AN EXPLORATION OF MATURE UNDERGRADUATE STUDENTS' EXPERIENCES OF DEPRESSION: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

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Abstract

This research was an idiographic investigation of the first-hand accounts of mature undergraduate students with depression. Participants were drawn from one Institution of Higher Education in Ireland. The number of mature students entering Higher Education in Ireland is increasing annually. The number of individuals with a diagnosis of depression is increasing also. To date, very little research has examined the experiences of mature undergraduate students with depression, in the Irish context. The focus was on undergraduate studies as the research aimed to examine an individual's first experiences of Higher Education. As the study aimed to provide a description of an individual's experiences of studying with depression, the participants had a current diagnosis of depression and were taking antidepressant medication. It is routine in Ireland to prescribe antidepressants for mild depression (e.g. HSE, 2016). Data were collected via in-depth semi-structured interviews with eight students aged between twenty-six and fifty years. Data were examined using Interpretative Phenomenological Analysis (Smith et al, 2010), which is an approach that facilitates a hermeneutic phenomenological enquiry into the unique lived experience, as well as convergences among participants. Based on the analysis of the material, the students' experiences were organised into three main themes: Journey through Academia with Depression; Managing Depression; and Altered Self. These themes indicated that the experience could be characterised as a journey through academia, with the journey getting increasingly more difficult as students entered their third and fourth years of a four-year undergraduate degree. Findings revealed that individuals had a complicated relationship with medication, and that they sought other ways in which to manage their depression. They also revealed the changes to their sense of self that they expressed as taking place during their academic journey. Individuals' accounts communicated the stigma around depression, the distinct dynamic among mature undergraduate students in relation to why they have come back into education, the difficulties in engaging in group work for individuals who experience depression, feeling isolated or disconnected, the challenges of receiving feedback on academic work, and a self-critical voice. The extent of suffering articulated by the participants leaves no uncertainty about the gravity of depression and the implications for their academic experience. Findings, which have implication for counselling psychologists working with mature students in HE, are discussed.

Key words: Mature undergraduate student; Higher Education; depression, antidepressants, Interpretative Phenomenological Analysis; counselling psychologist

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Chapter 1 Introduction

This research is an investigation of mature undergraduate students' experiences of depression using Interpretative Phenomenological Analysis.

Depression is one of the most commonly experienced health problems experienced by university students (Davies, Wardlaw, Morriss & Glazebrook, 2016). Reshmi, Schommer, Worley & Peden-McAlpine (2012, p.1) write that 'depression among college students is an escalating problem and has now surpassed substance abuse and alcohol abuse'. The Royal College of Surgeons in Ireland (RCSI) report in October, 2013 that 1 in 5 young adults in Ireland aged between 19 and 28 years was experiencing a mental health disorder at the time of the study, and this is broadly in line with European figures. Mood disorders emerged as the most prevalent lifetime disorder (with 56% meeting the criteria for lifetime mental disorder), followed by anxiety disorders.

For students in Higher Education (HE) depression is manifested through cognitive, emotional and physical symptoms (Khawaja, Santos, Habibi & Smith, 2013) with cognitive and emotional dimensions demonstrated by lack of concentration, self-blame, self-dislike, perfectionism, helplessness, hopelessness, sadness and pessimism. Psychological difficulties hinder a student's ability to concentrate in class (Leahy, Peterson, Wilson, Newbury, Tonkin, & Turnbull, 2010). Leppink, Lust & Grant (2016) document that students with severe depressive symptoms report worse academic performance, more frequent health problems and less physical activity.

The Higher Education Authority in Ireland (HEA.ie) reports an increasing trend in students over the age of 23 years embarking on an undergraduate degree (HEA, 2015). Students over the age of 23years are known as mature students (HEA, 2015) and comprise 15% (or 22,695) of the total population of undergraduate students in Ireland (n=151,300) for the academic year 2014/15. There are social and psychological challenges such as a job or family commitments and these extra responsibilities may make it very difficult for the mature student to become involved in social activities. The first year experience, according to The Irish Survey of Student Engagement (HEA, 2015), can often trigger depression among mature students, among other mental health issues, because of reflecting on negative school experience, early school leaving, financial commitments, juggling demands of the family and study, feeling different to younger student peers and needing support from the family.

Academic challenges of under preparation among mature undergraduate students argue Davies et al (2016) can exacerbate the experience of depression as it is some time since these students have left second level education. Arguably, many HE institutions assume that 'mature students' know how to study and may equate mature students (chronologically) with being mature and thus possess the skills necessary to work independently.

There are a number of approaches to treating and managing depression and the most common can include antidepressants, counselling and a combination of antidepressants and counselling (Bunting, Murphy, O'Neill, & Ferry, 2012). Antidepressants and cognitive behavioural therapy (CBT) have the most clinical evidence (Richards, Ekes, McMillan, Taylor & Byford, 2016). It is acknowledged that the prescribing of antidepressants even for mild depression when a patient receives a formal diagnosis of depression is routine in Ireland (HSE 2016; Irish Health Survey, 2015; RCSI, 2013). For patients experiencing depression, Counselling in Primary Care (CIPC) offer six to eight sessions with a psychotherapist or

counsellor. However, there is often a lengthy wait to see a counsellor. Thus, many patients are prescribed medicines while they wait for an appointment, or even in place of psychological therapies.

Reshmi et al (2012, p.2) reason that as there is so much variation in the understanding and treatment of depression and its problems, that 'it cannot be really understood at the system level'. Moreover, while many studies inform us about how depression is disabling for the individual the research does not get sufficiently close to helping us to understand depression in context (Smith and Rhode, 2015) or the highly personal experience of the illness. In my professional capacity as a lecturer, I have observed students' behaviours, which suggest mood disorders. Mature undergraduate students have also disclosed to me, as their lecturer, that they are 'struggling to manage work' and for some, this is the first time in their educational career. As I work in HE, am particularly interested in students' well-being, and also, having worked, clinically, with students, I want to try to understand what the experience of depression is like for mature students.

Reflective Statement

My interest in the topic was stimulated by my experiences of working in the university sector in which mature undergraduate students revealed to me, as their lecturer, that they had been suffering from depression (often it was described as suffering). Drawing on my own experience I became aware that students' accounts bore some 'common features', such as tiredness and the inability to concentrate, but there were differences, such as perceived lack of self-confidence and feelings of anxiety and low mood around class tests and assignments. Whilst I could appreciate that depression appeared to impact, negatively, their academic experiences, I could not appreciate the particular nuances of their depression, and I was

curious to understand individual experiences. I felt that I was a caring academic who was becoming more mindful of the impact of mental health on students' academic experiences.

One of my counselling psychology placements was in a community based counselling and psychotherapy service, which was located near to a large university, but not near to where I was working as a lecturer. Some of my clients, who were undergraduate and post-graduate students, had availed of the university's counselling services (usually six to eight sessions) but were seeking more long term support. Many of these individuals had been prescribed antidepressants, which is part of the diagnosis process in Ireland. Almost all clients had been, or were, taking antidepressants. Clients' experiences of taking medication differed: some were initially reluctant, and others took them straight away, and most reported that they were helpful. Many seemed to be sensitised to medication. I was cognisant that there were controversies about individuals' over-reliance on medication, but never having taken antidepressants, I did not have a personal experience of medication. I was also conscious that there were controversies about diagnosis of mental health disorders, but never having been diagnosed with a mental health disorder, I was very open to hearing more about individual experiences. Sometimes, a client would not be sure whether they really had depression or if their inability to do their work was more about stress and anxiety, and yet they had been diagnosed with depression. The more I listened to individuals' narratives, the more I realised that, whilst there are common features, the expression of the personal impact of depression is unique. I began to appreciate that the nature of the context, as Smith and Rhode (2015) observe, should be given due importance.

When working clinically with clients, who were students, there were times when I had to make sure that I was listening to a client as a trainee counselling psychologist, and not as a lecturer, who could impart some advice on how to manage a work load or finish an

assignment. I felt the tension in maintaining the boundary between my two professional roles. Individuals talked about the perceived stigma about depression in comparison to stress or anxiety, and that they could not tell their friends. It seemed to be that revealing that they were feeling stressed or feeling anxious was more acceptable among the student population than revealing that they were feeling depressed. The perceived stigma around depression really struck me when listening to clients' accounts.

In reading the literature that attempts to explain depression, I felt that the uniqueness of the experience was not sufficiently explored. I had never been impacted by depression, so I could not draw on my own experience. Also, I could not locate any research that had explored mature undergraduate students' experiences of depression, and I was curious about why this group had been under-researched. I considered it to be complex, and often difficult for individuals to articulate their experiences. It was an area of mental health that I believed was important to research and that my study would, hopefully, contribute to the area of students, specifically mature students, and depression.

As I was not proficient in qualitative methodologies, having undertaken quantitative research, I was initially nervous (and anxious) about my capabilities in conducting such a study. However, I did not want to conduct a quantitative study as the personal, unique, experience of depression was what was of interest to me. As a trainee counselling psychologist, my interest lies in the subjective nature of the experience, with emphasis given to an exploration of the significance of these experiences for the individual. In essence the research was stimulated by an interest in finding out: 'What does it mean, for a mature undergraduate student, to have depression?' I would argue that this project, which sets out to examine the under researched area of mature undergraduate students' experiences, makes a valuable contribution to understanding the lived-world of being a mature undergraduate student with depression.

Structure of the Thesis

Chapter 2 presents a critical review of literature in the areas of depression, students in HE and mature students. The literature sets out to try to explain depression from different perspectives, and how depression is treated. The chapter also examines studies that have investigated the impact of depression among the general student population as well as among mature students.

Chapter 3 presents the philosophical underpinnings of the methodological approach to the study. There is a discussion of why Interpretative Phenomenological Analysis (IPA) is the chosen methodology. There is also an examination of methods used to collect and analyse data. There is a discussion of the recruitment of participants, ethical considerations and how qualitative research validity is assessed. There is also a section on reflexivity, as this is crucial in IPA research. The following chapters report main findings and a discussion of these findings.

Chapter 4 presents main findings from the study. Three superordinate themes and their associated subordinate themes are described. Findings are grounded in participants' verbatim accounts, and some interpretations of the findings are presented by the researcher, as required by IPA.

Chapter 5 presents an analysis of the main findings. Findings are examined in light of pertinent research. There is a discussion of how novel findings contribute to the area of depression among the student population, with focus on mature undergraduate students.

Implications for counselling psychologists are also examined. There is a discussion of methodological considerations of the study. To conclude the chapter there is a section on the researcher's critical reflection on the study.

Chapter 6 presents a conclusion of the study. The main points of the research are illuminated as well as the rationale for using a qualitative approach to examining depression.

Chapter 2 Literature Review

In this chapter I will discuss Erikson's Life Span Theory of Development as it set out to explain the processes by which the individual and society intersect. An appreciation of such a theory or perspective can help us to understand that psychological and developmental changes take place for individuals over the course of their life. There is also a discussion of studies and research that have sought to explain depression, such as psychoanalytic and humanistic-existential theories, cognitive theories, genetics, biological functioning and the role of the environment in the experience of depression. I will also examine how depression impacts an individual's sense of self and identity. This will be followed by an exploration of depression among the general student population in Higher Education (HE), and how the illness influences students' experiences. I will then discuss challenges faced by mature students when studying for an undergraduate degree. I will conclude the chapter with an examination of research that has investigated approaches to managing depression, such as antidepressant medication and psychological therapies.

2.1 Setting for the study

In 2008 the OECD stated that 21 million people in 28 European countries had depression, with an estimated cost of more than 118 billion euros, 1% of the region's GDP (Boland and Murphy, 2012).

In 2007, the Lifestyle, Attitudes and Nutrition (SLAN) survey was conducted in Ireland. It reported on the mental health and social well-being of the population. Face-to-face interviews were carried out with 10,364 respondents aged 18 and older (62% response rate) in their homes. Probable major depressive disorders were assessed using the CIDI-SF measure,

employing a 12 month time frame. 6% were classified as having major depressive disorder (comparable to 5% European). Depression was cited as being highest among lower-income groups and those not in paid employment. In a more recent national survey The Royal College of Surgeons in Ireland (RCSI) reported in October, 2013 that 1 in 5 young adults in Ireland aged between 19 and 28 years were experiencing a mental health disorder at the time of the study, and this is broadly in line with European figures. Mood disorders emerged as the most prevalent lifetime disorder (with 56% meeting the criteria for lifetime mental disorder), followed by anxiety disorders. Major depressive disorder was the most common mood disorder with 1 in 25 meeting the criteria (4.4%). The Report concluded that over one half of young people will have experienced a mental disorder by the time they reach twenty-five years of age. The Irish Health Survey (2015) published that 1 in 10 individuals (n=10,323) was experiencing depression. 8% of respondents reported that they were experiencing symptoms of at least moderate depression and that the rate was highest in the 15-28 year age group. 10% of 15-28 year olds stated that they had visited a psychiatrist, psychologist or psychotherapist in the 12 months leading up to the interview. 44% of respondents also cited that they were using prescription medication in the two weeks prior to interview. Data were drawn from self-reports (questionnaire). In addition, the National Advisory Committee on Drugs (NACD) survey (2012), drawing on self-reports, documents that there is a prevalence of sedative and antidepressant use among adults in Ireland.

2.2 Erikson's Life Span Theory of Development

The life span view of human development, arguably, makes the most of the ability of individuals to adapt, successfully, to the environment and to enhance development across the life span. One of the fundamental propositions of life span developmental theory is that humans continue to develop and change into 'old age' (Kroger, 2002). Human development

occurs through interactions among three factors: culture (or society), biology and the individual agent (Stepinsky, 1985).

Erik Erikson (1965, 1968) developed a psychosocial or psychohistorical life span theory, which emphasises the impact of social and cultural factors on personality development (Kroger, 2002). Marcia (2015) argues that Erikson's theory is one of the most influential and researched psychoanalytical theories of development. His work appears in the majority of text books devoted to human development as well as personality development. Erikson's life span theory of development, in which the individual and society intersect (Douvan, 1997), encompasses the concept of a life cycle in eight stages. In these eight stages, Erikson provides a schedule for ego development ranging from infancy through to old age. His life span development theory entails eight age-specific 'crises' in ego strength (Marcia, 2015). Each of these has a social, psychosocial and somatic component. The successful resolution of each crisis is important for ideal movement through the succeeding stages (Kroger, 2002). An important concept in Erikson's theory is the acquisition of an ego-identity (Erikson, 1965, 1968), and the concept of identity is a particularly important feature of adolescence (Marcia, 2015). The establishment of a sense of personal identity, argues Kroger (2002) is the psychological 'bond' between childhood and adulthood.

The first three stages: trust versus mistrust (infancy), autonomy versus shame and doubt (early childhood), and initiative versus guilt (play stage) (Erikson, 1965), arise from Freudian psychosexual stages: oral, anal and phallic. These stages of ego growth reflect the individual's sense of oneself and of the world. They are fashioned by the child-rearing traditions of particular parents, which are embedded in their particular culture. The depiction of life stages after childhood, argues Marcia (2015), establishes one of Erikson's unique contributions to psychoanalytic theory development. The theory continues with an outline of

ego development, which extends beyond childhood through to adult years. These stages are: industry versus inferiority (school age), identity versus identity or role confusion (adolescence), intimacy versus isolation (young adulthood), generativity versus stagnation (middle adulthood) and integrity versus despair (old age) (Erikson, 1965). In relation to the participants in the current study, who are mature undergraduate students, they are in the stages of intimacy versus isolation (young adulthood) and generativity versus stagnation (middle adulthood).

All of the developmental stages have their roots in physiological changes (Douvan, 1997) and all take place within the context of appropriate social institutional 'rituals' such as industry at school age within educational institutions, schools or other cultural child educational practices (Marcia, 2015). The emergence of each of the eight stages, in sequence, comes about through the principle of epigenetics. For Erikson (1965, p.57) epigenetics is more than just a sequence of stages; it determines certain fundamental laws in relation to the growing parts to each other, and '[a] time factor determines the most critical stage of its development'. He notes that unless normal development takes place, the individual cannot grow into a psychologically healthy individual. The epigenetic 'plan' argues Erikson (1968) arises from the individual, but is supported (or interfered with) by social demands.

Erikson (1965) also provides a 'schedule' of associated 'virtues', which emerge from the resolution of each stage. Basic trust is hope, autonomy is willpower, initiative is purpose, industry is competence, identity is fidelity, intimacy is love, generativity is care, and integrity is wisdom. In regard to participants in the current study, their stage appropriate virtues are love and care.

In the first life cycle stage, which relates to infancy and orality, Erikson comments that 'a sense of trust and mistrust: their balance …helps to create the basis for the most essential overall outlook on life, namely hope' (Erikson, Erikson & Kivnick, 1986, p.33). Erikson (1965) notes that trust is a state of being and responding; it is a trust that is in the sameness and continuity of the outer providers, and it is also a trust of oneself. The second stage of human life cycle is autonomy versus shame and doubt, and it is linked to a physical development of muscular maturation and to the generalised forms of holding on and letting go with discretion 'to stand on his own two feet' (Erikson, 2965, p. 244). The alternative is shame and doubt. Shame and doubt are experienced 'personally' by the individual, but also via the adult world (Douvan, 1997; Munley, 1975). A favourable 'ratio' (Erikson, 1965, p. 246) between the two contributes to whether there is a 'lasting sense of goodwill and pride…or a lasting propensity to doubt and shame'.

The third stage is initiative versus guilt. The alternative to demonstrating initiative is 'a sense of guilt over the goals contemplated and the acts initiated' (Erikson, 1965, p.247). For example, if a child's curiosity is interpreted, by parents, as being destructive, then the child may develop a sense of guilt and a fear of punishment. If the crisis is managed successfully then the child develops a sense of purpose that will, later in adolescence, be the basis for curiosity and ambition (Munley, 1975). A favourable 'ratio' (Erikson, 1965) results in direction and purpose. The fourth stage, which corresponds to school age, is industry versus inferiority. At this stage, Erikson (1965, p.250) writes that the child 'develops a sense of industry and learns how to win recognition by producing things'. An important part of becoming industrious is the 'positive identification with those who know things and know how to do things' (Erikson, 1968, p.125). The crisis at this stage can arise, for example, when

an individual feels inferior if they have not found joy in their effort, and pride in their work. A favourable ratio (Erikson, 1965) results in method and competence.

The fifth stage, which corresponds with adolescence, is identity versus identity or role confusion. Marcia (2015) suggests that an individual's 'search' for identity finds a new interpretation as, to this point, the sense of identity has been emerging. Identity is based on psychosocial reciprocity (Kroger, 2002) that is between the individual and others in their social world. Erikson (1965, p.89) writes that adolescents are sometimes 'preoccupied with what they appear to be in the eyes of others as compared with what they feel they are…'. Thus, adolescents need to free themselves from their dependency on their peers (replacing their dependency on parents) in order to develop a mature identity (Marcia, 2015). Identity, once discovered, provides the young adult with 'a sense of 'knowing where one is going' and an inner assuredness of anticipated recognition from those who count' (Erikson, 1968, p.118). The strength of fidelity is particularly important at this stage, and it is defined by what the individual is faithful to, what they identify with, and what they are identified by (Erikson, 1982). The adolescent who 'fails' in their search for an identity may experience self-doubt and role diffusion or confusion (Kroger, 2002). A favourable ratio leads to devotion and fidelity (Erikson, 1968).

The following two stages: intimacy versus isolation (young adulthood, stage six), generativity versus stagnation (middle adulthood, stage seven) correspond, in this theory, to the life span development of the participants in this study. Intimacy versus isolation is concerned with 'the young adult emerging from the search for, and insistence on, identity …and is eager and willing to fuse his identity with that of others' (Erikson, 1965, p. 237). In this stage of life span development, the individual is eager to commit to others and 'abide by such commitments, even though they may call for significant sacrifices and compromises'

(Erikson, 1965, p. 237). Kroger (2002) writes that the danger or crisis at this stage is that an individual may avoid commitment to intimacy, which may lead to a profound sense of isolation. This isolation can be experienced in social, as well as intimate, relationships (Marcia, 2015). A favourable ratio (Erikson, 1965) is that of affiliation and love. The life span developmental stage of generativity versus stagnation should be a crucial one for an individual as it is the link between the generations (Kroger, 2002). Generativity is 'primarily the concern in establishing and guiding the next generation…….[and it is an] essential stage on the psychosexual as well as on the psychosocial schedule (Erikson, 1965, p. 240). This does not mean exclusively having and bringing up children, but it includes the creative contribution to society. Erikson (1965, p.240) writes that failure 'to develop [such] enrichment of interests may lead to a 'pervading sense of stagnation and personal impoverishment'. This stagnation is significant because it impacts future generations as well as the individual (Marcia, 2015).

The final stage is ego integrity versus despair (old age). In this stage integrity can be found in 'only him who in some way has taken care of things and people, and who has adapted himself to the triumphs and disappointments adherent to being, the originators of others or the generator of products or ideas…' (Erikson, 1965, p.241). Erikson acknowledges that the character of integrity is developed by the individual's culture, and lack of integrity creates a different sense of despair, which expresses the realisation, for an individual, that time is running out to progress along a different road to integrity or even to start another life. Thus, the individual may reflect on their life with a sense of longing for what might have been and for missed opportunities, and this despair 'is signified by fear of death' (Erikson, 1965, p.242). Essentially, Erikson brings the life cycle together inasmuch as integrity is both the foundation of the first stage and the completion of the final stage (Marcia, 2015).

Sneed, Krauss Whithourne and Culang (2006) note that the core stages that anchor this repetition are trust, identity, and ego integrity because each of these stages is characterized by the theme of continuity and wholeness. Although linked by the theme of wholeness and continuity, Erikson proposes that each stage would be dominant at different points across the lifespan. An example is the crisis of developing basic trust in others, which is in infancy (stage one), followed by the crisis of developing identity in adolescence (stage five). This is characterised by a nascent identity developing into a mature identity (integrating past and present, with a view to the future). Finally, there is the crisis of establishing ego integrity, which is about looking back over one's life and feeling good about the life that they have led.

Erikson (1965, p.274) writes that a crisis can emerge at any point in an individual's life, such are the 'hazards of existence' inasmuch as earlier stages can be re-examined later in life and later stages can be dominant earlier in life. An example is trust or mistrust, as it may be a dominant 'crisis' in infancy, adolescence or in adulthood. Basic trust versus mistrust crisis can reoccur during the stage of intimacy versus isolation (young adulthood) and its nature is shaped by the manner characteristic of adult relationships (Marcia, 2015). Moreover, as elements (for example, trust versus mistrust, or initiative versus guilt) from succeeding stages are present at every stage, Erikson (1965, 1968) suggests that there are possibilities of nascent resolution of crises not yet met at the proposed chronological age.

In summary, Erikson's life span development theory, which links psychological, biological and social/historical processes, describes a complete life cycle, within a categorisation of generations. These are presented as stages, and within each stage there is a nuclear conflict between opposing attitudes (Kroger, 2002). Resolution of this conflict or crisis results in a turning point, which is balanced between positive (for example, basic trust) and negative (for example, mistrust). Each stage is impacted by previous stages and will continue to impact,

and modify, subsequent stages of life span development. The theory is focused on 'normal' rather than pathological development (Marcia, 2015), as it intends to demonstrate a pattern of 'healthy' development (Erikson, 1965, 1968).

Some of the criticisms of Erikson's theory are concerned with the lack of detail within each stage, and the designation of a particular crisis to a particular stage (Marcia, 2014). There is also a concern with the order in which the stages occur and if there might be a need for sub-stages (Sneed et al, 2006). Moreover, can a developmental scheme adequately make sense of human behaviour. It could be argued that a series of stages can be seen as not acknowledging individual differences and putting individuals' unique experiences into pre-ordained categories, rather than working with the distinctive circumstances of each individual. However, Corrie (2010) argues that whilst we acknowledge that every individual has unique experiences, this does not mean that they share nothing with other people.

Erikson, also, avoids the negative aspects of life and possibly confuses what he would like, or thinks what should be happening in the integration of the individual and society (Sneed et al, 2006). However, in answer to this, Marcia (2015) argues that his work can be taken as offering a contrary perspective to the emphasis on the pathological in psychoanalysis. Questions also emerge about the social and political implications of the work and how Erikson seems to be supporting the status quo (Kroger, 2002) and that his assumptions are derived from his gender and culture (Sneed et al, 2006). It is reasonable to infer that Erikson's legacy is in extending developmental psychology from the psychoanalytical emphasis on childhood sexuality and pathology of the inner world to a life span psychosocial theory of development. I would argue that his thoughts on identity and crisis (for example, adolescence, young adult) and ageing, have had an influence on the therapeutic relationship inasmuch as there is an awareness of the implications of society and culture on the

individual's development. In relation to the participants in the study reported in this thesis, it is reasonable to infer that by coming back into education, they are forming a new identity, or adapting their existing identity. The recognition of an individual's possible struggle for identity, and the influence of the social and historical situation in which the individual lives, are crucially important in helping therapists to appreciate the lived experiences of their clients. In addition, it is useful to see such a framework as a help when working with individuals, rather than perceiving it as encompassing universal truths (Corrie, 2010).

2.3 What is Depression?

Depression or Depressive Disorder as it is referred to in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) (APA) is a common diagnosis. Depressive disorders include disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder, premenstrual dysphoric disorder, substance/medication-induced depressive disorder, and depressive disorder due to another medical condition. Dysthymia, sometimes referred to as mild, chronic depression, is less severe and has fewer symptoms than major depression. With dysthymia, the depressive symptoms can linger for a long period of time, often two years or longer. Dysthymia and chronic depression are both referred to as persistent depressive disorders (APA, 2013).

The common feature of depression is 'the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's ability to function' (APA, 2013, p.155). Other characteristics of depression are, not exclusively, experiencing a marked diminished interest or pleasure in activities, significant weight gain or loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive feelings of guilt, diminished ability

to think or concentrate, or indecisiveness and recurrent thoughts of death and suicide ideation (APA, 2013). These features occur nearly every day and cause clinically significant distress in social, occupational, or other important areas of functioning.

