful when they learned of other people's experiences with depression in the mass media. Stigma was also discussed at length; while some students felt that they had encountered stigma, others felt they had not. Regardless, both groups discussed experiences where their depression was de-validated or dismissed by loved ones. Every participant perceived the condition to be stigmatized in society. In this final chapter, I discuss the broader implications of the findings and the limitations of the study.

5.1 BROADER SOCIOLOGICAL IMPLICATIONS

Although my analyses identified many interesting and important themes, I want to close out this thesis by discussing three that are most relevant to developing the sociology of depression. An important theme that emerged in the findings is how much societal values and norms influenced participant understandings of their condition. For instance, in Chapter 3, whether or not participants felt that they had been influenced by typified depressive characters, they still recognized that these stereotypical representations were grounded in societal values about the condition. These social norms impacted how they understood their condition and interacted with others. Similarly, in Chapter 4 students' experiences with stigma was examined. Some students did not want to disclose their condition or even tried to distance themselves from their mental illness because they recognized that people with depression were often devalued according to societal values and norms. One example of this is how participants wanted to hide their condition or ‘pass’ at the university and in their workplace. From a sociological perspective, these findings suggest that social factors influence not only the personal experience and understanding of the condition but also in the decision to disclose. These findings suggest that in addition to struggling with depression, people also felt they had to maintain a ‘normal’ appearance in front of others. The implications of this study on the sociology of depression are that people with depression may chose not to receive medical care or support due to the knowledge that the condition is looked down upon. Not only is depression often non-visible and silent, people also felt that social values and norms encourage the condition to remain silent and non-visible. It is important that future research in the sociology of depression examines whether people with depression chose to disclose and why. This decision is important to better understand whether people with depression have experienced stigma, how they understand social values surrounding depression and if they decide to receive help.

A second important aspect of learning about participants’ experiences with depression is that many brought up having experienced at least one other form of mental illness. For instance, in addition to struggling with depression, participants reported struggling with PTSD, OCD, anxiety, ADHD, social anxiety, generalized anxiety, and eating disorders. The presence of co-morbidities is an important thing to note for future sociological studies of depression. Co-morbidities may, for example, further impact how people experience and understand their depression or their overall mental health. Participants brought up this detail when discussing their experiences with stigma, passing, and the mass media. It is important that future research in the sociology of depression examines how having multiple mental illnesses impacts how one understands their mental health. Intersectional analysis could be one approach to conducting this form of research. The presence of co-morbidities may, for example, further impact in unexpected ways how people experience and understand their depression or their overall mental health.

Finally, I want to note the importance of participants' experiences with stigma with respect to interactional dynamics, an aspect of depression that I was not able to fully flesh out in the previous chapter. Participants sometimes encountered stigma that did not align with Goffman's definition of stigma but that I still classified as "suppressed" stigma. I argued that suppressed stigma occurred when participants would try to disclose their depression to loved ones but they would reject that label and claim that participants did not have depression. This occurred in varying degrees: illness as a choice, deserving to be sick, and playing it down. In each scenario participants were treated as though their condition was not serious or real enough to draw attention towards. It is important that future studies in the sociology of depression examine if this form of stigma emerges among other mental illnesses or is replicated in another study that explores peoples experience with depression. This aspect of stigma also has important implications for the ongoing development of Goffman's classical concept of stigma in particular and interaction dynamics more generally.

5.2 LIMITATIONS

One limitation to this study is the small number of interviews I was able to conduct due to the time restrictions of the MA program. In the methodology chapter, I briefly discussed how I do not feel that I reached data saturation. I conducted 22 interviews (21 student, 1 counsellor) in total, but due to the diversity of experience among participants I still feel that there were new themes emerging but that could not be fully explored due to time constraints. If I had additional time and resources for transcription, I would have aimed for 35-40 participants in order to try to attain data saturation. I am happy that I conducted 21 student interviews as a goal of my study was to listen to students talk about depression in an empowering environment. Fortunately, I did not turn away students from participating in an interview because I thought that would be disempowering. In the end, I am very grateful and honored to have heard all of the participants who shared their experience with me and I would not change that. However, as a learning experience I recognize now that I would have completed my thesis sooner had I done fewer interviews.

A second limitation to my study is that all of my participants were from a single school, Lakehead University in northwest Ontario Canada. Both Lakehead campuses are located either in rural (Thunder Bay) or semi-rural (Orillia) areas. Interviewing students from both rural and urban centers would be beneficial to understand if they had different experiences with depression in the university setting. However, that the two campuses are located in different regions of Ontario and draw from different student populations (northern rural, southern suburban and semi-rural) did add to the diversity perspectives on depression.

A third limitation of my study is how I introduced my recruitment poster. I began the poster with the following questions: “Are you tired of feeling like you need to hide your mental illness? Are you a Lakehead University student who experiences depression? This study might be of interest to you.” When I introduced the first question of whether they experienced hiding their depression, I may have unintentionally encouraged students who had experienced stigma to join my study. Conversely, I may have unintentionally discouraged students who had depression but never felt the need to hide their condition.

5.3 FUTURE RESEARCH

Students with depression discussed experiencing supressed stigma. It is imperative that future studies examine whether students with depression or students with other mental illnesses have the same experience. One approach to this research could be to conduct a quantitative survey of university students across Canada to ask about their experiences with stigma while taking into account the themes found in this study. This type of project could be undertaken in collaboration with Student Assistance Services (or the equivalent at other universities) as the findings would be not only be of interest to sociologists but to service providers and administrators in determining how to allocate mental health and wellness resources.

Throughout this study, students discussed what they felt to be helpful or unhelpful regarding media representations of depression. It is important that futures studies examine what students with depression consider to be productive or counter-productive to representing their condition. This is beneficial because not only does the mass media communicate information about their condition, but people also placed their own meaning and values to these messages which at times influenced how they understood depression. If I were to conduct another qualitative study, I would be interested in exploring how people with other mental illnesses (i.e., anorexia, OCD, schizophrenia) interpret how the mass media represents their condition and the meanings they ascribe to these messages.

In this study, I examined the social experience of depression among Lakehead University students. This study matters because it explores how university students with depression understand their condition and interpret how the mass media and society perceive depression. This study draws on a number of interpretive approaches to inform my qualitative analysis. Both symbolic interactionism (Blumer 1969) and phenomenology (Berger and Luckmann 1966; Schutz 1967) is important to understand the multiple meanings students interpret from typified depressive characters. Aside from the theoretical framework, this study is important because it gives voice to university students with depression in an open and transparent manner. This study has the following goals: first, it provides an empowering space for students to share their experience with depression. Second, I draw on Goffman (1963) to highlight the variety and complexity of depression-related stigma and how students chose to navigate this. Third, the findings can better inform professors, students, health-care providers, and lay people on post-secondary students experience with depression. Fourth, it contributes to the sociology of depression by exploring the social experience of depression from the perspective of university students. Hopefully, this study sheds new light on student experiences with depression, stigma, and in how they interpret the messages from the mass media about depression. I am optimistic that future studies will continue to research this important topic.

Appendix A

Semi-Structured Interview Guide: Students

Background Questions

I'd like to begin with some background questions. Can you tell me a little about yourself: How old are you, where did you grow up, did you get diagnosed with depression by a medical professional or did you self-diagnose yourself, how old were you when you were first diagnosed/ self-diagnosed yourself with depression? How many years have you experienced depression? Prior to receiving the diagnosis of depression were there any other indicators that made you believe you might have depression? **OR** If you have self-diagnosed yourself with depression how did you come to believe that you had this mental illness?

The Stigma of Depression and the Choice of Disclosure or Non-Disclosure

Before proceeding to ask you questions about your experience with depression, I think it is important to first explain how I will be defining stigma throughout my study. Stigma is a social experience where an individual is viewed as different or 'less than' due to holding what is deemed to be a negative characteristic.

1. As a university student with depression have you ever experienced stigma from your mental illness and, if so, can you provide me with some examples?
    a. Probes: How did the experience make you feel? How did the stigmatic experience influence your perception of depression and your overall identity?

2. Do you believe that your perceptions and experiences of stigma have impacted your mental health and why or why not?
    a. Probes: How did the experience of stigma impact your mental health? Did the experience impact how much you discuss your depression?

3. Has the experience of stigma or the knowledge of mental illness being stigmatized ever led you to try to hide your disorder or 'pass' as not having depression, and if so how?
    a. Have you ever tried to hide or 'pass' as not having depression at the university? What do you think led you to make that decision and can you provide some examples?

4. How do you decide who to open up to about your depression? Conversely, how do you decide who to hide that part of yourself from?
    a. Probes: Does stigma play a role in this and in what ways? Does social setting influence your decision to open up? Are there certain individuals you are more or less inclined to open up to about your depression and why?

Depressive Frame: The next set of questions asks about how depression has influenced your daily life.

5. Have you ever had times when you perceived things to be worse than they actually are? Can you provide me with some examples?
    a. Probes: For example, many people with depression struggle with pessimism and sadness which impacts their daily interactions and interpretation of events. However, people with depression may look back on an event and question if their depression played a role in understanding the event to be more negative than it actually was.

6. As a student with depression have you ever experienced a negative event at the university? (ie. doing poorly on a test, not being able to get an appointment with the student health and wellness centre.) How did you perceive or understand that event? Looking back at the event now do you believe you may have perceived things to be worse than they actually were?

7. How has the experience of being a university student with depression influenced how you understand the stresses associated with post-secondary education?

8. Do you believe that your depression has influenced your perception on receiving or obtaining help with your depression? Can you provide some examples?

Media's Influence in Understanding One's Mental Illness

9. What is your perception of how the media discusses mental illness? (films, online sources, newspaper articles). Can you provide some examples?
    a. Probes: Overall do you think this is accurate or inaccurate and why? Overall do you think it's negative or positive and why?

10. Can you think of an example of the depiction of depression in the media that you felt was positive or helpful? Further, can you think of an example of the depiction of depression in the media that you felt was negative or problematic? Why?
    a. Probes: What sources from the media are you referring to? Do you believe it is accurate to your own experience with depression?

11. Has the depiction of depression in the media influenced how you have understood your own depression and, if so, how?
    a. Probes: Do you think it has influenced how you understand stigma associated with mental illness and, if so, how? How has it impacted your own mental health?

12. Do you feel the media portrays a predominant character when depicting depression? For instance, do you feel they tend to portray characters with depression to appear, act, and interact with people in a similar manner?
    a. Probes: Do you feel the depiction of these characters influence how you understand your own depression and/or interact with people? Why?

Concluding Questions

13. Given the impact of the COVID-19, I feel I would be remiss if I didn’t ask how it may have affected your mental health. Do you feel the COVID-19 pandemic has impacted your depression and overall mental health and, if so, how?

14. What are your perceptions on getting help with your depression from the university’s ‘Student Health and Wellness Centre’? Do you have any suggestions on how the university can make students more comfortable to reach out for help? What can the university do to make receiving mental health help more accessible?

15. Is there anything important about the social experience of living with depression as a university student that you would like to add on or discuss?

Thank you for your time!

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