In Ireland, the public health organisation: Health Service Executive (HSE) publishes guidelines for individuals seeking help for their health. In 2016 the HSE recommended that individuals, who feel they may be experiencing depression, should visit their General Practitioner (GP). The GP will give them a physical examination and run blood tests to rule out other conditions, which may have similar symptoms such as an underactive thyroid. In addition, the GP will use a classification system such as DSM-V or International Classification of Diseases (ICD) to identify whether the patient has depression (HSE, 2016). Patients are advised that their GP will be able to diagnose depression, and decide on the best course of action in managing the illness. A diagnosis means that the patient fulfils the criteria of probable major depressive disorder for an episode of depression for at least two weeks during the previous 12 months (APA, 2013).

Depression may first appear at any age (APA, 2013) but the likelihood of onset increases greatly with puberty. Incidence seems to peak in the 20s; but first onset in later life is not uncommon. Depression is usually a 'self limiting' condition and recovery is likely, even if individuals have subsequent episodes (Ridge and Ziebland, 2006). Self-limiting means that it tends to lift over time, even if improvement takes months or years and individuals have further episodes (Rhode, Lewinsohn, Klein, Seeley & Gau, 2013). Depression can occur as a single-episode, recurrent or chronic disease (Steinert, Hofman, Kruse & Leichsenning, 2004).

It is important to recognise that the concept of diagnosis is debated in relation to the usefulness of, and efficacy in, categorising illnesses. Diagnosis, states Wakefield (2010, p. 337) is 'the art of distinguishing one disease from another'. Thus, one assumes that the

patient has a disorder and that diagnosis is concerned with identifying the particular disorder. Frances (2013, p. 23) who was the chairman of the DSM-IV Task Force, and part of the leadership group for DSM-III and DSM-III-R, writes that when clinicians follow each criteria set for each DSM disorder they achieve 'reasonable agreement'. However, the boundaries demarcating the different disorders are 'fuzzier' in real life than they appear on paper (Frances, 2013, p.24). Arguably, when a lack of theoretical precision exists about distinguishing one disorder from another, then social values 'tend to determine what is seen as the 'real' boundary between categories' (Horwitz and Wakefield, 2012, p.222). Thus, when this arises, there can be misdiagnosis and misclassification of normal cases of sadness, for example, as a mental disorder.

Zimmerman (2012) asserts that the sensitivity (true positive rate) of a screening test refers to how well the test detects individuals with the illness. He further stresses that the specificity of the test refers to how well it pinpoints individuals without the illness. The positive predictive value indicates the probability that an individual who is considered to be ill, according to the screening test, actually has the illness (Wakefield, 2010). Zimmerman (2012, p.128) succinctly argues that a 'trade off' in selecting a threshold of a test resulting in 'high sensitivity is lower specificity'. If the specificity threshold is lowered then more individuals will be categorised as having the disorder, when in fact they do not (false positives). Arguably, if clinicians over-rely on a depression scale, for example, without adequate follow-up evaluation, then there is a problem. Also, there is the recognition that not all patients are at 'the nadir of their episode' (Zimmerman, 2012, p.133) when they present themselves for a clinical assessment, thus risking an invalid evaluation. Sadler (2004) asserts that not all patients can recognise or accurately describe how they feel, when articulating their

experiences. Patients and clinicians coming from different cultural backgrounds may have difficulties in agreeing that the 'problem' is depression.

Many mental disorders, asserts Wakefield (2010), consist of normal defensive responses to stress, such as anxiety or sadness, feeling angry or feelings of low self-esteem. He further emphasises that many health policies have been driven by epidemiology studies, in which DSM symptom-based criteria for disorder are applied to populations using symptom checklists. The diagnostic criteria that eventually became DSM criteria for major depression were originally constructed for, and applied to, hospital-based research studies as a way of differentiating schizophrenic patients from mood disordered patients (Frances, 2013). Here in lies a problem: how useful is a list of symptoms for discerning different disorders in a hospital –based sample when applied to distinguishing normal emotional responses from 'disordered' responses.

Frances (2013) contends that psychiatric symptoms, in a mild form such as sadness, are widely spread across the general population, as from time-to-time most individuals will experience some sadness, anxiety, or may have difficulties in concentration. Thus, isolated or mild symptoms do not define a disorder on their own, but must 'cohere over time in a specified way, and also cause significant distress or impairment' (Frances, 2013, p.86). Consequently, mild, transient 'symptoms' can sometimes be diagnosed as a psychiatric disorder as primary care physicians often have a limited length of time with a patient, and may have minimal training in psychiatry. Wakefield (2010) cautions that normal trait variation, in the population, must be distinguished from mental disorders. An example is when intense reaction to loss may be part of normal variation, and not a disorder. The context of the symptoms must be taken into consideration when assessing if pathology exists. This is because individuals are biologically 'designed' (Wakefield, 2010, p.344) to respond to the

environment, for example if they feel threatened. Therefore, to assess if the emotional response is disordered without knowing the context is not necessarily accurate. How useful then is the diagnosis of a disorder, such as depression, to a practitioner. Douglas (2010, p.29) suggests that while researchers may use DSM to assist inclusion and exclusion criteria for randomised controlled trials, in practice 'clients come context-bound and not neatly packaged as the DSM would have us believe'. Incorporating more practice-based research evidence into a diagnosis, arguably, may go some way to help understand the social, interpersonal and subjective experiences of the individual (Strawbridge and Woolfe, 2010).

Many approaches to explaining depression have involved cognitive models of vulnerability for depression, which involve an examination of the way in which an individual interprets their experiences (Alloy, Abramson &Whitehouse, 1999). Other approaches have examined genetics and biological functioning (Levinson, 2006) or the role that personal characteristics play in an individual's vulnerability to experiencing depressive episodes (Ridge and Ziebland, 2006). Environmental factors such as adverse childhood experiences and stressful life events can be precipitants of major depressive episodes. 'Genetic and physiological factors such as first-degree family members of individuals with major depressive disorder have a risk for major depressive disorder' (APA, 2013, p.166).

2.4 Psychodynamic and Humanistic Perspectives on Depression

'Psychodynamic' refers to the way in which the psyche (as mind, emotions, spirit or self) is seen as active, not static (Jacobs, 1994, p.4). The parts of the self can be described as Id, Ego and Super-Ego (Freud, 1949). Melanie Klein developed the idea of 'internal objects' (Jacobs, 1994, p.5). The internal aspects or objects of the psyche are formed over the childhood years, as 'the counterparts' (Jacobs, 1994, p.6) of external relationships between the child and

others, particularly, those with their mother and father. Psychological development (or personality) comes about through how a mother and father treats their child, but also how the child 'sees' and perceives their parents (Freedheim, 1993). Although it is recognised that these early events become modified over time and with experience of other relationships, these early experiences do not 'disappear' (Jacobs, 1994).

Freud distinguishes between mental activity, which is conscious and that which is not conscious, but easily becomes so, such as the memory of a feeling or event (preconscious) and 'mental processes or mental material which have no easy access to consciousness, but must be inferred and translated into conscious form' (Freud, 1949, p.20). This is the unconscious, and it is an important concept in psychodynamic work. It can be argued that Freud described the mechanisms of the conscious and unconscious in 'quasi-scientific' terms (Eagle and Wolitzky, 1993). The concept of unconscious conflict, which can be threatening or unacceptable, is central to traditional Freudian theory (Hartmann, 1958, p.196). Signals of anxiety trigger the activation of defense, such as projection, denial, repression or reaction formation, but any aspect of ego functioning can be utilised for defensive reasons (Bemporal and Vasile, 1999).

Psychodynamic theories of depression, which have grown out of theories and practices of Freudian psychoanalysis (Freud, 1949), posit that an individual's behaviour is affected by the unconscious mind and by past experiences (Cooper, 2017). Psychoanalytic perspectives regard various behaviours as symptoms of psychopathology and 'as indicators of a deep, underlying, and often unconscious, conflict' (Gilbert, 2007, p. 63). For Freud, many cases of depression are due to biological factors, whilst also acknowledging that depression is like grief in that it often occurs as a response to the loss of an important relationship (Cooper, 2017). Depression arises from anger directed inward towards a lost love object, which by

incorporation, had become part of the ego (Bemporad and Vasile, 1999). Freud modified his theory stating that the tendency to internalise loss objects (actual loss such as death of a loved one, as well as symbolic losses such as loss of a job) is normal and that depression is due to an excessively severe super-ego (or conscience) in that depression occurs when it is dominant (Freud, 1949). Sandler and Joffee (1965) suggest that depression should be considered a negative emotion much like anxiety, and that depression is experienced when the individual loses a former state of well-being. In relation to the loss of a loved one, it is not the loss of the actual object, but rather loss of the state of well-being that the object provides.

Bemporad and Vasile (1999, p.93) argue that clinical depression involves a change in an individual's sense of self, with the emergence of childhood modes of thinking and relating towards oneself and others 'that are no longer appropriate to adult life'. Negative self-evaluations, which relate to underlying beliefs 'become expressed in the context of the therapeutic relationship, particularly in the form of transference and resistance' (Eagle and Wolitzky, 1993, p.116).

Psychodynamic theory has developed over its long history and numerous adaptations of the original theory are seen today. One branch of more modern psychoanalytic theory is known as object relations theory, such as approaches developed by Fairbairn (1952) and Winnicott (1965) (Eagle and Wolitzky, 1993). Also, Neo-Freudians such as Adler, Jung, Sullivan and Horney have adapted and developed aspects of Freud's work such as transference and the unconscious (Wolitzki, 2005).

Psychoanalytic perspectives on depression have had a huge impact on more recent theories of depression, such as the model proposed by Beck (1983) in regard to the idea of the loss of self-esteem (Beck (1967) refers to the negative view of self) and object loss (Beck (1983) refers to the loss of events). Despite psychoanalytic theories being influential, they are

difficult to test empirically. Moreover, if the focus is on early childhood experiences as well as unconscious intra-psychic processes, then the therapist may not pay attention to other aspects of the client's life. There are also potential problems with transference as the individual may be aware of particular displaced transference of feelings and attitudes (Eagle and Wolitzky, 1999, p.121) and not all transference 'behaviour' is a repetition of early childhood 'reactions'. However, Cooper (1987) argues that a modern view of transference is concerned with a new experience rather than a repetition of an old one, but it is useful to see how new ways of relating are influenced by the past.

Person-centred therapy emerged in the 1940s as a therapeutic approach distinct from psychoanalytic and behavioural traditions (Cooper, 2012). One of its main advocates was Carl Rogers, who viewed the individual as an integrated organism (Rogers, 1961). Humanistic theories are based on the premise that individuals are 'self-actualising' (Maslow, 1970; Rogers, 1951) meaning that they have an innate tendency to develop their potential, and are self-aware. Lack of self-awareness in integrating the whole person can contribute to an individual's feeling of unworthiness, sadness and low moods (Cooper, 2012). Person-centred implies that the individual is always at the centre, and not the methods used or skills of the therapist. The term 'person centred' has seen a number of name changes (Dryden and Mytton, 1999, p.58) from Roger's non-directive approach, to client-centred, and subsequently when it was 'applied to other areas such as educational contexts, the term as person centred was employed'.

Van Deurzen's existential approach (e.g. van Deurzen, 2012) explores four dimensions of being, which are physical, personal, social and spiritual. The hypothesis that psychological distress is associated with a lack of meaning is 'one of the best evidenced of all existential claims' (Cooper, 2017, p.67) as individuals with lower levels of meaning in life have greater

levels of psychological distress (Frankl, 1959). Frankl (1988) suggests that there are three fundamental ways in which life can be meaningful, and through which we derive values. They are: we find meaning in life through our creative works; we find meaning through what we take from the world in relation to our experiencing values (van Deurzen, 2011) and from what we experience in our world; and we find meaning in the stand we take towards a fate we can no longer change. Cooper (2017, p.67) argues that one aspect of meaning is that it is 'future oriented'. For Frankl, meanings arise through being-in-the-world with others; it is through the interface with others and in contexts with others that we find and make meaning. The situations in which we find ourselves in our life call on us to actualise meanings in a particular way. For Frankl (1959) the most basic human need is to establish such meanings in our life. From a meaning-centred perspective, the need for meaning is that, when it is absent, individuals may experience deep psychological suffering, such as feeling hopeless, depressed, empty or even suicidal (Frankl, 1988). Moreover, the experience of such 'an existential vacuum' (Cooper, 2017, p.68) can trigger more intense existential neuroses and the individual may adopt self-destructive behaviours in order to fill the existential void. Furthermore, from an existential perspective, psychological well-being is seen to be synonymous with wisdom (van Deurzen, 2011). Psychological disturbance such as depression arise through either avoidance of the truth or an inability to cope with it (van Deurzen, 2012).

2.5 Cognitive Theories of Depression

Cognitive theories of depression are essentially diathesis-stress models (behaviour is a result of both biological and genetic factors, and life experiences) in which negative self-referential biases are thought to remain dormant until activated by relevant environmental cues such as stress or low mood (e.g Beck, Rush, Shaw & Emery, 1979). Essentially, models of cognitive

vulnerability (the individual has a susceptibility to mental health disorders determined by one's genetic make-up and early life experiences) hypothesise that the way in which an individual interprets their experiences represents a protective or risk factor for the development of depressive disorders when confronted by negative and stressful life events (Alloy et al, 1999).

Depression is believed to occur when negative self-beliefs and processing biases impede an individual's ability to regulate emotional responses to adverse experiences (Phillips, Hine & Thorteinsson, 2010). According to cognitive theories of depression, individuals possess representations of self-referential information (information about themselves in relation to others and the world) involving theories of failure, hopelessness, worthlessness and rejection (Abramson, Matalsky &Alloy, 1989). When such representations are activated by an environmental trigger such as an event that is considered to be stressful then self-schemas are believed to generate automatic and systematic biases in information processing (Beck, 2008). This processing results in the individual perceiving that they lack the ability to cope, are weak and are likely to fail. Cognitive structures are reflected in patterns of activation, such as a negative memory or emotion node. This negative mode activates all other nodes in an individual's associative network (Nolen-Hoeksema, 2000). Thus, activated schemas (representations of events or behaviours stored in an individual's memory) increase the likelihood of depressive episodes, and the presence of a negative self-schema represents a relatively stable vulnerability factor for future depression (Beck, 2008).

Cognitive models of depression predict that depressed individuals will exhibit negative biases in implicit attitudes towards self, and in all aspects of information processing. Particularly relevant facets of cognition include attention, interpretation, self-beliefs and self-esteem (Beck, 2008; Nolen-Hoeksema, 2000; Phillips et al, 2010). Thus, one can observe negative

biases in an individual who is highly self-critical, fault-finding and focused on their mistakes and failures. Beck (1967) stresses that depressive cognitions reflect negative evaluations of self, world and future, whereas anxious cognitions reflect anticipation of a physical or psychological threat.

Automatic attention allocation reflects an individual's goals, emotions, moods and task demands (Phillips et al, 2010). It is greatly influenced by prior experiences and therefore individuals with negative views of self may preferentially respond to negative self-referential environmental cues. In a cyclical fashion, such selective attendance, such as previous mistakes and failures, may maintain a depressed mood and serve to support detrimental self related cognitions. Nolen-Hoeksema (2000) argues that for the depressed individual, difficulties lie in disengaging attention from the negative information in their environment.

Dual process theories have been developed to help explain how an individual with depression processes the information in their environment (Forgas, 2000). They maintain that individuals possess two distinct information processing systems: an implicit system that involves automatic processing, which requires little cognitive effort and is guided by slow-forming associative memory constructs such as previous negative experiences or failures; and an explicit system that employs conscious processing and involves a motivated effort in which the individual is assessing their behaviour. According to Beck (2008) healthy mood regulation involves an interaction between the two systems. Implicit processing maintains current mood by gathering mood-congruent information until an appropriate threshold is reached. Therefore, if an individual is in a low mood they will be more receptive to information that supports that mood (for example, feeling sad so being receptive to sad news or events). At that time, explicit processing is triggered to restore homeostasis by seeking mood-incongruent information (Nolen-Hoeksema, 2000). Thus, attention is given to negative

information. Depression occurs when negatively biased implicit processing remains uncorrected by explicit processing, thus activating negative implicit schemas. In this way, the individual does not challenge or question their perceived inability to cope or that a previous mistake or failure may not necessarily be repeated. This results in negative explicit cognitions, increased dysphoria, depleted cognitive resources and a downward spiral into depression. Therefore, argue Phillips et al (2010) implicit cognitions are hypothesised to represent the origin of depression.

In regard to interpretation of life events Wisco (2009) posits that depression is associated with a set of maladaptive beliefs, including perfectionist self-standards, personal inadequacy and pessimistic predictions for the future. It is feasible to assert that our personal belief system is based on our experiences and interactions with others. Negative self-beliefs in a depressed individual may under score a negative bias in the interpretation of ambiguous information. Thus, the individual interprets information in an unrealistic self-referential manner (Nolen-Hoeksema, 2000). Perfectionism is a multi-dimensional construct with both adaptive and maladaptive aspects of functioning (Hewitt and Flett, 1991). Perfectionism is often conceptualised as a vulnerability factor that leaves the individual at risk for increases in depressive symptoms over time (Cohen, 2004) with stress moderating the relationship between perfectionism and depressive effect. There are two main dimensions of perfectionism. The first is personal standards, in which the individual sets exactingly high standards for themselves and they engage in rigid self-evaluations (Dunkley, Blankstein, Halsall, Williams & Winkworth, 2000). By so doing, the individual can experience high levels of stress. The second is evaluative concern (Hewitt and Flett, 1991) in which the individual is overly concerned with meeting the unrealistic high standards they perceive are set by other people. As a result, the individual is frequently dissatisfied with their

performance and engages in exacting self-evaluation. Moreover, perfectionists tend to engage in over-striving, repetitive checking and avoiding mistakes (Hewitt and Flett, 1991). Such individuals have perceived lower levels of self-efficacy resulting in negative self-belief about their ability to cope adequately, and this can manifest itself in an avoidant coping style (Trew, 2011).

Perfectionists tend to experience negative affect (a non-conscious experience of emotion) that is focused, above all, on concerns of self-control and self-worth (Dunkley et al, 2000). Cohen (2004) observes that perfectionists are more vulnerable to stress exposure because it disturbs their high desire for control, and uncontrollable stress is evaluated according to the 'all or nothing' evaluative standards of the perfectionist. Hewitt and Flett (1991) maintain that perfectionists, who are experiencing high levels of stress, are vulnerable to depressive symptoms particularly in relation to achievement-related stress.

Individuals who hold pessimistic beliefs about the future have also been observed in depression research where beliefs become automated through habitual thinking styles (e.g. Lavender and Watkins, 2004). Rumination (tendency to think, continuously, about causes, situational factors and consequences of one's emotional experiences that are upsetting) is a risk factor for depression as it expends cognitive resources and may augment implicit negative biases that the individual holds about themselves (Malmberg and Larsen, 2015).

Individuals with low self-esteem are more prone to ruminating over negative aspects of self, which in turn increases depression (Cole, Nolen-Hoeksema, Girgus & Paul, 2006). Self-esteem is an individual's global evaluation of his or her overall worth as a person (Harter, 1999). Individuals with low self-esteem can be described as sensitive to others' criticism and generally focus their attention on how others perceive them (Malberg and Larsen, 2015). They may feel shy, lonely and isolated from others (Cole et al, 2006). Individuals with

current depression may feel empty and sad and lose the capacity to ascertain pleasure from activities that once pleased them (Cohen, 2004). Beck (1967) stresses that low self-esteem causally influences the onset and maintenance of depression. Steiger, Allemand, Robins & Fend (2014) report that the experience of depression may influence self-esteem by influencing the way in which individuals process self-relevant information. For example, a persistent low mood associated with depression may lead the individual to make more negative self-evaluations by only attending to negative information in their environment and not hearing or being receptive to neutral or positive information.

Orth, Robins, Trzesniewski, Maes & Schmitt (2009) maintain that fragile self-esteem is linked to cognitive phenomena that suggest a fragility of self that may expose individuals to depression. In addition, individuals with low self-esteem are less likely to search for positive feedback from other individuals (Steiger, Allemand, Robins & Fend, 2014) and interpret feedback from others negatively (Hewitt and Fleck, 1991). Granek (2006), in a study that utilised grounded theory, reports that her participants, who were undergraduate students at a university, described their interpersonal relationships as central to their self-definition. When they were experiencing depression they were highly self-critical and were full of 'self-loathing and self-criticism in relation to others' (Granek, 2006, p.201).

2.6 Genetics, Biological Functioning and the Environment

Environmental factors such as adverse childhood experiences and stressful life events are often precipitants of major depressive episodes. Genetic and physiological factors such as first-degree family members of individuals with major depressive disorder have a risk for major depressive disorder (APA, 2013). Data gathered from twin studies demonstrate that heritability for depression is 40% to 50% (Levinson, 2006). Adoption studies provide some

support for the role of genetics in depression (Cadoret, 1978). The personality trait neuroticism accounts for 'a substantial portion of this genetic liability' (APA, 2013, p.166). Neuroticism is a term introduced by Eysenck (1967) to describe a high-order factor analysis of self-rated or observer-rated measures of personality. It is characterised by dysphoria, anxiety, tension and emotional reactivity (e.g. McCrea and Costa, 1985). Levinson (2006) maintains that neurotoxic effects (possibly related to excessive corticotropin activity) damage or kill hippocampal cells, which in turn mediate many depressive symptoms. Genetic factors could alter the balance of neurotoxic and neuroprotective responses to stress, while antidepressants have been shown to enhance neuroprotective effects (Angst, 1995).

Major depressive disorder and the neurotic personality trait argues Cadoret (1978) have overlapping genetic susceptibilities. Neuroticism has also been associated with greater subsequent negative automatic thoughts and poor coping skills in response to stress (for example, self-blame and over reliance on others' support) (Kercher and Rapee, 2009). Eberhart and Hammen (2009) carried out a study with female undergraduate students in which they conclude that students who sought excessive reassurance and were dependent on others for approval were more likely to experience stress over a four week time frame.

A number of epidemiological and clinical studies have provided data that suggest a strong association between various forms of early life stress (such as abuse and neglect) and depressive symptoms or disorders (e.g. Chapman, Whitfield, Felitti, Dube, Edwards et al, 2004; Edwards, Holden, Felitti & Anda, 2003; Lizardi, Klein, Ouimette, Riso, Anderson et al,1995; Lupien, McEwan, Gunnar & Heim, 2009; Kendler, Bulik, Silberg, Hettema, Myers et al, 2000). The role of early childhood life stress in the development of major depressive disorder, beyond the scope of examining genetic factors, has been demonstrated by twin studies (e.g. Kendler et al, 2000). An unfavourable family environment, as observed in poor

relationships between parents and children, or the mother being over-protective is also associated with an increased risk of depression (Lizardi et al, 1995).

Advances in neuroscience research have provided insights into the plasticity of the developing brain as a function of experience (Levinson, 2006). Enduring effects of early life stress on the brain and its stress regulatory overflow system, including the autonomic, endocrine and immune systems, may lead to the development of a vulnerable phenotype with increased sensitivity to stress, which then leads to the development of a number of somatic disorders such as depression (Kaffman and Meaney, 2007; Lupien et al, 2009). Heim and Nemeroff (2001) report that adult women, especially those with depression and who had a history of childhood sexual or physical abuse, exhibited markedly increased neuroendocrine and autonomic responses to laboratory stress. Levinson (2006) hypothesises that early life stress leads to changes in a connected neural network that fails to adapt and compensate in response to additional challenge. Essentially, these studies suggest that early life stress is a general risk factor, which leads to increased stress vulnerability and depression risk. However, it must be noted that there is much variability in the effects of early life stress among individuals as not all individuals who are exposed to such stress go on to develop depression as adults; they remain resilient even when exposed to significant levels of stress (Maercker, Michael, Fehm, Becker & Margraf, 2004).

In essence, data from genetic and environmental studies support the notion that genes and environment have significant interactive effects in predicting depression even in the absence of strong genetic effects (e.g. Kendler et al, 2000; Lupien et al, 2009). One can assert that exposure to early life stress or adversity can critically interact with trajectories of brain regional development to produce variable outcomes (Angst, 1995; Levinson, 2006). Thus, it is likely that the noted strong effects of early life stress on the risk to develop depression in

adulthood are moderated by genetic factors (Cadoret, 1978). Therefore, it is feasible to conclude that stressful life events are associated with risk for depression is a well-established finding in research literature.

2.7 Depression and Sense of Self

Miranda, Andersen & Edwards (2013, p.39) argue that individuals 'are shaped by the interpersonal contexts of their lives' and that the way in which individuals see themselves is characterised, to some degree, by the role that important relationships play in their lives. Depression is associated with interpersonal impairment (Hammen, 2000) and difficulties in relationships, so individuals who are experiencing an illness that can be unpredictable and overwhelming often experience damage to the self (Dickson, Knussels & Flowers, 2008). Ratcliffe (2014) reports that most of the experiences in which we relate to others is in a shared world and when an individual experiences depression there is a loss of interpersonal connectedness. The experience of depression can be like being cut off from the world.

Charmaz (1983) suggests that chronic illness is often associated with various personal changes such as loss of social networks, abandonment of meaningful activities and functioning, intrusion of medical regimes into one's daily life, increased dependence on others and social stigma. Bury (1982) posits chronic illness as a 'biographical disruption' or the changing of social interactions because of the impact of the illness. He further describes illness as an experience where 'the structures of everyday life and the forms of knowledge which underpin them are disrupted' (Bury, 1982, p.169).

The literature on identity and chronic illness include themes about adaptation, loss, disclosure, avoidance or denial, transition or positive growth or adjustment. It is reasonable to infer that these changes may become difficult for the individual to maintain a familiar sense

of self and identity (Bury, 1982). Identity is described by Erikson (1968) as subjective and involves a sense of self-sameness and stability over time. Nonetheless, a traumatic event can interfere with an individual's sense of identity and disrupt the continuity.

Individuals with low self-esteem, a correlate of depression (Nolen-Hoeksema, 2010) and also with high levels of hopelessness (Beck, 1967), may view themselves as having deteriorated self-esteem from their present self to their future self. Since depression is associated with the expectation of the occurrence of future negative events (Beck, 2008) depressed individuals may have an idealised view of a past self, while simultaneously holding a negative view of the current self (Sokol and Serper, 2017). Moreover, due to their hopelessness about an improved future, individuals may hold an even greater negative view of their future self. This possibility is consistent with the learned helplessness theory of depression (Seligman, 1972). In this way, individuals with depression feel helpless and hopeless, and this affects appraisals of future events (Hewitt and Fleck, 1991) as trying to assess future situations positively is pointless. Sokol and Serper (2017) maintain that individuals who are experiencing depression may feel alienated or dissociated from their future self. However, they also found that while there was a trend towards depressed individuals feeling hopeless and pessimistic about their future, they also noted an associated trend towards a more optimistic sense of future selves. This was due to individuals seeing themselves as having a 'recovery' trajectory in which they would improve from their depression in the future, and return to the positive characteristics that defined their past self. These findings are consistent with Frankl (1959) who posits that it is through suffering that an individual can enhance oneself. Mc Farland and Alvaro (2000) argue that after an individual experiences negative events, they can prompt a set of beliefs that focus on self-growth in such areas as personal strength and relationships with others. It is noted that the experience of an illness can itself sometimes trigger positive changes (Hyland,

Sodergren & Leith, 2006). Dickson et al (2008) write that some individuals accept their post-illness identities and replace them with new alternatives, and a new sense of self is created. Whittemore (2005) stresses that the integration of an illness experience into an individual's identity can result in psychological adjustment, as it is constantly re-evaluated and negotiated in relation to the inner self and lived experiences (Charmaz, 1983).

Charmaz (1983) outlines several social psychological factors, which may augment a sense of loss of self or identity for individuals experiencing a chronic illness. For example, an individual may be living a socially isolated life by withdrawing from social life due to rejection or stigma. There might also be the fear of becoming a burden to others. As depression is an 'invisible' illness, there is also the question of managing invisible social identities (Clair, Beatty & MacLean, 2005) inasmuch as just because depression cannot be seen by others in the individual's life does not mean that it does not exist. Individuals often find that they have to re-define the self at the onset of the illness (Dickson et al, 2008). Corbin (2003) argues that chronic illness can trigger drastic change, particularly in terms of roles, responsibilities and this can challenge an individual's identity. It can lead to the disruption of a desired life (Bury,1982).

2.8 Depression and Students

In Britain, the Heads of University Counselling Services (HUCS) published a nationwide report of UK based third-level institutions in 1999, called Degrees of Disturbance: The New Agenda. Whilst this study is not recent it is important because it drew attention to a rise in both attendance rates and mental health co-morbidity in students accessing student counselling services. In a later report compiled by the Association of University College Counsellors (AUCC, 2001) depression was the most common presenting issue at UK student

counselling services, with universities reporting between 38% and 49% of new referrals for depression in a given year. In Ireland, McKeon and Mynett-Johnson (1999) documented that depression was reportedly prevalent in one out of eight students at Irish HE institutions.

Royal College of Psychiatrists London (2003) report that there are increasing numbers of students presenting with mental health problems and that these problems can severely disrupt a student's capacity to study and learn. The transition to Higher Education (HE) is a critical period as it is during this time that students form friendships, social patterns and new living arrangements **(**Reshmi, Schommer, Worley & Peden-McAlpine, 2012). These new experiences can lead to adjustment difficulties, and harmful health-related behaviours can become established over the course of a student's years in HE. It is also during this time that managing lifestyle choices and developing personal independence can be challenging **(**Parker, Summerfeldt, Hogan & Majeski, 2004).

Factors such as academic stress, transition, isolation and financial worry mean that HE is associated with an increase in emotional distress (Dyson and Renk, 2006). Additional factors that may contribute to depression include negative life events, which affect self-esteem, life stressors, use of alcohol or drugs, past trauma and sexual abuse, domestic violence, family circumstances, life course decisions, academic hurdles, sexually related experimentation and violence (Leino and Kisch, 2000; Prinz, Hertrich, Hirschfelder & de Zwaan, 2012; Said, Kypri and Bowman, 2013; Storrie, Ahern and Tuckett, 2010). Richards and Timuluk (2013) state that in recent years, university mental health services in the UK and the USA have noted an increase in student numbers requiring support as well as an increase in severity of presentation.

Depression is one of the most commonly experienced health problems experienced by university students claim Davies, Wardlaw, Morriss & Glazebrook (2016). The authors note

that the mean prevalence rate has been estimated at 30.6% and there is evidence that students are more at risk of experiencing depression than peers who are not in HE. Reshmi et al (2012, p.1) stress that 'depression among college students is an escalating problem and has now surpassed substance abuse and alcohol abuse'. Khawaja, Santos, Habibi & Smith (2013) in their cross-cultural study of university students from Australia, Iran and Portugal, report that depression was the most prevalent psychological disorder. Moreover, depression may have serious consequences such as suicide (MacNeela et al, 2012). Indeed, this is a growing concern among clinicians in Ireland (Cannon et al, 2013). The symptoms of depression cause great difficulties for the individual with this condition, and in the case of students in HE this can include attending lectures, forming and maintaining friendships or even coping with day-to-day living (MacNeela et al, 2012). For students in HE depression is manifested through cognitive, emotional and physical symptoms **(**Khawaja et al, 2013**)** with cognitive and emotional dimensions demonstrated by lack of concentration, self-blame, self-dislike, perfectionism, helplessness, hopelessness, sadness and pessimism. Students in a depressed state argue Adalf, Gliksman, Demes & Newton-Taylor (2001) lack motivation and they experience impaired academic performance leading to decreased productivity and missed classes. The authors also report that depression is the main reason for seeking counselling at university counselling centres.

Although going on to HE is deemed to be a significant and positive step in life, the experience can challenge an individual's personal security, physical comfort and ability to enjoy pleasurable activities (Rodgers and Tennison, 2009). Also, Arnett (2000) claims that individuals enter college with a worldview that they have acquired through their childhood and adolescence (and even early adulthood) and the exposure to a variety of different

worldviews can often trigger an examination, and a questioning, of the worldview they held when they first entered college.

In moving into HE individuals need to establish new social support systems and renegotiate relationships with friends and family. Parker, Summerfeldt, Horgan & Majeski (2004) write that university life brings challenges such as managing lifestyle choices and the development of self-care skills and personal independence. The college environment and course content can be threatening and anxiety provoking. Such anxiety provoking experiences are taking exams, completing assignments, public speaking and meeting hundreds or thousands of other students. There is also living in student accommodation and having independence from parents.

Graham et al (2010) in a study which investigated how 'perfectionist concerns' conferred a risk for depression, asked their participants to provide weekly reports about how they perceived their performance as undergraduates. Findings reveal that students who were high in perfectionist concerns (negative reactions to failures, concerns over others' criticisms and expectations, and nagging self-doubts) not only tended to catastrophise their life experiences, they also struggled to accept their life experiences, and found it difficult to articulate a sense of purpose and direction in their lives.

Negovan and Bagara (2011) examined the relationship between self-esteem and vulnerability to depression among high school and first year university students. They report that the tendency to maintain high standards in academic pursuits can lead to greater performance, but is also associated with self-criticism and over-generalisation of failure. The authors suggest that this tendency is a factor that predisposes an individual to depression. Findings suggest that depression was likely to be a reaction to internal processes such as expectations, beliefs and perceptions, as well as external events such as academic or interpersonal demands.

Leahy, Peterson, Wilson, Newbury, Tonkin et al (2010) observe that the initial pressures placed on students in terms of finance, psychological challenges and adjusting to academic life can make depression more likely. Furthermore, the increasing demands and increased academic pressure, as the courses progress and become more complex, can aggravate depression (Khawaja et al, 2103; Mac Neela et al, 2012). It is reasonable to conclude that a lack of motivation to engage with academic work as well as cognitive problems such as lack of concentration, and affective problems, such as a low mood, increase as students progress through the years.

Carton and Goodboy (2015) in their study of student well-being and interaction involvement in class, report that students who are depressed interacted less with others and were less involved in their studies than their peers who were not experiencing depression. Psychological difficulties hinder a student's ability to concentrate in class (Leahy et al, 2010) and place more cognitive demands on a student (Khawaja et al, 2103). A lack of engagement notes Frymur (2005) hampers effective learning, motivation, satisfaction in the course and generally, obtaining higher marks for academic work. Leppink, Lust & Grant (2016) document that students with severe depressive symptoms report worse academic performance, more frequent health problems and less physical activity. In addition, in interactions with their peers, students who experience depression tend to pay more attention to others' behaviours and feelings towards them and tend to report negative evaluations of their social interactions with their class mates (Chow, Berenbaum & Flores, 2013).

Untreated depression can have a significant impact on students' quality of life and affects their educational experience. It can lead to decreased academic productivity and poorer exam results, absenteeism, social isolation and withdrawal from university (Buchanan et al, 2012; Davies, Wardlaw, Morriss & Glazebrook, 2016; Reavley and Jorm, 2010). Depression may

also affect students' acquisition of professional and interpersonal skills, which subsequently may impact their career development.

Psychological stress, especially in the field of health professions, has been investigated systematically since 1981 maintain Prinz, Hertrich, Hirschfelder & de Zwaan (2012) and research has documented high incidences of burn out and depersonalisation. Furthermore, depressive symptoms lead to the reduction of social activities, more social conflict and a withdrawal of support from others. Students on vocational courses such as medicine, nursing and social care may have additional concerns about how mental health problems may impact their career prospects, and may hold expectations that they should continue working when they are unwell (Bond, Jorm, Kitchener & Reavley, 2015). Moreover, it is reasonable to assert that students often put additional pressure on themselves and may be reluctant to appear less than capable to others. Also, the nature of the college environment may influence the level of mental distress considered 'normal'. This combination of factors, argue Davies et al (2016) often influences a student's perceived need for help.

Mowbray et al (2006) outline three primary reasons for the increase in mental health difficulties among students in HE. Firstly, the onset of many mental health difficulties often occur in late adolescence and early adulthood, and this is the time during which many individuals are accessing HE. A second reason is down to improvements in medications and changes in policies towards community-based treatments, which have led to increasing numbers of individuals engaging in community activities such as HE. A third reason is attributed to the number of stressors inherent in attending HE institutions, including leaving home, academic pressure and financial worries, and these can trigger a mental health episode for some vulnerable students.

Academic challenges of under preparation among mature students argue Davis et al (2016) can exacerbate the experience of depression as it is some time since these students have left second level education. Arguably, many HE institutions assume that 'mature students' know how to study and may equate mature students (chronologically) with being mature and thus possess the skills necessary to work independently. For the mature student returning to education there is a constant weighing of costs and benefits (Mac Neela et al, 2012). The mature student is adding college work to their already full life whereas, one may argue, the traditional student is going to college to build a life.

According to American College Health Association's National College Health Assessment II (ACHA-NCHAII, 2011) over 35% of students surveyed were taking medication for depression. They reported that they had felt so depressed during the previous year that it had been exceptionally difficult to function on a day-to-day basis. In further international research Bunting et al (2012) in their study of epidemiological estimates of lifetime disorders across Northern Ireland (based on DSM-IV), provide details that in over 18 year olds, a projected lifetime risk of a disorder was 48.6%, suggesting that mental disorders are prevalent in that Northern Ireland sample.

2.9 Mature Students

The Higher Education Authority in Ireland (HEA.ie) reports an increasing trend in students over the age of 23 years embarking on an undergraduate degree (HEA, 2015). Students over the age of 23years are known as mature students (HEA, 2015) and comprise 15% (or 22,695) of the total population of undergraduate students in Ireland (n=151,300) for the academic year 2014/15. Various pieces of national legislation aimed at increasing participation have been enacted since the mid 1990s. The 1997 Universities Act allowed for more places on

Higher Education (HE) courses and imposed a duty on universities to prepare and implement statements of their policies in respect of access to university education for all. The Equal Status Act (2000), the Disability Act (2005) and the Education for Persons with Special Educational Needs Act (2004) have created a framework for equal access and encouraged participation by under-represented groups.

Mature students can access a Back to Education Allowance (BTEA) (www.studentfinance.ie) and Student Allowance Fund (SAF) (www.studentfinance.ie) and collect social welfare payments (www.gov.ie) so, arguably, going back to education is more appealing, better supported and affordable in recent times. There are also growing trends of individuals in Ireland putting off attending university straight after secondary school and deciding to embark on study in their mid-twenties, or having been employed since leaving secondary school, but now finding themselves unemployed, and now decide to embark on an undergraduate degree**.**

One could argue that mature students appear to encounter a number of unique challenges in balancing education and personal goals with wider familial concerns. While most students enter HE through the CAO route (HEA, 2008) a number enter by means of a direct application or through completion of access courses (HEA, 2008; HEA 2015). The Higher Education Authority (HEA) established a National Office for Equity of Access to Higher Education in 2003, placing a central emphasis on the need to make equality an integral element of the intellectual, cultural, social and economic ethos of higher education (National Office, 2007). Mature or 'second chance' students were included in a strategy mapped out by the Commission on the Points System (1999) to increase the participation of under-represented groups (for example, non-traditional students) in HE. As part of the Points Strategy a target was proposed for each HE institution to set aside at least 15% of full-time

undergraduate places in each faculty or department for mature students and for recognition of entry routes other than through the Leaving Certificate results (Irish State exams taken at 17 or 18 years of age) (HEA, 2008). While access arrangements have increased (HEA, 2015), challenges involved in attending HE do not end once the student has gained entry on to a course. Mature students' needs vary and continue throughout their course.

There are social and psychological challenges such as a job or family commitments and these extra responsibilities may make it very difficult for the student to become involved in social activities. Also, the student may suffer from low self-esteem (Said, Kypri & Bowman, 2013), a sense of not belonging or the need to balance life between two cultures (Dyson and Renk, 2006). In addition, a mature student is less likely to have parental involvement in their educational experiences as well as an increased social maturity. Fleming and Finnegan (2014) report that mature students often study social science degrees or degrees in the humanities rather that professional programmes as there is scope for choice, opinion and meaning making within the course itself. Moreover, as MacNeela et al (2012) observe, choices for HE are different for younger students as mature students are more likely to attend college nearer home and are less likely to live on campus. There may be a focus on obtaining employment at the end of their course, which leads to a different view of their college experience. In addition, mature students bring with them a 'package of experience and values' (Rogers, 2002, p.71) and they enter HE with intentions, expectations about the learning process and their own set of patterns of learning (Lowell, 1979).

Studies such as those conducted by McGivney (1996), Shanahan (2000) and Smithers and Griffin (1986) have reported that many mature students who enter HE suffer from a sense of inadequacy about their perceived lack of academic skills and feel at a disadvantage when they compare themselves with their peers who are younger. Arguably, whilst many mature

students view education as a means to a ‘better life’ it is juxtaposed with the necessity to struggle in terms of financial poverty, time constraints, perceptions of tutor indifference and a sense of marginalisation (Bowl, 2001). Kevern and Webb (2003) in their investigation of women returning to education, note that their sample felt they could not meet the expectations of the standards of university whilst also addressing the needs of their families. The authors reveal that students’ reasons for returning to study were the outcome of a complex set of factors such as improving access to the jobs’ market, enhancing self-esteem or a route out of domesticity. For many mature students, in particular, argue Davies et al (2016) if they have pre-existing negative experience of past education, there may be a strong fear of repeating past failures.

Whilst the aforementioned studies highlight important information about students’ experiences of mental health, most data were gathered through self-reports. Data were drawn from questionnaires and presented findings quantitatively, highlighting trends and patterns, which was the rationale behind the research. In obtaining data in this way, one needs to be mindful of a number of possibilities: the participants may not have a level of self-awareness that makes them able to discern the reasons for their depression or indeed what influences their behaviour; individuals’ responses may reflect social desirability and may reflect the tendency to respond to items independently of their context; participants must choose responses from among a number presented, which ‘reflect’ best fit, rather than reflecting their personal response; responses may be idiosyncratic (reflecting the differences among the group), which can make generalising to ‘themes’ very difficult; individual differences can be hidden among ‘themes’; participants are asked to respond retrospectively, which may generate ‘inaccurate’ responses; and participants rarely get an opportunity to provide additional information unless they are invited for interview.

2.10 Managing Depression

There are a number of approaches to treating and managing depression, and the most common can include antidepressants, counselling and a combination of antidepressants and counselling (Bunting et al, 2012). Antidepressants and cognitive behavioural therapy (CBT) have the most clinical evidence (Richards, Ekes, McMillan, Taylor & Byford, 2016).

Leading health organisations such as the National Institute for Health and Clinical Excellence (NICE, 2009) have recommended that antidepressant medication be considered first-line treatments for moderate to severe depression in adults. Meanwhile, psychotherapy or counselling has been recommended by NICE (2009) for the treatment of mild to moderate depression before the administration of antidepressants because of the relatively high rate of side effects and adverse events associated with them, such as suicide ideation. Some published findings (for example, HSE, 2016) have indicated that antidepressant medications work more quickly in improving patient symptoms than psychotherapy in the initial phases of treatment, while psychotherapy was more efficacious after the initial phases. NICE (2009) recommends that if depressed individuals have demonstrated no response to medication or psychotherapy, combined therapy should be considered and a referral should be made to an appropriate health professional.

It is widely recognised that the efficacy of treatments for depression in clinical practice is constrained by a number of factors such as premature drop out and non-adherence (Kwan, Dimidjian & Rizvi, 2010). Also, the preference that patients have for a given type of treatment for their depression may influence their willingness to begin and complete the course of treatment (Royal College of Surgeons Ireland, 2013). Patient preference according to Corrigan and Salzar (2003) is a predictor of randomised trial recruitment and attrition.

These findings have not, however, examined the relationship between clinical improvement and preference. In addition, attrition rates of treatment are frequently equated with a patient's non-preference for the treatment even though explicit measurement of preference prior to commencement of treatment was frequently not carried out.

2.10.1 Antidepressant Medication

A major consequence of the DSM-III new classification, argue Horwitz and Wakefield (2012, p.213) was to make depression 'a more promising target for the new class of antidepressants'. In the drive for diagnostic purity (Frances, 2013) depression was separated from anxiety, and depression became 'a more favoured diagnosis for distress response' (Horwitz and Wakefield, p. 217). The introduction of Selective Serotonin Reuptake Inhibitors (SSRIs) in the 1990s was considered to be a milestone in the treatment of depression (Kramer, 1993). These drugs were considered safer than the old class of antidepressants (tricyclics) because it was more difficult to overdose on them (Gussamo et al, 2013). Many benefits were attributed to the medication such as increased self-esteem, better social functioning, more energy and better concentration (Kramer, 1993) and they were also found to be efficacious for the anxious individual as often observed in the young adult (Parker and Roy, 2001). These developments coupled with an increase in pharmaceutical advertising led to an increase in the prescription of antidepressant medication (Kramer, 1993). Horwitz and Wakefield (2012, p.215) claim that SSRIs were aimed at selling the disease of depression itself; pushing 'depression is a disease'. It appears, one could argue, that moving away from the age of anxiety (Frances, 2013) into the age of depression reflects that diagnoses are contingent upon altering social circumstances (Horwitz and Wakefield, 2012).

In general terms, antidepressant use has continuously increased in most European countries since the advent of (SSRIs) argue Gusmao et al (2013). The authors also note in their study,

which report data of a period of fifteen years, that there is a continuous growth in the use of antidepressants, with an average annual growth of 19.83%. In addition, there is an increased awareness of the extent of the impact of poor mental health and the increased need for treatment and support in Europe (Gusmao et al, 2013). One could argue that mental health organisations such as AWARE, in Ireland, for example, have contributed to the idea that antidepressants, along with other treatments for depression, are more accessible.

In Ireland in 2013 there were in excess of 1.6 million prescriptions for SSRIs and approximately 700,000 prescriptions for Serotonin noradrenaline reuptake inhibitors (SNRI) dispensed on the Community Drug Scheme (CDS), the General Medical Service (GMS) and the Drug Payment Scheme (DPS) (HSE, 2016). In any month over 110,000 patients are expected to be treated with an SSRI and over 40, 000 patients with an SNRI (Irish College of General Practitioners, 2016). These drug classes represent a considerable cost to the health system; in excess of 55 million euros in 2013. Six SSRIs and two SNRIs are authorised in Ireland. The tolerability of a particular drug is a subjective parameter and can depend very much on an individual patient's experiences. Furthermore, the inter-individual variation in tolerability is not easily predicted by knowledge of the drug's side effects (Taylor, Paton & Kapur, 2012).

Marcus and Olfson (2010) carried out an extensive review of trends in the treatment of depression in USA between the years 1998 and 2007. They report that there was an increase in the use of antidepressant medication and a decline in the use of psychotherapy. They argue that the trends reflect the introduction and promotion of SSRIs and other newer antidepressants, publication and guidelines to diagnose and treat depression and more adequate screening tools for depression in primary care. However, closer inspection of the data reveal that falling use of psychotherapy was seen in individuals aged 35 to 49 years and

who had had fewer than 12 years of education and/or were unemployed. It was not clear, nevertheless, whether declining numbers of patients availing of psychotherapy was due to individual preferences for antidepressant medication or difficulties with access to psychotherapy (for example, few available psychotherapists or ability to pay). It has been recognised (for example, Corrigan and Salzer, 2003; Hollon, Thase & Markowitz, 2002; Kwan, Dimidjian & Rizvi, 2010) that antidepressant medication in combination with psychotherapy tends to be associated with greater improvement of depression than medication on its own.

Whilst antidepressants can be efficacious, as demonstrated in RCTs when compared with placebo for major depressive disorder (Gatzche, 2014), it can be argued that their positive effects are over-estimated (Horwitz and Wakefield (2012). Also, clinically significant differences in efficacy are for severe cases of depression (Naudet and Falissard, 2014). Individuals in a 'real-life' setting are not the typical patients in a RCT claim Gatzche (2014) as their symptoms are often less severe, and as Frances (2013) points out, patients may present with a number of somatic and psychiatric comorbidities and do not meet the criteria for a major depressive disorder. Hence, there are implications for translating antidepressant efficacy, established in optimal circumstances (RCT), to a 'real-life' setting.

2.10.2 Psychological Therapies

Antidepressant medications are expensive, their use is limited by poor side effects, poor patient adherence and discontinuation relapse risk (Amrick, Gartleher & Gaynes, 2015). Findings suggest that psychotherapy (specifically cognitive therapy) has more enduring effects compared with pharmacotherapy (Abbas and Dreissen, 2010). However, Steinert, Hofmann, Kruse & Leichsenrich (2014) argue that long-term effects of psychotherapy for depression are not well studied and largely unknown.

Cuijpers, Berking, Anderson, Quigley, Kleiber & Dobson (2013) reason that there is evidence from a large number of randomised controlled trials (RCTs) that psychotherapy is effective in depressive disorders, resulting in moderate to large effects. Psychotherapeutic treatments such as Cognitive Behavioural Therapy (CBT), psychodynamic psychotherapy and interpersonal therapy are equally effective in the treatment of depression (Barth, Munder, Gerger, Nuesch, Trelle & Znj, 2013). However, it must be pointed out that these meta-analytic outcomes refer to short to medium term effectiveness and the number of trials investigating long term effects of psychotherapy is small. This may be because of the methodology used: studies with long follow up durations are more expensive and time consuming than pre-post trial or trials with shorter follow ups. In addition, attrition rates can be high coupled with confounding variables such as additional or alternative treatment during follow up, which are difficult to control for and can influence outcome.

Steinert et al (2014) argue that CBT is as effective as antidepressants and can provide long-term protection against relapse. However, the efficacy of the treatment depends on the skills of the therapists, who are expensive to train and employ (Amrick et al, 2015). The precise combination of cognitive and behavioural techniques will depend on a patient's skill as well as the therapist's skill (Freeman and Oster, 1999). The level of depression and the treatment goals can also affect the efficacy of CBT. Cognitive therapists are directive, active and use psychoeducation as part of the process (Amrick et al, 2015). As the process is collaborative, it is suggested that individuals with poor cognitive functioning may not respond well to CBT.

One potential alternative to CBT is Behavioural Activation (BA), which is a simple psychological treatment for depression (Amrick et al, 2015; Richards, Ekes, McMillan, Taylor & Byford, 2016; Steinert et al, 2014). Specific BA techniques include identification of depressed behaviours, analysis of triggers and consequences of depressed behaviours,

monitoring of activities, development of alternative goal-oriented behaviours and development of alternative behavioural responses to rumination. Individuals are asked to use cognitive and behavioural exercises to test, specifically, the accuracy of their beliefs that lead them to emotional distress and ineffectual coping (Amrick et al, 2015). Individuals monitor their moods and activities, plan exercises to assess negative beliefs and keep a thought diary to identify and examine the accuracy of underlying beliefs and negative automatic thoughts. Richards et al (2016), using independent raters, found that BA for depression was not inferior to CBT in terms of reduction of depression symptoms and was more cost-effective.

Interpersonal therapy (IPT) or CBT is often recommended for depression (Cuijpers, Geraedts, van Oppen, Markowitz & van Straten, 2011). IPT is a structured, time limited psychological intervention based on interpersonal theory (Bowlby, 1982; Meyer, 1957; Sullivan, 1953). It is specifically developed for the treatment of depression. It was seen to be as equally effective as CBT (Richards et al, 2016) in the treatment of depression, although the number of studies was small. IPT uses a medical model to understand depression write Freeman and Oster (1999) and it uses DSM criteria for both diagnosis and treatment, with diagnosis remaining a categorising aspect of IPT. As discussed earlier, the efficacy or usefulness of a diagnosis and the individual's capacity to describe their symptoms are matters for debate. IPT was devised as a research tool (Freeman and Oster, 1999) so its structure, such as the duration of the therapy, reflects its aim, which was to provide time-limited therapy that could specifically address depression (Klerman and Weissman, 1993). However, individuals with severe 'social dysfunction' (Freeman and Oster, 1999, p.144) may not benefit from IPT as it developed out of a theoretical belief of a mutual connection between life events (relationships) and mood (Klerman and Weissmen, 1993). Patients with poor social support may view the therapist as a substitution for the lack of others in their life, and this may impact the patient's self-

awareness in relation to their own capacity to establish relationships. As the therapy is time limited, missed appointments and the patient remaining silent, or avoiding topics, will impact the therapy. Both IPT and CBT are the only types of psychotherapy for depression that have been compared with control groups, other psychotherapies, antidepressant medications, and combination treatments (Cuijpers et al, 2011). Medication and psychotherapies work by different mechanisms and generally relieve symptoms in different temporal patterns. Pharmacotherapy, while recognised as having greater efficacy than IPT (Richards et al, 2016), may have limited benefit in situations such as complicated grief, where IPT can be extremely efficacious.

Phillips et al (2010) stress that current psychotherapies for depression focus on changing negative beliefs, interpersonal functioning, coping skills and emotional engagement. The most widely used intervention, cognitive therapy (CT) is based on the premise that modifying existing negative beliefs will rupture habitual cognitive cycles associated with depression (Beck et al, 1979). This general approach is supported by the findings that negative interpretation and self-beliefs were stronger predictors of depression than negative biases in attention, memory or self-esteem. However, relapse or recurrence rates following CT can be as high as 73% for certain patient groups (Richards et al, 2016). Therapies aim to alter conscious expectations, which could trigger corrective explicit processing in response to negative implicit output (Beck et al, 1979). Evidence suggests that the efficacy of CT is determined by how much it (indirectly) increases an individual's metacognitive awareness of their implicit responses; and that low levels of awareness predict susceptibility to relapse (Richards et al, 2016). To this end, according to Phillips et al (2010) Mindfulness Based Cognitive Therapy (MBCT) (Zegal, Williams & Teasdale, 2002) not only assists recovered depressed individuals to maintain positive conscious expectations, but also aims to increase,

directly, metacognitive awareness by training individuals to monitor their implicit responses. When vulnerable individuals become consciously aware of their explicit goals, that awareness should trigger corrective explicit processing. Mindfulness has been described as a form of participant-observation (Hofmann, Grossman & Hinton, 2011). It is characterised by moment-to-moment awareness of perceptible mental states and processes that includes continuous, immediate awareness of physical sensations, perceptions and effective thoughts. (Kabat-Zinn, 2003).

Hofmann, Sawyer & Witt (2010) argue that mindfulness based therapy (MBT) is a beneficial intervention to reduce negative psychological states such as stress, anxiety and depression. The authors identified thirty-nine studies with a total of 1140 participants who received MBT for a range of conditions including cancer, generalised anxiety disorder and depression. Effect size was robust and unrelated to the number of treatment sessions. Moreover, the treatment effects were maintained over the follow-up. Other therapies that are mindfulness-based are Compassion Meditation (CM), which involves techniques to cultivate compassion or deep sympathy (Hopkins, 2001), and Loving-Kindness Meditation (LKM), which refers to a mental state of unselfish and unconditional kindness to all beings (e.g. Kabat-Zinn, 2003). These approaches require that the individual engages in the imagining or actual experience of an emotional state as an object of attention or mindful awareness (Hofmann et al, 2010). The meditation exercises are believed to enhance attention, augment positive emotions and lessen negative states, while increasing empathy and compassion (Hopkins, 2001). The individual, through daily experiences of positive emotions, may, in turn, increase personal resources that engender positive consequences for the individual's mental health. The state of self-compassion, which is reasonable to assert, is difficult for a lot of individuals to reach, involves generating the desire to alleviate one's suffering, healing oneself with kindness and

being mindful when considering negative aspects of oneself (Neff, 2003; Neff and Vonk, 2009).

A number of studies conducted with undergraduate student populations, using self-reports to measure self-compassion, noted that individuals with high levels of self-compassion reported less negative emotion when faced with real, imagined or recalled negative events (Leary, Tate, Adams, Allen & Hancock, 2007). Participants were also more willing to take responsibility for negative events and were less likely to ruminate about unpleasant events compared with individuals who were low in self-compassion. Meditation practices, especially mindfulness mediation, have become a popular enhancement to contemporary cognitive-behavioural treatments (Hofmann et al, 2011). Encouraging individuals to experience the present moment, non-judgementally and openly, can effectively counter the effects of psychological distress (Kabat-Zinn, 2003).

In psychoanalytic therapy the therapeutic relationship is used to explore and resolve unconscious conflict through transference and interpretation (Cooper, 2012) with the development of insight on the part of the client. Psychodynamic therapy sessions are open-ended and are based on a process of 'free association' (a client responds spontaneously to a word spoken by the therapist, which then may trigger some previously unstated thoughts or feelings) (Cooper, 2017).

In working with depressed individuals, psychoanalytically, regard is given to areas of personal functioning in relation to others who were, or are, emotionally significant in the individual's life. In depression, feelings of anger, disappointment, criticism, neglect, love, for example, are turned inwards in ways that cause suffering for the individual (Freedheim, 1993). This can be observed in the individual's communication patterns. When the individual

'makes contact' with these feelings, the journey of recovery can start, and the depressive symptoms tend to abate (Jacobs, 1994).

One of the original aims of psychoanalytic approaches to therapy was, and still is, to make the unconscious conscious (Bemporad and Vasile, 1999), and in so doing, help the individual to act with more conscious awareness so that they can stabilise the common conflicting demands of a conscience (which is not always negative) and the external demands of the situation (Eagle and Wolitzky, 1993). There may be problems working with resistance as some clients will not, or cannot, talk freely because they are afraid of what may emerge (Jacobs, 1994). The suitability of an individual for psychodynamic psychotherapy rests on the ability of the individual to sustain a therapeutic alliance (Bemporad and Vasile, 1999), and use transference constructively in order to gain insight. The individual needs to be able to examine current relationships, including the therapist-patient relationship in psychotherapy (Eagle and Wolitzky, 1993) as well as the transference relationship and past relationships. If a client remains preoccupied with their initial presenting concerns then, arguably, they will have difficulty in benefitting from the psychodynamic approach as they will be unable to examine other facets of themselves. Bemporad and Vasile (1999) caution that psychodynamic psychotherapy is not suitable for individuals who do not possess sufficient cognitive and emotional capacities to engage in the process. A client who has seen numerous therapists before and only stayed a short time with them, argues Jacobs (1994), is also likely to repeat this in psychodynamic counselling.

Counselling for Depression (CfD) is a model of psychological therapy recommended by NICE (2009) for the treatment of depression and approved delivery within the Improving Access to Psychological Therapy Programme (IAPT). It is one of the therapies recommended in addition to cognitive behavioural therapy (CBT). It is based on a humanistic, experiential

model and is particularly appropriate for individuals with mild to moderate depression. In the humanistic approach to therapy there is the creation of an environment which facilitates client insight, leading to acceptance, change and personal growth, leading to the possibility of diminished depressive symptoms (Rogers, 1951). Rogers regarded a set of facilitative conditions such as empathy, genuineness, and unconditional positive regard as essential conditions for beneficial therapeutic change. It is reasonable to assert that the management of the relationship may be considered to be a technique in itself. By engaging in a relationship with a therapist, an individual is able to internalise and incorporate (introject) their relationship, which serves to replace the earlier maladaptive introjections (Hersen and Bellack, 1999). Rogers regarded psychological diagnoses, such as depression, as being unhelpful as labelling 'something' 'places evaluation in the hands of experts' (Dryden and Mytton, 1999, p.77). This will not help clients in taking responsibility for their own self-awareness. Whilst being empathic is important in therapy, Dryden and Mytton (1999, p.82) caution that therapists can sometimes experience similar feelings to the client so the person-centred therapist needs to feel secure in their own identity so as 'not to get lost as they move into their clients' worlds'.

In existential-humanistic therapy the client is a freely-choosing individual who is self-aware and meaning-oriented, and the aim of the approach is to help the client identify and overcome their resistances (a barrier to living life fully) (van Deurzen, 2012). These approaches require the individual to be able to reflect on their experiences and be willing to engage fully with the therapist in order to bring about change in their lives. The goal of existential therapy is to enable clients to come to terms with their past and present, and to reflect on their values and beliefs in their search for clarity on what they see as their purpose in life. The aim of the meaning-centred therapies is to help the client out of their 'existential vacuums' and find

meaning and purpose (Cooper, 2017, p.69). Importantly, this meaning is not something to be created, but to be discovered, and this can come about through therapy. Thus, it is argued that, each individual has things in their life that are intuitively meaningful to them, but are at an unconscious level. Therefore, the role of therapy is to assist the individual in bringing to light these feelings. Van Deurzen (2011, p.213) argues that therapists, working existentially, can help individuals 'to understand their motivations' and that it is important to help them 'to be themselves' as well as to find meaning in their lives. One could argue that existential therapy is suitable for individuals who feel alienated from society's expectations and for those who are facing adversity or changes in their personal circumstances. A limitation of the approach lies in the lack of emphasis on the illness-health dimension (van Deurzen, 2011) so individuals who are searching for a 'direct way' to relieve their specific symptoms are less likely to find the approach suitable.

Primary care physicians have emerged as the predominant mental health care providers insofar as diagnosing and treating depression, with the majority of patients with mood disorders receiving treatment in a primary care setting (Royal College of Surgeons, 2003; Wolf and Hopko, 2008). Sherbourne, Schoenbaum, Wells & Croghan (2004) maintain that in spite of primary care interventions for patients significantly reducing symptoms in 50% of patients, other studies such as Friedman, Conwell & Delavan (2007) and Croyle and Rowland (2003) highlight that as many as two-thirds of patients can remain symptomatic at long-term follow-up. In addition, Lesser, Coyne, Thompson, Klinkman & Nease (2002) report that the quality of care for depression is moderate to low. Whilst evidence-based reviews of treatment and management of depression within primary care settings have been conducted, Wolfe and Hopko (2008) draw attention to the fact that most studies are relevant to a subgroup of patients, such as older adults. Studies have reported findings from a wide range of

assessment measures and patient samples such as self-reported depression, mild or major depression, are often with older patients.

In Ireland, local services, as traditionally existed, are underfunded as a result of an economic recession, leaving General Practitioners (GPs) with few options. This is coupled with patients' expectations that a pill should be prescribed (Cannon et al, 2013). For patients experiencing depression, Counselling in Primary Care (CIPC) offer six to eight sessions with a psychotherapist or counsellor (HSE, 2016). There is often at least a six month waiting list, which can be compounded by patients not being available to take up appointments at any time, for example, only being available at 4pm on a Monday. In the absence of a full range of psychotherapy and counselling services, many medicines intended for moderate to severe psychiatric disorders are being prescribed for less severe symptoms (Reshmi et al, 2012).

2.10.3 Managing Depression Among the Student Population

While mental health issues in the public domain are resourced by community facilities (HSE, 2016) student support services in HE are often the first point of access (Richards and Timaluk, 2013) and consequently the primary care resource accessed by students in HE. Student support services also provide a necessary support link for students with mental health difficulties who require some time out of education or who wish to re-enter HE institutions following a period of absence (private correspondence, Rashleigh, TCD, April 2017). Although counselling is available for many students, misconceptions about treatment with a therapist may prevent individuals from using student counselling services (Richards and Timaluk, 2013). Some studies, such as that carried out by Aggarwal (2012), have explored students' attitudes towards people with mental ill-health. In this study students in a college of further education were surveyed and interviewed about their feelings about mental health. The results reveal that prejudices and stereotypes of individuals with mental health exist

among the sample population. Participants who had depression stated that they experienced classmates talking negatively about people with mental health problems and, as a consequence, they were reluctant to participate in group activities and class discussions. Participants believed that their non-participation had a negative impact on their learning. They also reported that they were less likely to seek professional help for fear of other students' comments.

According to medical guidelines (HSE, 2016) the treatment of depression and anxiety should ideally involve several modalities including medication, psychotherapy and psychosocial interventions, such as problem solving. As discussed earlier, some research has shown that, in the early stages, antidepressants work more quickly than counselling, while counselling is efficacious after the initial phases (Corrigan and Salzar, 2003; Kwan et al, 2010; Wittchen et al,1998). Davis-Berman and Pestelo (2005) interviewed social work students and practitioners who were taking medication for psychiatric problems. The younger students saw their medication as signalling that they were 'disordered' as the professionals were now involved. This was seen as a positive step in managing their depression as they now 'realised' that there was something wrong with them and it could be 'treated'. However, the older students reported that they had put off going to the medical doctor for as long as they could and saw taking medication as 'giving in'.

One can argue that for students, who have very busy lives and who are working to deadlines, and often live 'off campus', a 'treatment' which could expedite 'feeling better' would be attractive. Side effects of antidepressants are well documented, and include restlessness, sleep disturbance, social disinhibition (Martin et al, 2004; Offidani et al, 2013) as well as nausea, fatigue, sexual dysfunction and weight gain (Masand et al, 2002; Papakos, 2008). I would assert that while there are well known side effects to taking antidepressant medication, for a

student in HE, who is busy trying to manage academic workloads, social activities and demands of friends and family, and for whom making time for appointments to see a counsellor regularly may be difficult, medication may well be the chosen treatment for the initial management of depression.

A study for Progression in Irish Higher Education 2012/13 to 2013/14 (HEA Jan 2016), which drew on data from six HE institutions, documented that 6% of the general student population attend student counselling services. However, the rate of mature students attending the services at 12% is disproportionately higher than attendance from the general student body. Due to the fact that enrolment figures were smaller in some participating HE institutions than others, data across the six participating institutions are presented anonymously in order to ensure the confidentiality of students accessing counselling services. In four of the six institutions mature students represented a higher percentage of students attending counselling services than their overall representation amongst the full-time, undergraduate student population. For example, in one institution, mature students made up 4% of total full-time undergraduate population, but comprised 19% of students attending counselling services in that institution. In another institution, mature students made up 13% of the student population, but comprised 35% of the students attending counselling services in that institution.

It was suggested that mature students may attend more frequently than their younger peers because they are more willing to seek out support services, or that life circumstances and demands placed on them during their time in HE are such that their need for counselling may be greater than that of their younger peers (private correspondence, Rashleigh, TCD, April 2017). Mature students attend counselling for a variety of reasons including family issues, personal concerns such as self-esteem, confidence, depression and stress (HEA, 2008). The

first year experience, according to The Irish Survey of Student Engagement (HEA, 2015), can often trigger depression among mature students, among other mental health issues, because of reflecting on negative school experience, early school leaving, financial commitments, juggling demands of the family and study, feeling different to younger student peers and needing support from the family. Moreover, mature students reported higher scores for academic challenge and were less likely to work collaboratively with their peers. However, mature students also maintained that they had a feeling of a sense of personal satisfaction in pursuing educational ambitions (HEA, 2015).

CBT, which has been discussed earlier, is an established treatment for depression and many students would avail of it if it were available argue Richards and Timulak (2013). However, in Ireland there are barriers to accessing the support including a shortage of trained professionals, waiting lists and costs (Kohn, Saxena, Levav & Gega, 2004). The delivery of CBT programmes provided through the internet is one attempt to overcome such barriers to access (Richard and Richardson, 2012). Richards and Timulak (2013) in their analysis of online cognitive-behavioural interventions for the symptoms of depression in a student population, maintain that CBT can be delivered effectively on-line (eCBT). Richard and Richardson (2012) also document the efficacy of online interventions, both supported and unsupported by therapists or trained staff.

Many counselling psychologists work in university counselling services and with more mature students attending third level for the first time, an awareness of the impact of depression on the individual's sense of self as a student as well as the impact of depression on an individual's ability to manage their academic work is highly relevant. In addition, many trainee counselling psychologists are 'mature' students and an awareness of their own mental health in their pursuit of their academic qualification is also highly pertinent.

Reshmi et al (2012, p.2) reason that as there is so much variation in the understanding and treatment of depression and its problems, that 'it cannot be really understood at the system level'. Moreover, while many studies inform us about how depression is disabling for the individual and the side effects of medication taken to manage depression, the research does not get sufficiently close to helping us to understand depression in context (Smith and Rhode, 2015) or the highly personal experience of the illness. It is efficacious to investigate a particular population in an attempt to understand individuals' experiences of depression. In doing so, it is necessary to focus on a specific group. I would argue that this project, which sets out to examine the under researched area of mature students' experiences, would make a valuable contribution to understanding the lived-world of being a mature undergraduate student, with a diagnosis of depression. Health psychology is asserting that while the aetiology of an illness is important so is the psychosocial experience of that illness (Ogden, 2002). The role of the individual's beliefs and personal experience of the illness is crucial in understanding the nature and impact of the illness.

2.11 Research Question

The research question to be addressed is:

What is it like to be a mature undergraduate student with depression?

Based on the outlined rationale, pertinent literature in the area, and the research question, I identified four specific areas that I wanted participants to talk about in the interview:

1. How do you make sense of your depression?

2. How do you perceive depression affecting your experience of higher education?

3. How do you manage your studies with depression?

4. What is your sense of self as a student?

2.12 Chapter Summary

In this chapter I have examined research that has been carried out in order to explain depression. I have also inspected the area of depression among the student population, with additional focus on mature students in Higher Education (HE) (over twenty-three years of age). There was also a discussion of treatments and approaches used to manage depression. The chapter concluded with the Research Question, which is grounded in the aims of the study and in relevant literature in the area of depression and students in HE.

Chapter 3 Methodology

This chapter provides a discussion of Interpretative Phenomenological Analysis (IPA) as a research method, followed by a description of participant recruitment, data collection and analysis. Before discussing IPA there is a presentation of its epistemological and ontological roots.

3.1 Design

This study utilised a qualitative research design comprising semi-structured interviews to collect data. The qualitative approach taken to structure the design and analysis was Interpretative Phenomenological Analysis.

3.2 Different Views of Social Reality

The theoretical perspectives that have influenced the structure, purpose and direction of social research are many and diverse. However, three paradigms (perspectives) are most dominant. They provide a theoretical basis for the methodologies employed by researchers in the social sciences. These are 'positivism, interpretive social science and critical theory' (Sarantakos, 1998, p. 35). Epistemological positions taken up by qualitative researchers commonly range from radical relativist to naïve realist (Willig, 2008).

3.2.1 Epistemology

Epistemology is concerned with the relationship between the inquirer and the known. It is about the ethical or moral stance held by the researcher towards the world. Epistemological assumptions are concerned with the very bases of knowledge – its nature and forms, and how it can be acquired and communicated to other human beings (Cohen, Manion and Morrison, 2000). Hughes (1990, p.5) asserts that 'epistemological questions are questions among other

things about what are to count as facts.' For a social scientist, epistemological issues are to do with what is considered 'appropriate knowledge' about the social world.

Positivist researchers subscribe to the view that knowledge is objective and tangible. From a positivist viewpoint objects in the world have meaning prior to, and independently of, any consciousness of them. The worldview of positivists is one of absolute principles and constancies. This stands in contrast to the uncertain and ambiguous world which individuals experience at first hand (Crotty, 1998). Positivism is linked with the work of Comte (1798 – 1857) and was expanded by other theorists either of the same school, but a different branch (for example, logical positivism) or from another school of thought (for example, functionalism) (Sarantakos, 1998). Positivism entails an epistemological position that seeks 'to apply the natural science model of research to investigations of social phenomena' (Denscombe, 2002, p.14). Positivism defines reality as everything that can be perceived through the senses. Reality is 'out there', independent of human consciousness. It is objective and is governed by strict, natural and unchangeable laws (Sarantakos, 1998). For positivists, human beings are rational individuals who are governed by social laws. Their behaviour is learned through observation and governed by external causes that provide the same results (Sarantakos, 1998).

Interpretivism has emerged as an approach that rejects some of the basic premises of positivism (Denscombe, 2002). It is concerned with understanding the subjective world of human experience. Cohen, Manion and Morrison (2000, p.22) argue that 'to retain the integrity of the phenomena being investigated, efforts are made to get inside the person and to understand from within.' Interpretive theorists believe that the social actors, through assigning meaning systems to events, create reality and the social world (Sarantakos, 1998).

Denscombe (2002, p.18) argues that 'interpretivists view the social world as a social creation constructed in the minds of people and reinforced through their interactions with others'. Research helps to interpret and understand the social actors' reasons for their social actions. Research also helps to understand the way individuals conduct their lives and the meanings they attach to their actions.

A researcher taking up a relativist position argues that 'pure experience' does not exist and that the best we can do is to explore the ways in which culture and discursive practices are facilitated in order to construct different versions of reality (Bryman, 2001). This task requires using methods that can identify and unpack such resources, whilst staying alert to tensions and variations in different accounts of reality (Willig, 2008). The extreme relativist approach was considered unsuitable for the research reported here as an individual's account provides the researcher with information about their experience of *their* reality and not one solely created by language (Maxwell, 2005) in spite of the participant's description of their experience being mediated through culture and language (Pilgrim and Rogers, 1997). The aim of the research reported here is to inspect how participants make sense of their experiences, which are real to them, rather than how they put together such experiences. The realist position considers that data collected ought to give researchers information about the world and about how things really are, so methods are devised to capture these representations (Willig, 2008). A researcher adopting a realist approach would view reality as independent of the senses (Maxwell, 2005) but is still available to the researcher's theoretical beliefs and tools (Sayer, 1992). Essentially, there is a real world with which we can interact and to which our concepts and theories refer. A realist approach to research recognises the importance of meaning as well as the behavioural and physical phenomena in the explanations and interpretations of our understanding (Finlay, 2006). The extreme realist

approach was dismissed as suitable for this study as it posits that although actions occur in reality, they cannot be described truthfully by individuals on account of their subjective experiences of reality. In addition, it would be impossible for me, as a researcher, not to hold my own perspective on the participants' accounts. There is a number of epistemological positions in-between the realist and the relativist perspectives on the continuum. These include a perspective that combines the realist aim of getting a better understanding of what is 'really going on in the world' (Willig, 2008, p.12) with an acknowledgement that the data the researcher collects may not provide direct access to reality (Maxwell, 2005). This epistemological position is critical realism (Bhasker, 1975). Critical realism suggests that because phenomena are subjective they depend on the beliefs and expectations of the individual (Finlay, 2009). The study reported here is grounded in critical realism.

Another in-between perspective takes the view that experience is always the product of an individual's interpretation and therefore it is constructed rather than determined (Willig, 2008). This world is 'real' to the individual who is experiencing it. Such an epistemological position is that of phenomenology.

Phenomenology sees behaviour 'as determined by the phenomena of experience, rather than by external, objective reality' (Cohen, Manion and Morrison, 2000, p.23). According to Bryman (2001) one of the main intellectual traditions that has been responsible for the anti – positivist position has been phenomenology. He argues that 'it is concerned with the question of how individuals make sense of the world around them and how, in particular, the philosopher should bracket out preconceptions in his or her grasp of that world' (Bryman, 2001, p.14). Phenomenologists tend to emphasise the role of the social scientist in gaining access to people's common – sense thinking. Their aim is to interpret individuals' actions from their point of view.

3.2.2 Ontology

Ontological issues are concerned with the very nature of the social phenomena being investigated. Epistemology asks 'How do we know?' and ontology asks 'What is there to know?' In the following section there is a discussion of the ontological issues of objectivism, constructionism/constructivism and realism.

Questions of social ontology are concerned with whether the reality to be investigated is an objective (out there) entity which is external to the individual, or, alternatively, is a product of an individual's consciousness. These two positions are frequently referred to as objectivism and constructionism/constructivism.

Bryman (2001) provides an example of the position of objectivism. He suggests that it is possible to discuss an organisation as a tangible object. It has rules and regulations, and standard procedures for getting things done. An organisation considered in this way has a reality that is external to the individuals who inhabit it and has the characteristics of an object. Hence, it has an objective reality (Bryman, 2001).

Constructionism is an alternative ontological position to objectivism.[1] The position constructionists take is that instead of adopting the view that order in an organisation is a pre – existing characteristic, they argue that it is worked at by the individuals who inhabit it. The categories that people employ in helping to understand the natural and social world are social products. Their meaning is constructed in and through social interaction (Bryman, 2001). Research from a social constructionist perspective is concerned with the numerous ways in

[1]Crotty (1998, p.58) distinguishes between constructionism and constructivism. He uses the term *constructivism* for epistemological considerations focusing solely on 'the meaning making activity of the human mind'. He uses the term *constructionism* where the focus includes the 'collective generation [and transmission] of meaning'. This in itself is subject to debate because there is a further distinction between individual and social constructivism.

which individuals construct social reality, which are available in a culture (Willig, 2008). According to Robson (2002) constructivist researchers have difficulties with the notion of an objective reality which can be known. They consider the task of the researcher is to understand the multiple social constructions of meaning and knowledge. Hence, they tend to use observations and interviews which would provide numerous perspectives. Realism, which is an ontological notion asserting that realities exist outside the mind, is often taken to imply objectivism (Crotty, 1998). A realist ontology posits that the world is made up of structures and objects that have a cause and effect relationship with one another (Maxwell, 2005). Critical realism acknowledges that there is a real world that exists independently of our theories, constructions and that we experience sensations and perceptions of this world (Sayer, 1992).

The research reported here is concerned with inspecting the unique lived experiences of a group of individuals in a specific setting. I acknowledge that my lived experience as a researcher will play a part in the production of the findings. Thus, the study employs a critical realist stance (Maxwell, 2005) which acknowledges that an individual's reality is *their* reality but also recognises that knowledge does not come about in isolation (Willig, 2008). The accounts participants produce are their personal, interpreted experiences, and as such I acknowledge the subjective nature involved in understanding meaning.

Cresswell (2013) argues that researchers employ qualitative approaches in order to emphasise the researcher's role as an active learner, who can tell the story from the participants' viewpoints, rather than as an 'expert' who can pass judgement on participants. Essentially, we use a tradition of enquiry in which the researcher identifies, studies and employs one or more tradition of enquiry.

Cresswell (2013) discusses the five main theoretical approaches to qualitative research. These are: biography/life history, grounded theory, ethnography, case study and phenomenology. Taking each one in turn I will outline why four of the five methodologies were rejected as the most pertinent approach for this study. My focus is on the lived experiences of individuals, and importantly, their interpretation and expression of such personal experiences. Biography aims to capture the life of an individual. In this instance, the researcher has to make a strong case for studying this particular individual. Data are collected from historical and present day sources such as material/print information, conversations and observations. This is not what I set out to investigate. If I had taken a grounded theory approach then I would be aiming to construct a theory, which I would develop and refine in moving from the field to theory and back again. Grounded theory works from the premise that there is something to be discovered and this will come to light from the exploratory process (Willig 2008). The aim of my research is not to generate a theory, but to investigate the subjective and interpreted accounts of the experiences of a small number of participants.

If I had utilised an ethnographical approach then I would be collecting documents, observing and interviewing my participants. I would aim to provide a detailed account of their lives and I would be paying specific attention to cultural aspects of their accounts. In taking a case study approach I would be collecting a wide array of information and I would spend considerable time describing the context and setting for the case. None of these four approaches would provide necessary focus on the phenomenon under investigation, which is the lived experience of studying for a degree with depression. My aim is 'to get to' the meaning of such experiences for the individual, and this requires staying very close to their accounts. For such an endeavour, a phenomenological stance on data collection and analysis is most suitable. Moreover, the research methodology I use should be congruent with my

values, epistemological beliefs and ways of being. I understand that the meanings generated during data collection and analyses are not the unmediated expression of personal experience, but an account of embodied, culturally influenced experience produced in a specific socio-historical and political context.

Narrative analysis, which is concerned with the narratives that individuals construct in order to bring meaning to a world that is always changing (Murray, 2008) has a strong intellectual link with IPA (Smith, Flowers and Larkin, 2010). It was also considered unsuitable for this study as its application to psychological studies is relatively new whereas IPA is utilised readily and frequently in psychological research. Workshops and training in IPA were also available to the researcher so, in all, it was considered the most appropriate methodology for the nature of the study.

3.3 Phenomenology

Several commentators of phenomenological research (e.g. Dowling, 2004; Flood, 2010; Koch,1999) have highlighted difficulties with the approach inasmuch as some studies have lacked theoretical rigour by failing to elucidate epistemological and ontological underpinnings of the chosen phenomenological approach. In the following section I will outline the phenomenological approach, with the aim of describing how it has helped to shape the methodology underpinning this study.

Phenomenology, which has its roots in Husserl (1859-1938) and later philosophical discussion by Heidegger, Sartre and Merleau-Ponty (Speigelberg, 1982), set out to develop a scientific method, which would aim to reveal the essential structures (or essences) of phenomena. This approach has been utilised in psychology (e.g. Giorgi, 1985). Smith et al, (2010) draw attention to the founding principle of phenomenological enquiry, which is that

experience should be examined in the way in which it occurs and in its own terms. Husserl was interested in how individuals come to know their own experience of a given phenomenon (van Deurzen, 2010). In the case of the study reported here, the phenomenon under enquiry is that of students' own expressions of their experiences. In examining such a phenomenon, in detail, the essential qualities of that experience may be illuminated (Finlay, 2009). Smith et al (2010) highlight that, in the process of shedding light on such an experience for themselves, individuals might be doing it for others, also.

The phenomenological approach has been developed and modified over time and has now emerged as a diverse epistemological and ontological field of enquiry (Finlay, 2009). Two main fields of phenomenology have emerged (Pringle, Hendry and McLafferty, 2011): descriptive, which is based on Husserl's writings; and hermeneutic or interpretive, which was fostered by Heidegger, Gadamer and Ricouer. Husserl set out to describe universal structures/essences, which are shared by individuals who have a lived experience of the phenomena. Husserl believed that the impact of context could be bracketed through various methods, which would allow us 'to return to the thing itself'. Moreover, in such a phenomenological approach to enquiry it is important to suspend all judgements and presuppositions about what is real (Cresswell, 2013).

In adopting a phenomenological attitude to experiences, we need to step outside our everyday experiences and engage in reflexivity in our turning away from observing objects in the world to turning inward towards examining our perception of these objects. It is through a process of eidetic reduction that we have to move to the essence, or the properties lying underneath our subjective interpretation of the object (Finlay, 2009). In doing so, we consider the different possible instances of the object, with the aim of establishing the essential features of the object.

Husserl's phenomenological stance is not without criticism (Smith et al, 2010). Husserl was a philosopher, not a psychologist and, as such, most of his texts about the process of phenomenology were conceptual, and his ideas were concerned with generic processes.

Heidegger, however, argued that individuals are always embedded in lived experiences, and thus, the context can never be bracketed out. For Heidegger, 'phenomenological reduction means leading phenomenological vision back from the apprehension of the thing…to the understanding of the being of this being' (Kakkori, 2009, p.21). Every encounter between individuals requires an interpretation, which is influenced by the individuals' social, cultural and historical contexts. Thus, understanding for Heidegger is not about establishing the 'essence' of the lived experience, but becoming cognisant of the interpretive influences. Essentially, this is 'the being of this being' (Smith et al, 2010). For Heidegger, human beings are 'thrown into' a world of objects, relationships and language (Finlay, 2009), and as such, are always in-relation-to-something (van Deurzen and Adams, 2011). In taking a Heideggerian stance (1962/1927, p.192) the researcher brings their own fore-conception to the encounter and thus, cannot help but look at any new stimulus through the lens of their own experience (Smith et al, 2010). Thus, we should be careful that, in interpretation, priority should be afforded to the new object under discussion, rather than our preconceptions. In so doing, researchers make sense of these fore-structures in terms of the things themselves (Creswell, 2013).

The research methodologies defining themselves as phenomenological are not easily divided into descriptive and interpretive (Pringle et al, 2011) and, at best, exist along a continuum (Finlay, 2011). The position adopted by the researcher is governed by the stance taken in regard to the position of the researcher, data collection methods and analyses. These

considerations emphasise the degree of reflexivity and the level of certainty (description or interpretation) in the final presentation of the phenomenon under investigation.

If I were to take a more descriptive phenomenological stance to my enquiry of students' experiences, then I would be providing a rich description of the essential concepts shared by my participants. To adopt this approach, I would be seeking to establish 'the essence' of such experiences. For some of the students, this may be the first time that they have considered or been asked to describe their experiences. My interest is more focused on a phenomenological approach, which is rooted in hermeneutics and would engage 'the interpretive element to explicate meanings and assumptions in the participants' texts that they may have difficulty in articulating' (Ajjawi and Higgs, 2007, p.617). A phenomenological methodology, which is hermeneutic or interpretive in orientation, is congruent with my standpoint as a researcher. Pringle et al (2011) note that a number of interpretive guidelines have been increasing over the last decade. In accordance with the epistemological position adopted in this study Interpretative Phenomenological Analysis (IPA) is the most appropriate method of qualitative analysis. IPA recognises the central role for the analyst in making sense of that personal experience (Smith, 2004). Finlay and Ballinger (2006) describe IPA as aiming to take participants' perceptions and experiences and, by using an idiographic approach, focus on their perceptions, linguistic and physical being. In the following section I will outline IPA and why this phenomenological approach is being used in this study.

3.4 Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is concerned with 'detailed examinations of human lived experience' (Smith et al, 2010, p.32). It sets out to conduct this examination in a manner which allows that experience to be expressed in its own terms, rather than according to a pre-defined category system (Smith, 2004). IPA is influenced by the works of Husserl

and Heidegger. Husserl's work has helped IPA researchers to focus centrally on the process of reflection in the examination of the phenomenon under investigation and the importance of bracketing assumptions. Whilst Husserl was interested in establishing the essence of experience, IPA attempts to capture specific experiences as experienced by particular individuals (Smith at al, 2010). Heidegger's argument that individuals are 'thrown into' a world of objects, relationships and language helps IPA researchers to focus on experience and perception. By adopting an IPA approach, a research project would attempt to understand that individuals' relationships to the world are essentially interpretative (Pringle et al, 2011). The focus would be on individuals' attempts to make meaning out of their activities (Smith at al, 2010). IPA is used to explore lived experiences. Although IPA is more of a philosophical stance rather than a prescriptive method (Larkin et al, 2006) a number of conventions have developed. For example, thematically analysed semi-structured interviews are the most frequently used mode of enquiry. Through identification of themes within a participant's account, the researcher aims to gain insight into how the world appears to them (Smith, 2004).

IPA is also underpinned by hermeneutics (Smith, 2004). Heidegger was a hermeneutic phenomenologist (Smith et al, 2010) and, as such, he was interested in the way in which a phenomenon emerges into the light. Hermeneutics offers an important theoretical insight for IPA researchers. IPA is an interpretative phenomenological approach and, in following Heidegger's direction, it is concerned with examining how a phenomenon appears. In addition, there is importance afforded to the researcher in making sense of this appearance. IPA is also influenced by idiography (Smith et al, 2010) as it is concerned with the 'particular'. IPA's commitment to the particular is seen on two levels (Smith, 2004). Firstly, there is the commitment to the particular regarding 'detail' and the high level of analysis;

secondly, IPA is committed to understanding how particular experiential phenomena (event, process or relationship) have been understood from the perspective of specific individuals in specific contexts. In the case of the study being reported here the specific individuals are mature undergraduate students undertaking a programme of academic study and the specific context is an institute of Higher Education (HE) in Ireland.

A characteristic of IPA is that it is inductive. This component is shared with most qualitative research inasmuch as semi-structured interviews are used (Finlay, 2011). This method necessitates that the interview stays relevant to the broad area of research. Nonetheless, IPA holds sufficient flexibility to allow for unanticipated insights to be ascertained. By maintaining an inductive position, the IPA researcher is guided by reasonably broad research questions rather than adhering to exacting hypotheses. Although the aim is to be inductive, it is recognised that, just like objectivity, a pure inductive approach is not realistic. In reality, the research process entails an interplay between induction and deduction, but the former is foregrounded. Individuals' experiences and interpretations of such experiences are not independent of context (e.g. Smith, 1999). In this study participants are interviewed in their place of study by a researcher who, although does not work with the students, is identified as a member of staff of that institution. As discussed earlier, I acknowledge this subjectivity as part of the process of understanding and attributing meaning. Therefore, reflexivity is a crucial part of the analytic process (Finlay, 2011). Reflexivity invites researchers to engage with how our own reactions to the context of our research allows us to hold particular insights and understandings as well as having emotional responses to interviewees' behaviours (Willig, 2008). I needed to be cognisant that I needed to reflect on my role in the research process, and how the research process and findings may alter my way of thinking about the subject matter.

IPA utilises small, purposively selected and carefully situated samples, and this approach often makes use of single case analyses, with the number of participants usually between four and eight (e.g. Smith, 1999; Smith and Osborn, 2007). A large data set confounds the goal of the idiographic approach, as detail is lost. As such, it is not helpful to think in terms of representativeness with so few cases. Sampling is purposeful with the aim of finding a homogenous group connected by a shared experience as opposed to a representative group of participants. When analysing a data set of transcribed interviews IPA guidelines suggest taking one transcript at a time and analysing the narrative in its totality into an idiographic, thematic form before moving on to the next (Smith, 1999). As much as practicable, the researcher should approach each transcript on its own merit. Only when each participant's data have been analysed should comparisons and contrasts be made to identify a common set of themes. This approach to idiographic analysis serves to respect and represent both the individual and the group (Smith and Osborn, 2007).

In IPA the researcher situates participants in their specific contexts whilst exploring their particular, subjective perspectives. This process starts with a detailed examination of each case before moving on to more general claims (Smith et al, 2010). A challenge for IPA researchers is to translate the insights of phenomenological philosophy in to a practical, but coherent, approach to the collection and analysis of third-person data (Smith, 2004; Smith et al, 2010).

In the study reported here, students' lived experiences have meanings impressed upon them by the students themselves – what is the meaning behind their experiences in a specific context? The students' experiences are embodied; and Smith et al (2010, p. 36) argue that individuals 'reflect cognitively on this embodiment'. Students are also concerned with 'every

day arrangements' and the choices that they make. For example, some may worry that some of the choices that they make may affect family members. These are all existential issues.

IPA is always interpretative (Smith, 2004), but there are different levels of interpretation. Smith et al (2010) stress that analysis typically involves 'progressive' movement through these levels, culminating in a deeper analysis of the phenomenon. An example, taken from Smith et al (2010) would be the following: first level –main emerging substantive themes generated in the participants' transcribed texts would be identified; second level – a closer look at metaphors would be carried out; third level – a detailed reading of the temporal construction of the participants' accounts would be conducted. This example illustrates that there is a gradual deepening of the analysis and interpretation of the participants' accounts, whilst staying close to the participants' texts. The research is, in essence, an interpretative process, with a two-stage process of interpretation (or double hermeneutic) at play. The researcher is trying to interpret a participant's interpretation of the world (Smith, 2004). This position is articulated by Smith and Eatough (2007, p.30) when they note that 'In one sense the researcher is the same as the participant, drawing on mental faculties they share. At the same time the researcher is different to the participant, always engaging in second-order sense-making of someone else's experience'.

Thus, the researcher's viewpoint is not considered a bias that needs to be eliminated, but as an essential precondition in understanding another's experience (Willig, 2008). The concept of the hermeneutic cycle, or double hermeneutic, underpins the interpretative element of IPA.

Smith and Eatough (2007) recognise that IPA has a theoretical alliance with cognitive psychology inasmuch as there is a connection between an individual's narrative and their thinking. The IPA method is most closely allied to Bruner's (1990) view of cognitive psychology (Smith and Eatough, 2007) as meaning and meaning-making are central aspects

of cognitive psychology research. IPA differs from cognitive research as it employs qualitative methods to devise ideas about cognitions, beliefs and feelings. Despite these differences, IPA is still cognitive in character as the subject exploration is essentially the mental constructs held by the participants.

Smith (2004) states that the primary criterion for deciding if IPA should be chosen as the method is the commitment to inspecting the personal and lived experiences of participants and how they obtain meaning from these experiences. Thus, if the research question is consistent with the philosophical underpinnings of IPA, it is suitable to adopt the method. This method is considered to be particularly useful to the study of 'questions of considerable importance to the participant either on an ongoing basis or at a particular juncture' (Smith and Eatough, 2007, p.38). These issues are frequently transformative (e.g. Smith and Osborn, 2007) and are often about identity and a sense of self (Smith, 1999). This is why IPA is particularly suited to examining a mature student's experiences of undergraduate education.

In choosing IPA for my research methodology, I endeavoured to explore, describe, interpret and situate the ways in which students make sense of their experiences. In order to carry out such a project I needed to access rich and detailed personal accounts from individuals who were able and willing to provide a view of the phenomenon under investigation. Smith et al (2010, p.46) highlight that researchers need to identify, describe and understand two related aspects of the participants' accounts: firstly, the 'key objects of concern' in their world; and secondly, the 'experiential claims' made in order to develop a phenomenological account.

In summary, in IPA research the focus is on individuals' experiences and understandings of a particular phenomenon. Research questions are grounded in an epistemological position – researchers assume that data will provide them with 'relevant' information. Questions focus on individuals' understanding of their experiences and questions are exploratory, not

explanatory. As IPA research is concerned with detailed accounts of lived experiences, questions neither set out to ascertain information in order to make 'grand' assumptions or generalisations, nor to ascertain what is right or wrong.

IPA is not without criticism and challenges. The role of language can be problematic in IPA. Social constructionists argue that language constructs rather than describes reality. Thus, it can be argued that an interview transcript communicates more about the way in which an individual speaks about a specific experience, within a specific context, than about the experience itself (Willig, 2001). IPA acknowledges that experience is never fully accessible to researchers. Eatough & Smith (2006) appreciate the action oriented nature of language, but also dispute the constricted notion that individuals are only discursive agents. For example, in IPA it is acknowledged that there is a chain of connections among embodied experiences, how a person speaks about those experiences, and how the individual makes sense of, and has an emotional reaction to, those experiences (Smith, 2011). It is recognised, however, that the ability of the individual to articulate the detailed features of experience adequately is questionable. Individuals may labour to use language in such a fashion that they convey the subtleties and nuances of their experience (Willig, 2001). Smith and Osborn (2008) recognise that individuals frequently have difficulties in communicating what they are feeling, but suggest that an individual's emotional state should be interpreted by the researcher by analysing what the individual is saying.

Chamberlain (2011) draws attention to the increased codification and legitimisation of IPA, and argues that, in respect of the value in research studies, this has brought about an unreflective and uncritical implementation of the method. Moreover, the increased use of codes may lead to constructing overarching themes and subthemes, which suggest that the researcher's task (i.e. the analysis) is completed when higher-order themes are categorised

and described from the data. There is also the suggestion that this emphasis on themes could have the impact of producing an analysis that is undifferentiated from a thematic analysis (Chamberlain, 2011). Smith (2011), in reply to this observation, asserts that the researcher needs to be confident in their presentation of the analysis. He further articulates that IPA guidelines are not expected to be prescriptive, but rather the researcher is encouraged to be flexible and adapt the guidelines to best fit their research project.

It is recognised that Chamberlain (2011) asks important questions about the methodological underpinnings of IPA, and these questions have been attended to in a number of published articles, which have utilised an IPA approach to research. Examples of research that have demonstrated how detailed analysis and rich levels of interpretation might be attained are: Dickson et al, (2008); Eatough and Smith (2006); and Smith and Osborn (2008). Smith and Osborn (2008) stress that IPA is an approach rather than a rigid method, which permits the researcher to adapt the approach to address the needs of the research project.

Giorgi (2010) also provides a critique of IPA when he directs attention to a lack of rigorous scientific method, particularly so in the absence of replicability. If a researcher cannot repeat findings, how can they claim validity or reliability for the research? Smith and Osborn (2008, p.67) respond to this assertion by stating that 'this lack of replicability is unavoidable' and comes about through IPA's non-specific method as researchers have their own way of conducting their projects. As discussed earlier, qualitative research rejects positivist scientific principles, so the notion that a researcher cannot repeat participants' interpretations and experiences is a strength as the philosophical underpinning is informed by subjectivity (Finlay, 2009). Moreover, a researcher cannot expect *not* to bring some of themselves to the process as the research is concerned with human interaction within a lived context. The research is not about testing hypotheses or examining variables. As discussed earlier IPA is a

two stage interpretation process or double hermeneutic (Smith and Osborn, 2007) as the participant is trying to make sense of their world and the researcher is trying to make sense of the world of the participant. In my deliberations about IPA being the most appropriate method for the current research, I recognise the subjective and interpretative stance of the researcher and participants. The research reported here is an idiographic study of the experiences of a small number of mature undergraduate students within one institution of Higher Education.

3.5 Sampling

Sampling must be theoretically consistent with the qualitative framework, in general, and with IPA's orientation, in particular. Thus, samples were selected purposively because they could offer a research project a particular insight to a specific phenomenon. Frequently, participants are contacted via referral, opportunities or snowballing. In the research reported here, participants were recruited through purposive sampling. Participants were recruited on the basis that they could give me access to a perspective on the phenomenon under investigation. Purposive sampling is a non-probability form of sampling (Bryman, 2012). The researcher does not seek to sample research participants on a random basis as the goal of purposive sampling is to sample participants (or cases) in a strategic way so that those sampled are relevant to the Research Questions (RQs) that are being posed. Given the inductive and idiographic nature of IPA, generalisations are not made from a single study alone (Smith, 2004). Due to the practical constraints placed on IPA research by the method's ontological roots, the researcher must find avenues to generalise from findings. Smith and Osborn (2007) argue that one way is through theoretical generalisability and generalisability from a whole body of research. Thus, the study is assessed in terms of how it illuminates

current literature. A second way is to build a body of incremental idiographic studies with the aim of devising theoretical statements applicable to all cases (Smith, 1999).

3.5.1 Inclusion criteria

Mature Students (23 years and over) undertaking an undergraduate degree

Currently diagnosed with depression by a doctor and taking antidepressant medication

3.5.1.1 Mature students

I focused on the experiences of mature students in higher education (HE). As discussed earlier, in Ireland a mature student is defined as someone who is 23 years or older on the 1st January in the year in which they register for their degree (HEA, 2015). This group, or cohort, of students comprise 15% (or 22,695) of the total population of undergraduate students in Ireland (n=151,300) for the academic year 2014/15. This number is increasing annually.

For 18 year olds HE is seen as a natural progression from secondary school, but not so for mature students (HEA, 2015). Studies devoted to examining the undergraduate student experience, including mental health (My World Survey, 2013; Mac Neela et al, 2012) have focused on 18-21 year olds. Thus, mature students' experiences of higher education have been neglected in the Irish context. As mature students, who are undergraduates, are a sub-group within a larger group (undergraduate students) within the full group of students in HE, I did not restrict the group even further by imposing an upper age limit. In my professional experience most mature students range from 23 to 30 years of age, but increasing numbers of older students are entering HE, due to lack of employment opportunities or deciding that once they have reared their children they want to undertake a degree.

The focus was on undergraduate studies as I wanted to capture a participant's first experience of HE rather than a second experience, as its 'impact' may be tempered by knowledge and practice of strategies used to navigate academia.

3.5.1.2 Currently diagnosed with depression by a doctor and taking antidepressant medication

As the focus of the study was on students' experiences of studying with depression they needed to have a current diagnosis of depression. The focus was not on individuals' experiences of depression prior to commencing their studies. As I was not carrying out a 'screening' to ascertain that the participants were depressed and had met criteria established by DSM-V, I needed to establish that participants had a formal diagnosis in order to keep the sample as homogenous as possible. As discussed earlier, the prescribing of antidepressants even for mild depression when a patient receives a formal diagnosis of depression is routine in Ireland (HSE 2016; Irish Health Survey, 2015; RCSI, 2013) and this was used to confirm that the participants did have a formal diagnosis from their GP. In line with Smith's (2004) recommendations for IPA studies, the inclusion criteria outlined would enhance the homogeneity of the sample.

Attendance at counselling was not considered a criterion for inclusion. Although student counselling services, which are based on campus, are available during most days of the week, as mature students tend to live off campus their access to counselling may be restricted. It is reasonable to suggest that as many mature students have commitments outside their academic pursuits, there may be additional time constraints placed on mature students in relation to making and attending counselling appointments. There are also misconceptions about counselling (e.g. Richards and Timaluk, 2013), and stigma around mental ill health (e.g. Aggarwal, 2012) so these may prevent students from seeking counselling. Therefore, taking

all of this into consideration, it was deemed that including attending counselling as a criterion for inclusion in the study was not practical.

3.5.2 Recruitment of participants

In the study reported here participants were recruited via a flyer in the Students' Counselling Service and Students' Union within one institution of Higher Education in Ireland (see Appendix 9). Five individuals responded to the flyer and three contacted me through snowballing: one participant mentioned the study to two further participants, who met the criteria for inclusion. My contact details were provided for interested people to contact me. Once I was contacted I emailed and arranged an initial phone call. If the individual met the inclusion criteria, and expressed an interest in taking part in the study, I emailed an information sheet (see Appendix 1) so the participant had time to consider whether or not they wished to be involved in the study. If the participant decided to take part they contacted me and a convenient interview time was agreed via an email.

The purpose of the phone call was to establish that a participant met the inclusion criteria and that I considered them to be sufficiently robust to take part in the study. I also supplied information about the study. Interested students were told that I would interview them, face-to-face, about their experiences and that this should take up to an hour. They were also informed that I was a member of the lecturing staff but that in the research interview I would not be in the role of a lecturer but as a researcher interested in their experiences. Individuals also had the opportunity to ask me some questions about the time and location of the interview and for more details of the topic. If the individual expressed an interest in being interviewed, then I checked that they matched the inclusion criteria. I was aware of the possibility that a student may want to change their mind about talking about their experiences so I informed them that they could take their time and think about it. If they still wanted to go

ahead then they could contact me as they had my details from the flyer. Whilst I emphasised that I would not be discussing their details with any lecturers and that if they chose not to take part their studies would not be affected, I was still cognisant of the power relationship between lecturer and student. Thus, I needed to make sure that they felt empowered and it was their decision to take part in the study. I emphasised that even when they had the information sheet they didn't have to agree to take part if they didn't want to. I let them know that if they wanted to take part in the study after having read through the information sheet that if they contacted me then we could agree a convenient time to conduct the interview. Participants were informed that interviews would take place in the building in a seminar room near the Students' Union during working hours (9am-6pm).

I had also prepared myself for the event in which an individual contacted me who did not meet the criteria. If this were to arise I would have to let them know, sensitively, why they did not meet the inclusion criteria. This was to be on a case by case basis, and reasons for non -inclusion were specific to each individual. This did not happen and all participants who contacted me met the criteria and were willing to be interviewed.

When I met the participant for the first time, after having established that they met the inclusion criteria (via the initial phone call) and were willing to take part, I went over the purpose of the study again and asked if they were still willing to talk about their experiences. I stated that may be talking through their experiences of depression may be upsetting so they were free to withdraw at any point. I talked through the ethical considerations of a participant's right to withdraw and also the matter of confidentiality (British Psychological Society's Code of Ethics, 2009) (See more details on ethical considerations later in the chapter). One potential participant contacted me the day of the interview to say that she

would be unable to take part in the study as a family member was ill and she needed to leave college and go home.

3.5.3 Sample

I aimed to interview eight participants and if they dropped out then I would need to recruit more. As one interested and suitable participant cancelled her interview as she needed to leave college for an indefinite period of time, I recruited another participant, meaning that I conducted eight semi-structured interviews in total. Smith and Osborn (e.g. 2007) argue that for a detailed analysis of participants' experiences, a small sample is best utilised. In qualitative research, it is not an aim to generalise to a population (Creswell, 2013) and, as in keeping with the recommendations of IPA (e.g. Smith, 2004), the sample is not designed to be representative of a larger group (mature undergraduate students), but rather to focus on varied and intricate experiences of these particular individuals who are experiencing depression.

It is acknowledged that participants were recruited from only one institution. This means that the sample is specific both geographically and culturally, as the location of the Institution is in a market town in a semi-rural part of the country. It is also acknowledged that the participants were recruited from the researcher's own workplace. I am aware that the sample cannot be considered as representative of all mature undergraduate students and I cannot make a more general application of the findings to other institutions or to other mature students. In addition, participants may have chosen to take part because they considered me 'a sympathetic ear' or conversely, other suitable participants (who met the inclusion criteria) may have chosen not to take part because I worked in the Institution. Whilst I emphasised that I was interviewing them as a researcher, who is interested in their experiences of

depression, I acknowledge that my status in the Institution may have contributed to whether or not individuals chose to participate.

Table 3.1 Participant Details

Pseudonym	Gender	Age	Ethnicity	Course of study	Length of time since diagnosis (months)
Niamh	Female	27	White Irish	Social Studies	13
Aoife	Female	26	White Irish	Social Studies	20
Orla	Female	33	White Irish	Social Studies	16
Michael	Male	34	White Irish	Sports and Leisure	18
Patrick	Male	29	White Irish	Sports and Leisure	4
Eoin	Male	31	White Irish	Social Studies	30
Ailish	Female	27	White Irish	Sports and Leisure	26
Mary	Female	50	White Irish	Social Studies	8

All participants are white and Irish. This was not surprising as the particular campus is set in a busy market town in a semi-rural part of the country. It was not surprising that there are more females (five) than males (three) as there are more female mature undergraduate students than male mature undergraduate students enrolled in the campus (HEA, 2016). Although there are ten full-time undergraduate degrees offered to students, participants only came forward from two undergraduate programmes. The spread of ages is from twenty-six to fifty years, with the average age of thirty-two years. These would correspond to Erikson's stage six: intimacy versus isolation (early adulthood, approximately, eighteen to thirty-nine years) and stage seven: generativity versus stagnation (late adulthood, approximately forty to sixty-four years) (Erikson, 1965). Seven of the eight participants are within stage six of

Erikson's life span developmental theory. Interestingly, only one of the eight participants in the study reported in this thesis, has a child, and only one participant reported that she is in a long standing intimate relationship. Most said that they want to work with children after completing their course of study. Some participants said that they want to advocate for others with mental health problems, so this may, if viewed through the lens of this stage of development, be contributing to (and guiding) the psychological well-being of individuals in society.

3.6 Ethical Considerations

Bryman (2012) points out that the main areas of ethical concern relate to harm to participants, lack of informed consent, invasion of privacy and deception. Other ethical considerations are: right to withdraw, confidentiality and debriefing.

3.6.1 Risk of Harm

Avoidance of harm in a study is a priority. Harm entails physical harm, harm to participants' development, loss of self-esteem, stress and 'inducing participants to perform reprehensible acts' (Bryman, 2012, p. 135). The principle risk identified in the research was the possibility of emotional upset triggered by asking the participants to reflect on their emotional state of depression. The Participant Information Sheet (PIS) made reference to this risk. As I was fully cognisant that a participant may get upset talking about their experiences of depression I had to make preparations to support them sensitively. Participants were informed that they could decline to answer any question. No participant refused to answer my questions. Participants were also informed at the outset that they could turn off the recorder at any point in the interview and they were shown the 'off' button on the recorder should they wish to use

it. If I determined that the participant was too upset to talk for an extended period of time, either by their body language or they were becoming upset and they chose not to continue I planned to terminate the interview, sensitively, and thank them for their participation. One participant asked me to pause recording as she wanted to gather her thoughts, but no participant asked me to stop the interview and no participant asked to withdraw from the study.

I was fully aware of how my position as a lecturer at the Insitution was conceived as a 'power relationship' and that I may, in the future, meet any of the participants as a student. The participants responded to an invitation to take part in the study and were cognisant that I was a lecturer in the Institution. I was aware of the potential problems of the dual relationship of student and lecturer and as a way of minimising this I recruited participants, who were not my own students, from a campus located some distance (75 km) from where I conducted my lectures. However, in the event that participants and I may, in the future, be in the same campus, I made sure that they knew that unless they acknowledged me, I would not acknowledge them. This was discussed during the initial phone call and again before the interview began. No participant expressed a difficulty with talking about their depression to me in an interview.

3.6.2 Right to Withdraw

I stressed to participants that, even if they expressed an interest in taking part and even if they fulfilled the criteria for inclusion, they could withdraw at any time. I emphasised that being in the study or withdrawing from the study would not affect their studies in any way. No participant asked to withdraw from the study either during the interview or after it had taken place.

3.6.3 Confidentiality

I went over the limits of confidentiality before I started interviewing. I reassured the participants that I would not be talking to the counsellor, other students or lecturers about the interviews. Participants were self-selected so they knew that I was a member of staff. If they agreed to take part in the interview, then they had to read and sign a consent form. I made it clear to participants the limits of confidentiality around self-harm and potential harm to others. For example, if I believed that the participant was planning to harm him or herself, or another, then I would inform the participant that I would contact a counsellor at Student Counselling Services. This was made explicit at the outset to the participant, before I began interviewing. Although I did not share identifying or personal information about the participants to the counsellor, she was aware that I was interviewing and that, if I determined that a participant was in distress, I would refer him or her to her should talking to me not be sufficient. All participants told me that they were very familiar with the Student Counselling Services. I did not make any referrals to the student counsellor during or after interviewing participants. I abided by the British Psychological Society's Code of Ethics (2009) and the Data Protection Act (1998). As such, transcribed data will only be used for research purposes and will not be kept longer than is necessary. In line with Middlesex University this is five years from the date of publication. Data were kept in a secure place (a locked filing cabinet) and were encrypted. Also, I made clear to participants that all identifiers would be removed from the documents when they are written up as the project, or as publications and pseudonyms will be used throughout the report in order to protect participants' identities.

3.6.4 Informed Consent

Informed consent had to be obtained prior to the commencement of interviews. Participants were required to read and sign a consent form. I reminded them what topic was being covered

in the interview. I re-visited the issue of consent within each interview itself, for example, by asking: 'Are you okay to continue/Are you okay to talk about that?'

3.6.5 Debriefing

After the interview I made sure to ask them how the interview had been for them. I talked through the debriefing sheet (see Appendix 2) which had relevant information on it (my contact details, the details of the professionals who work in the Student Services, and who can support a student in distress) should they wish to talk about feelings that had been triggered by the interview. I also talked through the Student Services leaflet, which contained contact information of the professionals who are on site, and who could support a student in distress.

The focus of the interview was on a participant's experiences of depression while being a student. This was conveyed in the information sheet and repeated in the screening phone call. I was relying on self-reporting. However, I was prepared that a participant may reveal other medical conditions during the interview even though the questions were not focusing on general health. One participant mentioned that she had other medical conditions as well as depression. In line with IPA research (e.g. Smith, 2004) the interviewer is interested in the participant's sense making of their lived experiences, so it was appropriate that participants may want to talk about other medical conditions.

3.7 Assessing Research Validity

A variety of guidelines exist for assessing validity and quality of qualitative research (Finlay, 2009). Yardley's (2000) broad guidelines have been recommended by Smith et al (2010) for use in an IPA study. These principles are: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

3.7.1 Sensitivity to Context

Existing theory in the area of depression and students was explored so that there was sensitivity to the theoretical context of the topic being investigated (Yardley, 2000). From the beginning of the project I had been cognisant of the nature of the research and the importance of being sensitive to the students' participation, and in the writing up of the findings. Consideration of my reflexive role and how participants may have seen me in our interactions was borne out in the way in which I conducted the research.

3.7.2 Commitment and Rigour

Smith (2004) highlights the importance of attentiveness to participants' accounts during the research process and staying close to the data. Commitment and rigour is seen in the degree of engagement shown, and the thoroughness of the study in relation to the sample and the detailed analysis. Moreover, as a novice researcher I worked very carefully through each transcript and kept close to the data when reporting findings. As I work in HE I am particularly interested in the topic and have great respect for students in coming forward to share their experiences with me.

3.7.3 Transparency and Coherence

Transparency in the writing up of findings is crucially important (Smith at al, 2010). Through engagement with my supervisors and integrating their feedback I sought to present a coherent and faithful account of my findings. As examined earlier, reflexivity is a factor in the transparency of the research (Finlay and Ballinger, 2006; Yardley, 2000) and an examination of reflexivity is presented in **Chapter 5: Discussion**. The coherence of a study is also evidenced in how well the philosophical underpinnings of the study and the research process 'fit together'.

3.7.4 Impact and Importance

The final principle of impact and importance of the research is given most importance by Yardley (2000) as the validity of research is assessed by whether it presents work of value or of use. Given the increasing numbers of mature students entering HE in Ireland (e.g. HEA, 2015) and the prevalence of depression in the Irish population (e.g. HSE, 2016) and use of antidepressant medications to manage depression (HSE, 2016) the research can provide important information to professionals working within HE in Ireland. The research can also give an under-researched section of the student community an opportunity to voice their experiences of HE.

3.8 Data Collection

I obtained detailed, first person accounts of participants' experiences. Data comprised detailed one-to-one face-to-face semi-structured interviews about mature students' experiences of studying for an undergraduate degree with depression. The aim of the interview was to facilitate an interaction, which permitted participants to tell their own stories in their own words. Thus, for the most part, it was expected that the participant talked and I listened. The interview schedule (Appendix 3) was developed in accordance with the aims of the study, relevant literature, and from attendance at an IPA workshop (Dublin, Ireland). Suggestions from published guidelines (e.g., Smith and Osborn, 2008) also guided the questions. Questions were intended to capture an open expression of the participants' lived experiences (Smith et al, 2010). This would include words and images, metaphors and meanings. Questions were organised as a chronology: past, present and future narrative, with the intention of allowing the discussion to open up. In this way, the least amount of structure would be applied. I was aware of the literature around students and depression, but I wanted the participants' lived experiences and interpretations to emerge, so questions were not closed

in nature. This was influenced by IPA guidelines (e.g. Smith and Osborn, 2008). The questions were intended to explore areas such as meaning and selfhood, and managing depression, as literature (for example, Bury, 1982; Charmaz, 1983; and Dickson et al, 2008) highlight how individuals who experience illness often experience changes to the self. Also, literature (for example, Bunting et al, 2012; Gusamo et al, 2013 and HSE, 2016) discuss the use of antidepressants and psychological therapies in managing depression.

In addition, conversations with counselling psychologists and counsellors who work in the HE sector also helped to highlight the pertinent issues around students and depression. The pre-determined questions permitted a deeper understanding and further clarification of the phenomenon under investigation. Smith et al (2010) stress that primary research questions in IPA focus on individuals' understandings of their experiences, and are open, not closed, in nature. Van Manen (1990) writes that interviews serve two purposes: firstly, they enable to researcher to explore and gather rich in-depth experiential data and; secondly, the interview is a vehicle to develop a conversational relation with a partner (interviewee) about the meaning of experience.

The interviews enquired about how the participant experienced depression, their feelings about having a diagnosis of depression and taking medication during their time as a student, and how they managed their studies with depression. The semi-structured approach was sufficiently flexible to allow me to follow a participant's lead, whilst addressing the main topics of concern. In line with adopting an inductive, rather than a deductive approach (e.g. Smith and Osborn, 2008), the interview did not adhere to a strict structure and questions were sufficiently open to allow the participant to elaborate on particular experiences without interruption from me during the process. For example, asking a participant to elaborate on how they manage their academic studies was not always necessary, as some participants had

already given this aspect of their life considerable thought during their studies prior to taking part in the study.

The interviews ranged from forty-four minutes to one hour and six minutes. They were recorded on a digital audio-recorder and I transcribed them as soon as practicable. In qualitative research the researcher is not aiming to generalise to a population or the sample is not claiming to be representative of a population (Smith, 2015). Thus, I am not claiming that my participants' experiences are representative of all mature undergraduate students' experiences of depression. However, in line with IPA research, each participant's lived experience is important and specific to them, and therefore was carefully examined and valued.

I undertook a pilot study, in which I interviewed one participant, and her data are included as part of the main data set. This is common practice within IPA research (Smith, 2004). The participant in the pilot study was recruited through the flyer, was assessed as meeting the inclusion criteria, and was sufficiently robust to take part. Her interview lasted fifty-six minutes. The aim of the pilot was to assess the efficacy of the methodology, and to ascertain whether the interview questions were valid and reliable. It is normal practice in qualitative research, argues Cresswell (2013), to conduct a pilot study and Samson (2004) considers pilots as helpful in qualitative research as they can help to 'fine tune' the research instrument such as questionnaires and interview schedules. By undertaking a pilot study my aim was not to provide a standardised interview schedule, but to ascertain feedback from the participant about the questions – Were they meaningful? Could the participant answer them? Was the length of the interview the appropriate duration? The aim of the pilot in qualitative research is to elicit feedback in order to develop interview questions (Finlay, 2009). The findings from the pilot helped me to pace subsequent interviews and let each participant pause when they

needed to do so. In the debriefing the participant told me that she was used to reflecting on, and talking about, her depression so she did not require many prompts (for example: 'Could you please tell me more about how you were feeling about your diagnosis?') I was cognisant that not all participants may be so self-aware about their depression and that I would need to be ready with some prompts, whilst recognising that within IPA interviews are not standardised (e.g. Smith, 2004). In addition, I wanted to ascertain my perspective about the interview – Were the questions appropriate? Were the participants comfortable? Was I comfortable asking such questions? I became more comfortable asking questions and letting participants pause and 'go off on a tangent' and come back to the question later, as the interviews progressed. I made sure that I gave each participant time at the end to talk about anything that they felt I had missed, or a topic on which they wanted to elaborate.

3.9 Data Analysis

Data were analysed in accordance with IPA guidelines (Smith and Osborn, 2008). The interviews were transcribed verbatim. A specifically detailed transcription is not a feature of IPA as the focus of attention is on the content and the prosodic features of the interview (Smith et al, 2010). Thus, all words spoken by each participant were recorded and transcribed, and notes were made of non-verbal utterances and notable pauses were recorded. In the transcribed interviews square brackets encasing three full stops denote that some text is missing: […]. Square brackets containing text denote text that I have added text to clarify the meaning of the quotation or to remove identifying information: [ ]. Three full stops inside brackets denotes pauses in speaking: (…).

The aim of IPA is to ascertain a detailed inspection of each participant's account of their meaning making, cognitions and views of the world (e.g. Eatough and Smith, 2006), whilst

the researcher attempts to obtain 'an insider's perspective' (Smith et al, 2010) of the phenomenon under examination. As discussed earlier, IPA recognises the dual nature (double hermeneutic) of such an interpretative approach and the role of reflexivity in the process.

In keeping with the idiographic nature of IPA, each transcript was read a number of times in order to ascertain a general view of a participant's account. Each was taken in turn in order to carry out an in-depth analysis (Smith et al, 2010). This involved listening to the interview while re-reading the transcript while making notes on what I found interesting and on my impressions and initial interpretations. These were noted in my reflexive diary. I also made notes about how I felt the interview had gone and if I had noted any interesting non-verbal behaviour (for example, a participant turning away from me in the chair, or my moving in closer to hear the participant's voice). With each reading I felt more enmeshed in the data and felt myself becoming more responsive to what has been said by the participant.

The subsequent step involved me moving on to making notes about *descriptive* (describing what the participant said), *linguistic* (language use – pauses, metaphors, repetition, tone), and *conceptual and interrogative* (what the participant made known implicitly, and also how I understood the participant's words) themes in the right hand margin. This engaged the hermeneutic principle of IPA.

The next step involved noting emergent themes, which were drawn from the transcript as well as initial commentary. Emergent themes reflected both the actual words (e.g. *fog*) and thoughts articulated by the participant (e.g. *I struggle*), and also my interpretation of these words and thoughts (*it seems to be difficult for [name] to engage with the work*). Themes were noted in the left-hand margin of each transcript and a chronological list of emergent themes was compiled. Some themes, which were similar were readily collated. Frequency of

themes was considered when considering their significance for the participant. They were then grouped together to form clusters of related themes. During this process I was mindful that I had to stay close to a participant's words and not permit my assumptions to shape my findings.

Identifying connections across themes was the next step. This involved clustering emergent themes with shared meaning through the process of *abstraction* (putting like with like and choosing a name for the cluster); *subsumption* (an emergent theme aids in collating other themes); *polarization* (themes that are opposite in emerging themes); *function* (what is the role of a specific account); *contextualisation* (searching for temporal and narrative features in a transcript); and *numeration* (how frequent the theme appears) (IPA workshops held in NUIG, Ireland, November and December, 2016). Quotations from the text (the clusters) were taken from the transcript to form the sub-themes. This step was carried out for each transcript. In keeping with the importance of the idiographic nature of IPA, effort was taken not to be influenced by earlier analyses of transcripts, and thus, I had to approach each transcript 'independently'. This was aided by always grounding themes in a participant's own data.

The following step involved looking for patterns across all eight interviews. Master themes were formed, which reflected participants' experiences of depression. Themes were re-named (for example: *navigating relationships* was renamed *feeling disconnected* as this conveyed the context of participants' accounts more evocatively). Three superordinate themes and their associated subthemes were formed, which were considered to reflect, faithfully, participants' accounts of depression.

In writing up my research I endeavoured to stay faithful to the participants' accounts and was explicit in signalling my interpretation of their words. IPA requires that the researcher

provides a *description* and an *interpretation* of participants' accounts (e.g. Smith, 2004). Thus, some of the findings report what participants are saying (description), and some of the findings are more interpretative, which may include a participant making social comparisons (for example, *stigma*, a *burden*) and a participant's use of metaphors (for example, *fog*, *deep hole*) (Smith, 2004). As part of the analytic process my supervisors read and commented on the content of the interviews and my engagement with the participants' words. I also discussed my findings (themes) at a number of IPA meetings and with a professional colleague who has supervised and examined a number of IPA theses. By working through all narratives, it became clear which themes emerged as possibilities. This helped to prune and make the analysis as interpretative as possible. For example, some participants conveyed their determination to remain on their course of study in spite of their struggles, but there were insufficient verbatim quotations for this to develop into a theme, as advised by Smith et al (2010) guidelines. One participant also referred to family relationships as being challenging, and whilst this was acknowledged as being part of her lived experience of depression, this theme did not emerge in other narratives, so it was not included.

Smith et al (2010) suggest a virtual audit and this was carried out, so all data and the research process notes, which were filed in a systematic fashion, were available for an external researcher/auditor to follow the researcher's decision making and selection of themes. A peer counselling psychology student as well as an experienced researcher were asked to review the course of data analysis. Their feedback did not suggest making changes or engaging in further exploration of the researcher's interpretations. As no changes were suggested, the themes were not revised.

In addition, in conducting hermeneutic research, a self-reflexive stance is integral to the process. Therefore, I used my reflexive diary in order to record the assumptions I made, as well as documenting my reposes to, and influences on, the research process.

3.10 Reflexivity

Evaluative criteria within phenomenological approaches describe 'owning one's perspective' as an important element of qualitative research (Elliot, Fischer and Rennie, 1999, p.222) thereby acknowledging the subjective aspect within the research process (Willig, 2001). Due to the interpretative nature of IPA and the central role of the researcher, the issue of reflexivity requires due attention in terms of acknowledging that the possible preconceived ideas and beliefs could potentially influence the analysis and generation of themes (Brocki and Wearden, 2006; Madill, Jordan and Shirley, 2000). However, the aim is not to minimise these, but rather to accept the inevitability of bringing one's personal perspective to bear on the research (Madill et al, 2006). To this end, my professional background, the origin of the idea and the themes I expected to find are outlined to support greater transparency within the study's findings. An extract from a diary I used to record my thoughts during the project is presented in Appendix 11.

I am cognisant of the fact that how the participants saw me more than likely affected the information they shared with me during the interview (Richards and Emslie, 2000). For example, as a lecturer a student may have been reluctant to talk about interactions with other lecturers or complain about the structure of their course as impacting their experiences, although I stressed that my role in the interview was one of an interested researcher, not as a lecturer. Or, a student knowing that I am a lecturer, may use the interview context as an opportunity to talk about their problems or concerns about the course. Similarly, I am

cognisant that my personal perception of the participants affected how I constructed questions and the interview. For example, I had to be careful that I did not make assumptions about how I expected a student to engage with the course content. Students, over the years, have disclosed information about how low mood impacted their abilities to complete assignments and also how medications affected their abilities to concentrate and be creative, for example. I needed to be conscious that I had a view of students' experiences of depression and taking medication, and that I needed to be mindful of this in order to capture what the participants actually said (or did not say). I was also highly aware that I had assumptions and views of the research topic and the impact that this could have on how I viewed and reported the data. Essentially, being reflective necessitates being critically aware of how the participants may have perceived me as a researcher and how I, in turn, perceived them.

The social standing of the researcher and participants in relation to each other is a key element, which may influence the production of data. This is often conceptualised as the researcher being an 'insider' (a member of the group being researched) or an 'outsider' (an individual not sharing the same social position as the participants) (Cresswell, 2013).

Merton (1972, p.22) argues that 'individuals do not have not a single status, but a status set: a complement of various interrelated statuses which interact to affect both behaviour and perspectives.' One may be an insider in some aspects of the research culture but not in others and one's position as insider or outsider may shift with different aspects of the research and it is possible 'simultaneously be to some extent an insider, and to some extent an outsider' (Hellawell, 2006, p.490). I am aware that I was moving along this continuum as I were neither a complete outsider nor a complete insider. I was an insider as I was doing research in my own Institution where I was keenly familiar with the culture, its workings, its 'lived experience' (Brannick & Coughlan, 2007 p.69) and many of its personnel. I was an outsider

in that I was not a fellow student in the Institution, and my position as a lecturer there and a researcher set me apart from the group. I had neither been diagnosed with depression, nor taken antidepressants. I was not researching the organisation or the practice of colleagues and did not expect to experience 'role conflict' or 'role duality' which Coughlan (2007) describes as likely hazards of individuals researching their own organisations.

I have limited experience of qualitative interviewing so I approached this research as a 'novice'. As I have developed therapeutic skills in my training as a counselling psychologist, I had to be mindful that the interviews were not therapy. None the less, having acknowledged this, I would assert that having therapeutic skills and having worked, extensively, with a student population in educational establishments, I would be able to use these skills to support participants should they have become emotional during the interview. I recognised that a competing demand in the interviews was duty of care for participants and concern for their emotional well-being as well as eliciting data, which was pertinent to the topics being researched.

I was also cognisant that there are stereotypes of depression as a general 'thing', whereas, in reality, I would argue that being depressed is a profoundly individual experience, and this was borne out in the participants' personal accounts of their depression.

Despite my keen interest in the research topic, I was sentient to some of the challenges that needed to be faced in carrying out the work. They included adopting the mindset of a qualitative researcher and undertaking the interviews in an unfamiliar role – that of researcher and not as a lecturer or indeed as a clinician. I needed to be alert to the possible potential for taking on the role of clinician or invoking knowledge I had of the Institution or the courses undertaken by the students. However, I felt well positioned to undertake this sensitive research due to my counselling training and skills, and my many years of working with a

student population. I was also committed to hearing an individual's perspective on what it is like for them to engage in study with a diagnosis of depression.

3.11 Chapter Summary

In this chapter I have discussed why I adopted IPA for the study reported in this thesis. I have illustrated how the research is adhering to the philosophical underpinnings of IPA. The discussion of methods used to collect and analyse data offers clarity, and permits the reader to see what has been carried out. The following chapter reports the analysis, with sufficient verbatim extracts from interviews, along with interpretation, as required in IPA. This provides an illumination of the themes derived from the participants' accounts.

Chapter 4 Analysis

In this chapter there is a presentation of the superordinate themes derived from the analysis process, which is intended to convey the participants' experiences of depression. The themes and their associated subordinate themes, which are interconnected, capture the lived experiences of participants who are undertaking an undergraduate degree. Progressing through academia is articulated as being shaped by depression, which impacts individuals' ability to study, make plans and relate to other students. All participants convey that they are finding ways to cope with their depression. Participants also reflect on their sense of self and how that has changed during their academic journey.

Table 4.1 Superordinate Themes and their Associated Subordinate Themes with Key Quotes

Superordinate Theme	Subordinate Theme	Key Quote
Theme 1: Journey through Academia with Depression	*Changing Expectations of Studenthood*	I used to have this very clear idea that I was going to you know sail through my undergrad […]And now I don't even know if I will get through the undergrad (ll309-312). I'm just (…) I'm struggling so much so I guess I don't really know what I see the future as but it's not something that I'm excited about anymore (Niamh, ll 212-313)
	Struggling to Engage	Sometimes it feels like trying to walk up a river against the tide or something like that (...) It's that kind of tiring everything is tiring (…) (Eoin, ll 46-47)
	Feeling Disconnected	[…] then it's like a light switch. One minute I am (...) the light is on and I'm friendly I'm enjoying myself em (…) up for anything and I can socialise

		with other students in my house. Next minute the switch comes off and you are down in the dumps again. You don't want to do anything. You isolate yourself and can't be with others so that varies day to day[…] (Patrick, 298-300)
	Paradox of Diagnosis	I'd like to think at some stage this will be something to look back on and that it won't be it (...) feature in my life forever but it would still be there on my medical record. It will still be something that's used to used to define me and something that's used to assess whether I'm a risk of some sort (Niamh, ll290-294).
Theme 2: Managing Depression	*Relationship with Medication*	I didn't go to the doctor for ages because I knew that I would be kind of put on medication and didn't know how it would affect my study. I didn't want to become dependent on it (Aoife, ll175-177)
	Experiencing Control	It's changing my thoughts of what I think depression is. It's more of an understanding but that's been hard to be honest (Michael, ll83-85).
Theme 3: Altered Self	*The Self as Inauthentic*	I don't want to share how I feel with other students 'cause they wouldn't understand. (…) It's like a stigma put on people. So it's that fear you don't want to be different from anybody else. You just want to fit in[…] (Michael, ll395-397)

	Comparing Present Self with Previous Self	Sometimes I'm just so tired and not interested that I can't be bothered 'cause it's such an effort. That's not how it used to be and I think it's getting worse 'cause I'm really down [...] I was always very happy and I don't like my identity and it's not really me (Ailish, ll. 158-160)
	The Self as Critical	Even though I got a 2:1 for my ordinary degree I still think I'm stupid. I don't see the degree that I got doesn't change the fact em that I'm stupid box. That box is still big and full (…) You can put as much in as you like and like it's never going to come up. Then with all the feedback for assignments like when you don't do well as you'd hoped (…) more fortune telling like will I get a good enough honours degree? (Orla, ll. 498-501)

4.1 Superordinate Theme 1: Journey through Academia with Depression

The journey that the participants have embarked on is a degree, and their experience of depression is perceived, and articulated, as shaping and changing their academic journey. For participants, their journey through their academic course is communicated as getting harder as they are now facing into the final years. When they started their journey they did not know how it would evolve, but they were hopeful. Participants' experiences of depression are also identified as changing their relationships with their fellow (student) travelling companions.

Four subordinate themes are: *Changing Expectations of Studenthood*; *Struggling to Engage*; *Feeling Disconnected*; and *Paradox of Diagnosis*.

4.1.1 Changing Expectations of Studenthood

The first subordinate theme: *Changing Expectations of Studenthood* communicates the reported adjustments or reimaging of participants' plans or thoughts around 'being a student'. All participants talk about wanting to come back to education but as they progress through the higher years of their studies (years three and four of a four year programme) their college experience is changing as expressed:

The work's getting more difficult and it's getting harder to manage (Michael, R.2)

It was just getting harder and harder for me (Patrick, R.2)

I'm struggling this year (Mary, R.4)

We can get a sense here that the difficulties experienced by participants are incremental; it was not always this hard to be on the course, but now it is becoming increasingly more challenging.

Some participants refer to being on the course as an opportunity, in education, that they thought they would not have again. Other participants talk about college not being what they had originally expected, and some participants talk about experiencing a lack of optimism, which they had felt at the beginning of their academic journey. For example:

[...] coming back as a mature student is a chance in college that I never thought I would get again […] (Eoin, R.8)

Patrick wonders what he would do if he were not on his course, even though he conveys that he is struggling:

I thought about what else could I do and I've wanted to come to college for years and now I have the opportunity and I'm struggling to manage it (R13).

Reminiscent of Eoin's comment that being at college is a *chance* that he has now been given, Patrick is conveying a sense of longing. Here we can sense a disappointed Patrick; this is something he has wanted for a long time and it is proving to be much harder than he had anticipated.

Other participants talk about college not being what they had originally thought it would be:

It's really hard because like that's why I came to college when everything was okay em (…) I thought I could do well (…) you know (...) work hard enjoy the study (…) the course and get good marks (…) well okay marks like. I want to study to get a good job in social care at the end of it but it's harder than I thought (Aoife, R.6).

Aoife suggests that she had not expected her journey to take the path it has taken and she had not anticipated the difficulty she is now experiencing. She conveys a sense of disappointment and almost a sense of her hopes as being dashed. She looks back on the beginning of her journey and reflects on her aspirations: *work hard enjoy the study.* The quote suggests that maybe Aoife was not really prepared for what would lie ahead on her journey through academia so what did she think college would be like for her? Mary also conveys sense of disappointment that her initial expectations and the course itself are not 'matching':

[...] To be honest the course isn't really what I expected but don't get me wrong I like it and I want to finish it. It's just that I thought it would be different somehow (…) y'know that I could use my experience y'know as I'm quite a bit older [...] (Mary, R.20)

Although Mary does not name what she thought her education would be like for her, she is able to articulate that her experience is, possibly, not living up to her aspirations. Two other participants convey a lack of optimism, which was seen at the beginning of their journey. They talk about their initial hopes for doing really well and coming out of college with a first class degree, so the difficulties they are now encountering were not envisioned. Here we witness what Niamh and Eoin had hoped for themselves when they started out on their journeys. Here is Niamh:

I used to have this very clear idea that I was going to you know sail through my undergrad. I was going to do a post grad and hopefully closer to the city as in Dublin and I would work in a really great job there. You know I I sometimes look up the different jobs that are going and some of these dreams jobs for me (…) and I used to have those were so clear. And now I don't even know if I will get through the undergrad. I'm just (…) I'm struggling so much so I guess I don't really know what I see the future as but it's not something that I'm excited about anymore (R.21).

In this quote we can see that Niamh communicates that she started her academic career with optimism and hope for the future and that she would not struggle in actualising these plans: *sail through the undergrad*. She was going to use her qualification to work in her *dream job* but now she cannot envision it. Thinking about such jobs seems to be upsetting for her as they remind her of her initial hopes. Depression is communicated as being limiting for Niamh and the future as well as the present is now unclear, and her initial excitement is no longer present. Weariness due to being worn down by pressure is overshadowing her actions and her aspirations: *I'm struggling so much.* The temporal effect of depression is seen here as it is affecting not only her present life, but her plans for the future are now uncertain.

Eoin also started his academic career with hopes of success and optimism, and here we see his initial determination to succeed:

If I set a goal for myself em I had a goal of trying to get to a first class honours degree (…) That's put tremendous pressure on me [...] (R.8)

Eoin started off with a clear goal, such was his interest in coming back into education. He was determined to actualise his plan. However, Eoin communicates that his quest for success has depleted him of his energy as he goes on to illustrate vividly: *And I just forced myself and the more I forced myself the more of a toll it took and eventually it just crushed me* (R 19).

This refrain conveys the effort that was involved in working towards his initial target: *first class honours degree* and the weightiness of his experience. The image of being crushed by the sheer labour of his work powerfully articulates a complete flattening of previous hopes and aspirations.

Participants report a sense of disappointment that academia is not what they initially perceived, the difficulties of what they are doing, a loss of ability to make plans for the future, and plans being interrupted or put on hold, such as engage in further study or to develop a career in their chosen field. Their expectations of studenthood have changed.

4.1.2 Struggling to Engage

Difficulties or struggles are conveyed in three domains: physical, psychological, and the structure or requirements of the course.

In the physical domain, all participants talk about their embodied experience of depression: overwhelming tiredness, lethargy and weightiness:

'It's the pressure of academics being on your shoulders. It's like having a few weights on your shoulders' (Michael, R.4)

I'd feel like a ton of bricks and my mood would go down. But also I'd feel really lethargic (...) I'd feel like somebody is pushing me down physically (Mary, R.9)

It's like cliffs and you can see the waves and they are crashing up against the wall. It's like the depression. It keeps coming back like the waves and keeps crashing up against me the whole time (Orla, R.5).

There is the suggestion that depression is likened to an external force on the participants. Michael and Mary articulate that their bodies feel weighted down. For Michael the challenges of his course are likened to heavy objects, which suggest that there are difficulties in moving forward. For Mary, the weightiness, to which she assigns a human 'quality', also levels her mood, suggesting that the pressure has psychological as well as physiological elements. There is a sense here that the participants cannot move or they are passive recipients, such is

the heaviness of depression. For Orla, her bodily sensation is such that depression keeps coming back at her and the force is unrelenting. The participants' images of depression are vivid, powerful and highlight their on-going effort to keep going.

Eoin also likens the heaviness of his depression to the force of water when he articulates:

> Sometimes it feels like trying to walk up a river against the tide or something like that (...) It's that kind of tiring everything is tiring (…) Everything has this extra like it takes the most amount of effort just to get into a lecture go from the lecture to the canteen keep up a conversation (…) The idea of a conversation can exhaust you (…) It can when you are in that space (…) It's just something that takes constant constant relentless effort (R8).

We get an impression in this quote that Eoin's bodily experience of depression can be extremely forceful and wearisome. Such is the force of his depression that he has to make a huge effort to move against it as it seems to be stronger than he is in this illustration. There is even huge effort involved in moving around the building. The pauses in his speech may be an indication of the effort to gather his thoughts. It is almost like an example of how much effort is involved in formulating a response. There is a palpable sense of his weariness in this extract. In using concrete examples: a *lecture* and a *conversation* he communicates the unrelenting, inescapable and all-consuming power of depression over two activities that he does during the day. This quote suggests that when Eoin is experiencing depression he needs to try even harder at everything he does, and even the possibility or thought of engaging with others renders him exhausted.

In the psychological domain all participants give examples of how they have problems concentrating and engaging with their work, and they interpret these difficulties as being part of their depression. Participants convey that they are aware that know they should be doing their work, but they cannot seem to control their concentration and attention in order to make this possible.

Niamh's difficulty with concentrating is an illustration of participants' struggles to engage with their academic work:

> […] when I get there [to a lecture] and I'm listening to (...) you know whatever is being said be it a law or a policy or something about government and I have to listen listen (...) to something like that and in my head (…) you know I have all this just fog and it's just really hard to concentrate(…) I would get stuck then on a point and miss the rest of the class because I'm thinking about (...)something so (...) I guess em my point being so rambly is an example of my thoughts when I'm trying to concentrate on one thing my mind goes off on a hundred different things that is is really really difficult to focus [...] (R.3)

This extract depicts the difficulty that Niamh undergoes being present in a class: *I have all this fog and it's just really hard to concentrate.* She cannot focus, she misses key points in lectures and because her ability to pay attention is impaired by her depression, she cannot engage with her studies. Her depression is so dense that her internal fog renders everything slower for her. Her mind seems to be constrained by this inner force. The stuckness that Niamh experiences suggests an inability to move forward. The fog, that is her depression, has enveloped her mind and has limited her capacity to be present, and when she tries to find a way through this fog her thoughts are unclear. The pauses she takes in this extract and her perceived difficulty in being concise, which she calls being *rambly*, reflect the challenges in formulating a coherent response. Niamh seems to be highly aware of what is happening to her as she expresses: *this is an example of my thoughts when I'm trying to concentrate on one thing and my mind goes off on a hundred different things*.

As well as experiencing difficulties with concentration, all participants give concrete examples of tasks that they cannot complete due to struggling to engage. Here is Michael, who tells us he strains to write down his thoughts:

> Em like your concentration is gone. Like I said just doing assignments I've often sat at a computer screen for three hours and not written a thing. You're just in your own world just thinking you're over worrying about stuff you're stressing yourself more from worrying 'cause you can't write and that makes it worse 'cause you know you need to do the work and that's more pressure and like that's tiring. Em all that thinking for nothing (ha ha). So that's how bad it can hit you (ha ha)(R.28).

Michael is conveying here that his concentration is *gone*, suggesting that he once had it, but now it is lost. This inability to do his work is frustrating and yet he perseveres. He seems to be engaged in a lot of thinking about what he should be doing, but he cannot do it. Michael switches pronouns in this extract, which may be suggestive of his interpretation of his depression as being an external force like *weights* on his shoulders and that it is separate from him. Michael laughs in this quote as maybe he is using humour as a way of downplaying the seriousness of his depression. He communicates the effort involved in shifting his mind into action, and to go and do what is needed to be done. His awareness of the effort required to complete the task (writing) seems to impede his decisiveness.

Participants are also bothered by not being able to retain information:

I can't remember a thing. It's not staying in my head it's quite hard. So I've gotta try it all again and again and I might have to do it loads of times before I remember anything (Patrick, R.13).

This quote suggests that more effort than usual is required for Patrick and this adds to his struggle to engage. If the information does not remain in his head, then where does it go to? Mary is frustrated by her lack of engagement: *I can't seem to control my concentration and I get angry as I'm a good student* (R.10). This refrain suggests that Mary interprets that she has power over her mind but it is not working for her as it is letting her down. It also suggests that she is observing that there is a loss of her familiar self: *a good student.*

Eoin highlights the impact of his inability to focus:

Y'know even simple things like you are in class em taking notes. If you are just not into it no matter how much you try you are not going to be able to give it your full concentration. Even though there is MOODLE and SWAN and a lot of learning. And certainly for me it's that first lecture on whatever it is. Once that's covered that's where seventy percent of what I learn I get from that. So if your mind isn't there for that for weeks at a time you find yourself coming up to exams and you are looking at it and you legitimately wonder 'Have I ever covered this?' (R2).

Eoin indicates that taking notes should be easy, but because his brain is not working the way he observes it used to work, even this task is difficult. He reflects on how important it is for him to be in the right mood so that he can engage his mind, but he cannot do so: *mind isn't there.* If his mind is not there with him in the lecture, where is it? And if it disappears *for weeks at a time* where does it go and how does it come back?

In the domain that communicates participants' struggles with engaging with the structure of the course or the course requirements, the unpredictability of depression, which makes planning ahead difficult, is communicated. Michael tells us:

> I just take a day at a time. I don't plan ahead just in case. And it's hard to plan ahead as I can be okay one day and then suddenly I'm back down again in the hole (R25).

The image of being in a hole suggests Michael has to labour to get himself back up and out of his depression and, as he previously stated, then *all of a sudden it's back to normal again and I can get the work done or at least do some of it. That's what it's like* (R15).

Being in a hole suggests he feels trapped, in difficulty, and he needs to find a foothold to get himself out and on to level 'ground'. As depression is unpredictable, the hole in which he finds himself may or may not be familiar, and may vary in depth.

Part of the unpredictability of depression affects participants' abilities to organise a schedule for study or for getting assignments completed. Orla describes her experience of the unpredictability of her depression:

> The lecturers are asking you does this date suit for handing in (...) and I'm like 'Well I don't know'. I can't plan a month in advance to tell you how I'm going to feel in a month's time for doing assignments. And then when you are told to do the assignment saying to do it straight away because of the depression. I just don't have the motivation and I'm not in the mood and the I don't know what you call it but I don't have the thing to do it straight away. So I end up em it goes later and later and the later it goes the more I freak out and panic and get stressed about it. That makes the depression worse (R.7).

In this extract we can witness a concrete example of trying to timetable assignment hand up dates. This is communicated as a real concern for Orla so she conveys a sense of anxiety when she thinks about deadlines for handing up her work. Also, in not being able to anticipate how she will feel suggests a loss of control over her emotions. The suggestion is that Orla is experiencing her depression as affecting her mood and concentration, and renders her unable to engage with her studies. Although she cannot name what is missing, she knows that something that keeps her engaged is not there.

Throughout the interviews, all participants convey the difficulties they have in trying to engage with their studies, and the struggles that they experience in getting their work done.

4.1.3 Feeling Disconnected

All participants talk about difficulties in their relationships with other students, whether it is due to the unpredictability of their depression as their mood changes, or that participants are worried about the gaze of other students. In this theme, participants convey feeling lonely. There is a sense that participants feel disconnected from their peers. This is expressed through their experiences as being with others as part of their course, or in informal, more social encounters. Michael and Ailish articulate what it is like to be in a group for an activity, as part of their course:

[...] Em like different tasks em(…) like (...) em group activities like say last week when we were hiking (…) like leading a group. I had to be up at the front (…) em (…) that was hard as I didn't feel like it(…) em but I had to do it (…) em so I tried like I didn't want to be there 'cause I wasn't in good form[...] (Michael, R.7)

[…] it's so hard to relate to others sometimes (...) even there today I had to sit at the front of the bus on my own and that nearly killed me. I'd love to be back with all the people chatting away and planning the exercise (…) but I couldn't join in (...) like I literally couldn't do it [...] (Ailish, R.17).

Michael and Ailish convey the sense of effort that is required to be with others in a group situation. Michael repeats 'had to' suggesting that he almost had to force himself to be with others. Ailish communicates that not being able to relate to others was painful, and she is experiencing feelings of isolation profoundly: *nearly killed me*. There is a sense that although their bodies were there, their minds were not engaged, such is the sense of disconnection from other students.

Participants also communicate feeling disconnected from other students in social encounters. Patrick describes the unpredictability of depression and the impact it can have on his social relationships, which he communicates as an important part of his college experience:

I tend to not really socialise with groups I don't know so unless I was invited in to a conversation I would kinda keep out of it. So it's kind of em when I start socialising I can open up (...) not that I open up about having depression em that's the last thing that will come out of my mouth. … then it's like a light switch. One minute I am (...) the light is on and I'm friendly I'm enjoying myself em (…) up for anything and I can socialise with other students in my house. Next minute the switch comes off and you are down in the dumps again. You don't want to do anything. You isolate yourself and can't be with others so that varies day to day (R.23)

The metaphor of a *light switch* may convey the unpredictability of depression for Patrick and it can hit him at any time, so part of him needs to be prepared for when the light is flicked off and he is back in that blackness. Also, there is a sense that when he is in the light he can open up and be present with his friends, while when in the dark he is experiencing being closed and alone. At the beginning of the quote Patrick tells us that he needs to be with people he knows, as being in the company of unfamiliar individuals renders him uncomfortable and he would not initiate the communication. He reveals that he can socialise: *I'm friendly I'm enjoying myself (...) up for anything* so he is communicating that it is not that he does not know how to be with others, but when the darkness of his depression is present he cannot tolerate being with others, such is its impact.

Mary finds that because her depression is a *rollercoaster* it is difficult to adhere to plans to meet up with other students and in the following quotation, we see how the unpredictability of depression affects social relationships:

Because like I said the day before I might have made a plan say to meet up after class and I would be looking forward to it and then when the time would come I just wouldn't be able to or kinda I would have that awful lethargic feeling where I wouldn't be physically able to. Em (…) And then the consequence of that would really really bring me down again. And then I have stopped making appointments. I now make the excuses before the date so that I don't have to (Mary, R4).

In the first part of this quote Mary conveys some optimism in regards to social relationships: *looking forward* to the plans she has made, but disappointment comes in as she cannot go through with them. She then tells us that it is not that she changes her mind; rather it is that she cannot muster up the energy. Her awareness of not being able to be with others is communicated as being weighty and makes moving difficult. Finally, as a resolution, Mary decides to refrain from making future appointments and this pulling back from others is contributing to the weightiness of her depression, which makes it hard for her to move.

The theme of loneliness is observed in all accounts and Aoife's struggle to be with other students is movingly communicated:

I feel really alone (…) I'm kinda em(...) isolated and then with college with all those students as well.(…) I was just isolating myself I found it really hard to make friends so that was (…)Em (…)Then in the morning when I come into college that makes it really hard as well just to know that I would be on my own for the day as well (R3)

The sense of dread at the thought of being on her own all day as she cannot interact (make friends) with other students is conveyed here. It is almost as if the difficulty around being with others is a reminder of her sense of disconnection from other students, and the anticipation of being in her isolation all day is suggested as making this disconnection even harder for her.

The need to be alone, or away from the company of other students, when experiencing depression, is observed in all accounts, and is particularly lucid in the following quote from Eoin:

> It's not easy walking into a room with about fifty people and at the best of times it's not easy walk into a room with fifty people many of whom are strong and opinionated or even to walk into the canteen on certain days that noise that over load of the senses can be tough. If you are feeling anyways down it's very easy to withdraw it's very easy to hide away. It's not like a work place where there is only ten or twelve people. When you are here there is a thousand students (ha ha). It is very easy to hide in a big building so (R2).

For Eoin, being a student in the company of fellow students is like an assault on the senses: an *overload* and when it gets too much he can *withdraw*. However, for him, the sheer number of individuals around him makes the difficult relational part of his depression easier to manage: *it is very easy to hide in a big building* suggesting that when he is experiencing depression he does not want 'to be found'. The pulling back from meeting strong people who could offer opinions suggests that it is an effort that Eoin chooses to make.

There is a sense, in the participants' accounts, that even if they want to be with others, it is difficult because they feel a disconnection or feel different. When this feeling becomes too difficult, they withdraw and isolate themselves.

4.1.4 Paradox of Diagnosis

All participants received their diagnosis of depression during their time as a student, and no-one reveals, in their interview, that they are surprised by it. In this theme, participants talk about accepting their diagnosis, and how they perceive depression as a 'real thing'. Participants also talk about the implications of their diagnosis for their college experience. Some participants communicate concern about what the diagnosis might mean for their personal life, such as life after their degree.

It seems to be important for some participants that they got 'confirmation' that what they have been experiencing is not imaginary:

Yeah like it is something real not just in my imagination. It was important to me to have that em diagnosis. It is real so I need to get on with it (Ailish, R19*)*

With the diagnosis I now see that it is not all in my head that someone does believe that it's there's something is wrong. It's not just me being a hypochondriac or something, which was something that I thought for a long time (Orla, R25)

These short extracts illustrate that the diagnosis somehow gives a name to what they had been feeling: it is a real thing and not fictitious. There is something called depression and this is what they are experiencing. For Ailish there is a sense of: 'Now I know what I have I can engage with it'. For Orla, there is a sense that, finally, being believed that her depression exists, is important.

For some participants the idea that there is something *wrong* with them and that the diagnosis by a medical professional confirms this brings with it a sense of relief (as it is not something vague in the mind of the individual) and fear (as it is on medical records so it may influence career choices). If something is wrong, then maybe the diagnosis can help to put it right? This is communicated in participants' accounts:

It's not just in my head I don't know what's wrong with me. Now I know what's wrong with me. That's the personal feeling I got. Em er so that was the relief. So now I know what's wrong with me. This is what's wrong with me (Patrick, R71)

I guess with the diagnosis I know now there's something wrong with me so it's not just a feeling (Aoife, R.8).

For Patrick and Aoife, the diagnosis is interpreted as bringing some relief, and possibly, as the experts have told them that it is real: this feeling actually has a name, and that name is depression. So, there may be an opportunity to do something about it.

Niamh, however, interprets her diagnosis as threatening, and her diagnosis is not a relief. She perceives her depression as being brought about by years of unrelenting pressure, but the diagnosis is telling her something that is difficult to hear. She is asking herself important questions about the implications of her diagnosis:

> [...]But then there was that other part of that (…) that was really dread provoking. It meant that this wasn't a phase. It meant that this was something that could potentially follow me forever and if the medical model is right and it is (…) what if it is something to do with me and my brain and my makeup then will this be (...) Will this feature in my life forever? Will this continuously be a thing? So there is a fear and dread around that […](Niamh, R19).

For Niamh, here is a possibility of what she had suspected, but there is also the dismay that her depression may not be a consequence of years of pressure. Access to clinical assessment offers Niamh the opportunity to conceptualise the illness as separate from her self: *a thing*. To be able to hold her depression 'at arm's length' as it were helps her to make sense that 'an external force' is causing her illness. This suggests that if being under excessive pressure is at the root of her depression, then she can remove some of it and she can get some control back in to her life. If it is interpreted as a specific, awful, time in her life it can be worked through and she can eventually leave it behind her. To think anything else would suggest that she is at fault (brought it on herself) and therefore has to take on the burden of responsibility. However, professionals are telling her that her depression has a biological root and therefore it is an integral part of who she is. So, how can she be depression free? In Niamh's account, more so than in the other interviews, there is a huge sense of foreboding at the thought of a loss of power over her body.

Eoin provides a different account of his diagnosis from the other participants, as for him receiving one was extremely positive. In this quote he recalls how his diagnosis brought about a change in his life:

> At that moment and in the days immediately following it it was the beginning of me doing something about it. I had known now looking back. I was in poor mental health from the age of eleven to twelve years old (…) So for me initially it was very much a sign of no more running no more hiding nor more pretending. It was like it or not this is where I am and I am doing something about it. And it's not just going to just go away (…) So for me initially that diagnosis was a very positive thing (…) I do think with depression there is maybe a bit of stigma but largely there is a bit of empathy towards it or sympathy at least. Em but personally the diagnosis was the beginning of actually getting better. And whatever costs that has come with it has been worth it because you know without it life is only ending one way and it was bad (R.16)

In this quote we can see that Eoin reflects on his diagnosis as something that may support what he has been experiencing for some time: *I was in poor mental health from the age of eleven or twelve.* He conveys that he had put off getting a diagnosis for some time as it was too difficult to face, so he spent some years *running (...) hiding (...) pretending.* His level of acceptance: *Like it or not this is where I am and I'm doing something about it* suggests his making a decision to take charge of his mental health, and that he was prepared for his diagnosis. The quote finishes with Eoin telling us that whilst a new stage in his journey commenced with his diagnosis: *beginning of actually getting better,* the consequence of having a diagnosis seems to be necessary for his mental health. Like Ailish, there is a sense of: 'I can now move forward with my life'.

Participants also talk about what the implications of having a diagnosis of depression might mean for their college experience. Here is what Patrick has to say:

> Like shit which way is this going to affect my college work? Does it mean I have to drop out? Can I carry on with depression? Can I manage the work? I must keep it to myself. Which way is this going to affect my personal life? Does my family need to know about this? Can I work with children when I finish? Again you are thinking about this at the same time and you start stressing and you get worse (ha ha) (R68).

We can see here that Patrick has a lot of questions about the implications of his diagnosis. The diagnosis seems to be bringing him lots of uncertainty and anxiety around lots of areas of his life: academic, social, personal and professional, rather than providing him with answers

or an explanation. We might wonder which questions are the most important for him to find an answer? This quote suggests that he is unsure about his journey through academia as he ponders on whether he will be able to continue his depression. Patrick continues:

[...] I got diagnosed. I have that image now of severe depression. How do other people see me? And that fear of people isolating me as: 'That's the depressed person.' Students don't really know what it means (R.69).

This quote illustrates Patrick's worry about being isolated by his peers and being given a label: *the depressed person* by people who do not understand what depression is like for him. He is conveying that depression may be seen as a uniform 'thing'. This suggests that, for Patrick, the depressed person is not his true self as it is an image. Patrick conveys his underlying fear that other students, on hearing that he has a diagnosis of depression, will make identity assumptions based on this, and his fear of being isolated by others is tangible.

Whilst all the participants refer to the stigma around depression and express the concern they have about it being misunderstood, some participants reveal a worry about not being able to work in their chosen field after graduating from their course. The diagnosis is interpreted as having an implication for their personal lives too. The diagnosis of depression brings with it a palpable fear for Orla:

But then there's times I see it [diagnosis] as a burden because now as a social care worker we have to register with CORU that we have depression and stuff so because there is such stigma against it. Then I'm like if they found out that they will not want me and like I might not be able to work with children so why am I doing the course? (R8)

Here we see Orla articulate the perceived repercussions of having such a diagnosis: *I might not be able to work with children*. The description of the diagnosis being a burden suggests that it is something that is a nuisance; it is not perceived here as being helpful. She suggests that she experiences depression as something that needs to be kept hidden from others. The idea that if her depression is revealed she will be rejected: *not want me* highlights her worry about being different or having an illness that is misunderstood. She is communicating the

feelings of a potential rejection by others. She is anticipating that she will not be able to make good or full use of her degree: *so why am I doing the course?* This suggests that Orla is now questioning her reason for coming back into education.

In this superordinate theme: *Journey through Academia with Depression*, the participants reveal the difficulties they were, and are, having on their journey through their course of study. These are in relation to making sense of how their anticipated journey has changed, how their depression has had an impact on their ability to engage with their studies, how being with other students is difficult and isolating, and how getting their diagnosis of depression, while still on their journey, is both affirming and worrying.

4.2 Superordinate Theme 2: Managing Depression

The second superordinate theme is *Managing Depression* and the two subordinate themes are: *Relationship with Medication* and *Experiencing Control.*

All participants got their diagnosis whilst undertaking their degree and all were prescribed medication. Whilst medication seems to be helping most participants with their low mood, it has side effects, which are interpreted as interfering with participants' concentration and attention. Participants express a conflicted relationship with medication, but all communicate that they continue to take their antidepressants. Most participants convey that medication is not a 'cure' for their depression, but as something that can help them whilst they are on their course. All participants seem to be accepting that they are ill and are seeking ways, other than medication, to find some control and manage their illness.

4.2.1 Relationship with Medication

In the theme: *Relationship with Medication*, participants talk about their feelings about medication prior to taking antidepressants, such as negative views about medication. Some talk about their feelings about having a lack of control over their bodies, as they need a tablet 'to keep going'. All participants communicate examples of the side effects of their medication, which are largely negative. Some participants also talk about how their medication affects their engagement with the practical requirements of their course work.

All participants express that they were initially worried about being prescribed medication because of the associated side effects:

I didn't go to the doctor for ages because I knew that I would be kind of put on medication and didn't know how it would affect my study. I didn't want to become dependent on it (Aoife, R17)

Em it took me a while to get on the tablets the anti-depressants because I didn't know what the consequences would be and I didn't want to take the risk and become dependent on them (Patrick R12)

I always had this fear before taking them of the zombie effect and you know (...) em that it would change me completely as in I wouldn't know myself (Eoin, R9).

These short quotations illustrate the worry that participants had about their life being impacted, negatively, if they started taking medication. There seems to be a perceived lack of autonomy and distrust involved in taking medication: *become dependent; zombie effect*; *I wouldn't know myself*. These quotes highlight the negative perception the participants had of medication, suggesting that there are lots of reasons for not taking medication. Being like a

zombie suggests losing human feelings and the qualities that makes Eoin an individual; thus through taking medication he would lose his individuality and become almost like a 'robot' or 'unhuman'. The notion of dependency for Aoife and Patrick also suggests the loss of individuality, and the qualities that make them who they are.

The conflicted relationship participants seem to have with medication is articulated by Ailish:

> I don't really want to be on anti-depressants. I don't think they are any way beneficial at all for me at all y'know. I think it is an easy way out like my doctor prescribed me the anti-depressants when he diagnosed my depression (…) like it's an easy way out (…) It doesn't make any sense to me at all. I'm actually quite annoyed about it (…) You can take away their college career like the whole lot by giving them this one tablet that completely destroys (R25).

Here we see Ailish communicating her conflicting thoughts around taking medication. In this extract she suggests that she considers that her GP did not give sufficient thought to prescribing medication as she repeats: *it's an easy way out.* Ailish is emphasising that medication, generally, is detrimental for a student: *can take away their college career* suggesting that as she is taking medication she is going along with what the medical professional even though there is such a perceived risk involved.

Michael and Patrick express not being happy about needing a tablet to help them, as they perceive they no longer have control over their bodies. Here is what Michael has to say:

> Ahh (…) as in like ah (...) you're trying to (…) you're taking this tablet to help you feel the way you think everyone should feel. So it takes that independence away from you. You have to depend on a tablet to feel better […] (R39)

Here we see Michael talk about his experience in the third person, perhaps reflecting his distancing himself from the person who needs to take a tablet in order to help him feel better. He articulates that taking a tablet means losing some autonomy over his body: *takes that independence away.* This suggests that the medication has got something that belongs to him and it is now lost. His comment about taking a tablet *to help you feel the way you think everyone should feel* suggests that he perceives he is relying on his medication to experience

‘ordinary’ emotions. Patrick also does not like the idea that he does not have autonomy over his body:

I like to manage my own health (...) don’t want to take a tablet to keep me going. I don’t like the idea that I need a tablet em that I have to take a tablet to keep me going (R 15).

Patrick also conveys a feeling of loss of power if he has to take medication as if he cannot manage without it: *I have to take a tablet to keep me going*. His relationship with medication is conflicted as he continues:

They are the professionals. They are the experts although it’s my body. I’m the one taking the tablets. They are just telling me what to do (…)em I’m completely against the tablets but if it's going to help er if it's a short term thing that going to help me out in the long run. I will do it. It means I can stay in college (…) Yeah just a short time (R72).

This quote suggests that whilst he recognises that it is his own body, Patrick is handing it over to *the professionals* but he can do this because his interpretation of this is that it is as a short-term way of coping.

All participants reveal that their ability to concentrate on their studies is impaired and interpret medication as being a factor in this impairment. Here we see detailed reflections by two participants: Eoin and Niamh. Here is Eoin:

Concentration is definitely affected. Em if I'm going through a bad patch of depression that would cause severe concentration problems anyway. But certainly I find the antidepressants do affect concentration em reading. I have to be little bit more em you know short bursts of stuff which isn't always easy as a student. You can’t do everything in short bursts sometimes. […] One hour is the most of intensive em (…) can be difficult. I would be reading and reading the same paragraph again and again and ask what happened (ha) (R9).

For Eoin, he interprets that his concentration is made even worse by his medication. This seems to put extra demands on him as a student as he cannot sustain his effort and it requires more organisation: *short bursts*. There is the suggestion that even when he puts in this extra effort, he cannot retain the information, so it can make the experience more challenging for him.

Here is what Niamh has to say:

So like em I think I mentioned before I could sit in a lecture and there could be really informative em presentation something really really interesting and I would only hear or really really hear or absorb one sentence or one piece. And if for example a lecturer or a facilitator at the end of the session said 'Can you tell me one thing that you can take away from today?' I would really struggle with (...) recalling what I actually heard recalling any of it [...]and that's really unsettling for me because again I'm the type of student that likes to soak up things and em would really take something ponder it and give back something and em [...] (R.19).

The medication that Niamh is taking to manage her depression is suggested as exacerbating one feature that makes being a student so difficult: *recalling what I actually heard recalling any of it*. Nothing seems to be going in now. Her ability to process information and contribute to class discussions is severely disabled, and this is communicated as causing anxiety. The emphasis of trying *to really really hear* or absorb information in lectures may denote the intense effort that is required in engaging with the lecture and, after all of this, she can merely recall one sentence.

Some participants express how the overt effects of taking medication draw attention to their difference from their classmates. Orla provides a vivid account of how she perceives other students can observe the impact of the medication on her body:

I have a tremor in my hands constantly. It's shaking (*holds out her hand to show me*) so when you are doing presentations and stuff you're supposed to em people think you are nervous. But if I get nervous it gets extremely more shaky and you're going 'oh' and people think 'oh my God she is really nervous' so you think 'Oh God I don't want everyone to notice what's wrong'. You are trying to avoid people noticing that there are any side effects (…) Or sitting in a class and all of a sudden like your head is getting zapped and you are trying focus on a lecturer telling you about some ethics or something and you are like going 'Oh what on earth are they doing?' and just let me out of here but you cannot. I've often had to walk out of classes just because I just couldn't handle it. Or you just go out go to the bathroom and think you are fine and go back in and you feel within two minutes back in the class you need to go out again and you're like ' Oh oh everybody is looking at me' and you can't and it makes you more paranoid. You miss quite a lot of college if you waited for the effects of medication to just go away but they don't (ha ha ha) (R13).

In this detailed quote Orla provides concrete examples of how the side effects of her medication affect her ability to be present: shaking hands, which she perceives may be interpreted by others in her class as a sign that *she is really nervous.* Her private experience of medication is being made public, as the effects can now be seen by others. It is interesting that she wanted me to see or verify that her tremors were real (and her hands were shaking) and maybe this was a way of getting me to see that it is real and not something that is made

up or exaggerated. She tells us that she is embarrassed that people pay attention to her, suggesting that she needs to fit in, but she cannot as other bodily sensations interrupt her ability to concentrate and sit attentively: her *head is getting zapped.* She needs to leave the class during lectures, as it is so distracting. When she has to remove herself from the group, she interprets this as drawing more attention to her difference from her classmates.

Participants who are on a course with a practical requirement communicate that the side effects of their medication are worrying: Here is Michael:

I am even slower at thinking. So like I do a lot of the outdoor sports and even in a situation where em for example em somebody a couple of weeks ago ended up in the water from a kayak and my reaction was slower than normal so I don't know if it was the tablets or not (ha ha). Yeah I'm being trained in that area and I can't react like the other students (R18).

In this quote Michael provides a concrete example of experiencing a negative change since taking his medication. He also compares his performance against that of his peers: *I can't react like the other students* which suggests that he is observing how he is different from others in the group. Later Michael tells us: *I need to be able to react quickly (Michael, R19)* so a slower reaction rate may suggest that he will not be able to make full use of his training.

Ailish is on the same course and expresses concern:

I find it very difficult very very very difficult. You have to be on the ball all the time because it's such an intense course especially physical em there's such a load em (...) I'm not on the ball like I used to be, like it takes me longer to react em it's been hard to cope with it being on antidepressants because of how they make you feel like your concentration is all over the place and yeah I'm definitely slower at thinking and it's definitely the tablets (R7).

In this quote Ailish indicates that she interprets that her ability to engage in the practical requirement of her course are impaired by her medication. She cannot control her concentration: *all over the place*, and when she reacts she is even slower than she would like to react.

Some participants talk about the positives of taking medication such as:

It works on your mind as in like you are not as worried as you should be. It kind of blocks out that er stress so I can get stuff done without over thinking like I do em when I'm feeling under pressure (Michael, R30)

Now that they are working my mood and motivation has kinda upped to another gear. Yeah I have more interest in what I'm doing now (Patrick, R2)

*They have a positive effect. They are really working on me (…) don't really help with the concentration but my mood has really lifted. I don't go down as far as I used to (*Aoife, R.17*)*

I don't get as low as before I started taking them so that's helpful (Mary, R.21)

Antidepressants just hold back the overwhelming feeling. And as a student that can make all the difference some times. You can keep going as you can keep your mood constant (Eoin, R9).

These short extracts illustrate the positive responses to taking medication on one of the features of depression experienced by all participants: low mood. Lifting their mood is perceived as helping to boost motivation, such as Patrick expresses, and a consequence of this effect, is the suggestion that he can get some work done. Aoife and Mary interpret the side effects of medication as keeping their mood from going as low as before. Holding back overpowering negative emotions and the associated stress levels are also interpreted as being a positive effect of medication for Eoin. It is suggested that, as a consequence, he can move forward with his work.

This theme: *Relationship with Medication* shows us that participants have a complex relationship with antidepressants. Most express a concern with becoming dependent on medication. Participants report that their attention or concentration is getting worse and some

convey that they interpret medication as contributing to this decline. Herein lies the conflict: take medication to help manage some of the physiological features of depression, but the side effects impact concentration.

4.2.2 Experiencing Control

In the theme: *Experiencing Control* participants talk about managing their depression by accepting that they are experiencing depression. All participants convey that they are finding some control in their lives such as becoming aware of environmental and psychological factors that can contribute to their depression. They also express that they are taking responsibility for making changes in their lives and that they are trying to do things that they enjoy.

For all participants, the process of acceptance of their illness has been facilitated by time. Through talking about their depression, participants have become more 'in tune with', or aware of how they respond to psychological, physiological and environmental factors:

[…] *I've learned now through counselling (…) I've learned it's better to speak up and ask for help earlier rather than waiting until it goes completely down because then it's just too far of a thing to climb out of (Orla, R.18)*

I understand a lot more now than I used to em. It's a lot easier to understand and easier to deal with like in terms of college too y'know going to the counsellor for support. Like I won't leave it until I'm too low. I'm better at knowing when it's gonna hit me now (Ailish, R.19)

Like I got a lot of support from the college counsellor for my assignments and exams. Yeah they're the stressful times for me and then with the over thinking I get depression (….) well yeah talking to her about what's going on is helping[…] (Patrick, R.21)

Well I find [name of counsellor] the college counsellor is fantastic. Talking about what is going on for me and how I can manage college as well as daily life is keeping me going, keeping me here to be honest (Mary, R.26).

These pieces of text illustrate participants' on-going awareness of how they respond to cognitive, physiological and environmental events in their lives. Not waiting until depression has got a grip before seeking help seems to be helping Orla and Ailish. The image of going down or being low indicates the impact of depression, and it is almost as if they endeavour to catch it before it levels them. Patrick and Mary communicate the benefit they derive from talking about their experiences with the counsellor, suggesting that 'opening up' to another person is helping them to find structure and helping them to manage their depression. For Patrick, there is the suggestion that he is 'getting out' the thoughts that are in his head, and discussing his over thinking, which seems to be making doing his work difficult; and for Mary, she articulates the benefits of counselling as reaching her personal life as well as her life as a student.

Participants convey that accepting that they have a problem is an important step in managing their depression. There is a suggestion that acceptance is represented as an important factor in enabling them to undertake the personal growth required for their recovery. They report that through therapy or counselling they have begun to change the ways in which they think about their behaviour and consequently they have begun to take more responsibility. For some participants, acceptance is difficult as Michael expresses:

It's changing my thoughts of what I think depression is. It's more of an understanding but that's been hard to be honest. It's more accepting the more you understand it the more you can accept it's happening to you and then you can do something about it like to manage it (R24).

So, for Michael who interprets communicates that depression as a 'weakness' and as something that has to be kept hidden, he is helping himself by accepting that he has

depression. He shifts to third person, which might suggest that he still needs to keep it at some distance from himself: *the more you accept it's happening to you (…) then you can do something about it.* Michael goes on to reveal how he is being proactive in living with his depression after listening to his GP:

[He told me] '*Just get in that pattern of getting up in the morning. Have something to look forward to'. That seemed sensible. I liked the sound of that and I thought I'd try so I try to set myself little goals I suppose, like get out in the fresh air* (Michael, R.27)

Here we seem to see a more positive Michael, which is in contrast to his thinking around taking a tablet (takes away his independence). The suggestions seem to resonate with him, so he is willing to try something different and in doing so he can get some control back in his life: *set goals.*

As part of making sense of their depression, some participants reveal that they are more aware of perceived bodily changes, which they experience as precipitating an episode. By recognising these changes, they can try to stop their depression from taking control, or at least lessen the impact. Such changes that participants talk about are inconsistent sleeping patterns (over sleeping or insomnia), lack of appetite, feeling irritable, low mood or experiencing impaired concentration. Mary conveys that she is becoming more aware of her body and how she interprets it is part of her sense making of her depression:

So if I catch myself down and my shoulders down (…) and I think 'Okay. So you are acting like a depressed lady today.' So what would a happy woman be like so I put on the physiology of a happy woman that seems to be working. It's not easy. It's an easy concept but it's not as easy to keep it going (…) But I do find it's helping me. I do think I need to take a little bit more control of my illness rather than just accept (…) Maybe accept that I have it em to recognise the triggers and then use the healthy mechanisms now like bringing in more stuff and hopefully lead to more confidence and self-esteem so I can bring back friendships. Try to do the things I used to enjoy like painting (…) yeah (…) I was quite good at painting and I enjoyed it found it relaxing (R16).

In this quote Mary gives the impression that she is looking at herself in a mirror or standing outside herself as an observer, and is commenting on what she sees: a depressed Mary (lady).

Part of her coping is to be aware of her stance and change it, but this is not easy for her to actualise. She recognises that she can take back some autonomy if she stays alert to her triggers. Mary expresses that she is going to be more active in seeking out pursuits she enjoys, thus making choices about her activities.

Two participants talk about managing their depression through 'being active'. Patrick and Michael, who are studying sports and leisure, take exercise and try to be outside as much as possible. They convey complementary perspectives. Michael tells us:

> […] doing a walk around the local lake before I come in to college just to get my mood up and y'know being active is important (…) being in the fresh air in that environment would up your spirits and make you would look forward to the day ahead **(**R.10).

Patrick tells us:

> I love the outdoors so when I am outside em I'd rather be outside than inside. I'd rather be doing exercise than sitting about (…) when you're outside as well you're just em listening to nature around you and it's very therapeutic and helps my mood. Being inside and sitting sitting. I don't like that (R.14).

We can see that Michael and Patrick are using their surroundings in order to engage in something that they enjoy and from which they believe they derive benefit. They communicate that they can identify that their *being active* or *doing exercise* is better than *sitting about* for their mood.

Niamh tells us she can help herself to manage her depression by removing some pressure: *Let go of the whole need to have a distinction* (R.15). Removing pressure is also interpreted by Eoin as something that can help him manage his depression, and have more control in his life, as he reveals:

> The key is to manage it before it gets to that stage [feeling very down] but when I'm actually in it there is a certain amount (…) you do have to step back. And in second year I was one of the class reps. I was an officer for the students' union. I had to step back from things like that em just to give myself that little bit extra space. Life relationships and things like that do suffer because I have to step back from them because they can be stressful. Sometimes not coming to college. You don't want to get into the habit of doing that because it's very easy to fall behind. But sometimes a day or two can make a big difference (…) If I do get depression now I

know it will pass. I know what I need to do and if I do take away certain stresses in my life it will come around [..] (R.5)

This quote starts with Eoin's reflection on what he does when he is in a depressed state: *when I'm actually in it* - he makes the choice *to step back,* thus removing himself from the situation. This suggests that even when he is experiencing depression he possesses sufficient self-awareness to help himself to recognise what is happening to him. His concrete example of this action is to relinquish his extracurricular activities: *class rep* and *officer for the students' union* to lessen the pressure. Sometimes when it really gets too much he chooses *not coming in to college* suggesting that this would be a last resort so he is making choices to help himself. The quote finishes with Eoin telling us that through his lived experience he is aware that it is not constant and that if he can manage his stress he can manage his depression.

The sense of acceptance of their depression promotes a sense of autonomy for participants, who recognise the need to move forward with their lives, which includes their studies. This involves a shift towards acknowledging their illness identity or their current depressed self.

This superordinate theme: *Managing Depression* reveals the paradoxical nature of the participants' relationship with medication, which is reported as helping some aspects of depression, but exacerbating others. Whilst the subordinate theme: *Experiencing Control* is not as strong as the theme: *Relationship with Medication,* in regard to quotations, all participants express a desire to manage their depression through means other than medication. Through developing a stronger sense of personal agency; for example, in not wanting to be dependent on a tablet, participants communicate that they need to manage their illness. Through counselling, some convey that they are implementing adaptive and coping behaviours, which allow for a sense of autonomy.

4.3 Superordinate Theme 3: Altered Self

Participants are able to reflect on how they interpret physiological and psychological manifestations of their depression as disrupting their sense of self: how they perceive changes and alterations in their self. Seven participants are able to look back at their self before they began to experience depression and compare it with their present self. All participants convey that they want to keep their depression hidden from others in their social world. All participants convey a negative and critical view of their selves. In this superordinate theme there are three associated subordinate themes: *The Self as Inauthentic*; *Comparing Present Self with Previous Self*; and *The Self as Critical*.

4.3.1 The Self as Inauthentic

All participants convey that they choose to keep their depression hidden from others and that they try to reveal a happy and sociable self to people in their social world, and that this is an effort. All participants communicate a sense of their depression as being misunderstood by others in their social world.

Most participants tell us that they experience their social self as inauthentic: false or fake or an act. Here we see what Patrick has to say as he emphatically tells us that he chooses to keep his depression hidden:

> You can't relate to people that don't have it as in like I don't think that somebody that doesn't suffer from depression would understand. So if they can't understand something how can they help so you try and hide it from them. I don't want to share how I feel with other students 'cause they wouldn't understand. (…) It's like a stigma put on people. So it's that fear you don't want to be different from anybody else. You just want to fit in. Being at college is hard with all those people and then being different too (R70).

In this detailed quote it is suggested that there is a strong sense that being perceived as being 'different' from other students is really worrying for Patrick so he chooses not to reveal his depression: *you can't relate to people that don't have it* [depression] so *you try and hide it* because *they wouldn't understand*. This suggests the difficulty that Patrick has in being with

others who he perceives do not understand the 'true' him. Patrick tells us earlier in his interview: *Well you know you are doing your job well if no-one knows you're trying to hide it in the first place* (R.9) so he conveys that he experiences his social self as something he is choosing to work at and display.

All participants movingly describe presenting a 'public face', which is interpreted as being acceptable and what they perceive is expected of a student. Here are some of the ways in which participants describe their inauthentic social appearance:

For my friends I always have a smile on my face. I always come in and I'm looking happy(...) like a false face. So that's a pressure in itself. Just to try and hide it. Even though they wouldn't know that I would be crippled inside (Michael, R21)

I think most of it that I put on is a mask like a coping kind of thing: I'm fine (...) I'm great (...) I'm perfect(...) Don't notice that I'm not (Niamh, R.7).

It might not be the real you but you were selling yourself basically. It's what the public want to see but it's not what I'm feeling. So I suppose that would be my face for I am the depressed nervous wreck behind it the false face (Mary, R2).

These extracts highlight the inauthentic image of themselves that participants interpret as being required of them in the college environment. It seems to be important that they are observed as being able to cope or to act 'normal'. There are indications from these quotations that managing their 'public image' requires a lot of effort, but it is interpreted as being necessary and can help them to manage their depression. It is like the real Michael is incapacitated and struggling. The powerful image of crippled on the inside and acting 'normal', which is perceived as being happy and smiley, suggests a stark contrast between public image and private experience. The image of a false face or a mask suggests having a

barrier between the individual and others as the authentic or real Michael, Niamh or Mary may not be accepted. Also, it suggests that being behind a 'cover' can conceal them from the gaze of others.

The inauthentic image, which the participants convey to others, is interpreted as being especially hard work for the participants involved on the sports and leisure degree as they are engaged in a lot of group work. Ailish explains:

I kind of feel like I have to be like that [happy and lively]. I don't know really. I can't show I have depression 'cause they don't understand. I have to be happy the whole time and maybe some people see it [her depression]. I don't know. I have to pretend I'm ok and 'cause my course is very practical. I gotta work with other students (R33).

Her interpretation is that if she presents her private, true feelings: the depressed Ailish, she will not be accepted by others in her group. It suggests that presenting her inauthentic social self is an effort worth making, as she needs to work with others. There seems to be the worry that if the other students 'see' her, she will be isolated.

Participants seem to convey a 'matter-of-fact' approach to hiding their emotions and presenting what they consider to be the 'acceptable' or normal face of a student. Orla, however, conveys the most discomfort of all participants in not being able to let others know how she is feeling, and this bothers her as she says:

And then you are hiding who you are as you've got this fake thing and eventually you just lose 'Who am I?' This is a question I go through in my head quite a lot. 'Who am I?' I don't know because am I the person who acts like this so nobody knows what it's like or am I the depressed horrible person that I think I am so you don't know really know who you are? It's like I'm lost (...) I don't know (R.22)

In this quote Orla's questioning of her identity suggests that she is confused: *Who am I?* and *I am lost.* This suggests that she cannot find her way. Part of her journey and coping with depression requires presenting a public face: happy, smiley, but it seems that this external image, which is *fake*, is being internalised. This suggests that the boundary between her authentic and inauthentic self is getting less clear. She indicates that she can stand outside

herself and there is a dissociative element to her experience: *Am I the person who acts like this?* and *am I the horrible depressed person?* If Orla does not recognise herself, then who can tell her who she really is?

Participants seem to be concerned by others labelling or characterising them by their illness and are choosing not to reveal their authentic self for fear of being seen as different, which they see as having a negative impact on their social and academic experiences. As part of their concern they all present a public face that they perceived is acceptable to others in their social world.

4.3.2 Comparing Present Self with Previous Self

Participants are able to look back over their experiences of depression and reflect on changes in their sense of self. For some participants the present self considers the previous self with a sense of longing and loss for what might have been, whether it relates to plans for further education (Niamh and Michael) or plans to have a successful career in the chosen field of study (Ailish, Michael, Niamh and Aoife). Eoin and Mary, however, do not view their present self with a sense of loss. In this theme participants move back and forth from the present to the past when talking about their experiences of depression.

For many participants, in their reflections on their previous self, talk about it in positive terms. For many participants, in reflecting on their present self, talk about it in negative terms, suggesting that something is missing. Participants can look back at their previous, non-depressed, self with a sense of loss of friendships and loss of possibilities, suggesting that the relational aspect of their depression is highlighted.

Here we see three accounts of the observed changes in their previous and present self from Niamh, Aoife and Michael, and all express a sense of longing for their previous self.

In Niamh's account there is an impression of loss of hope and control. She can remember, with clarity, a time before she began to experience depression. Niamh had energy, was optimistic and confident, and she can reflect on that time: *Here I am with my little house, my little car, my little boy, all my awards, all my scholarships amn't I great in college with all my distinctions?* […] (Niamh, R.8). Her previous self was successful and was able to manage the different aspect of her life: home, family and academic study.

Niamh's previous self was attentive, present and could be with others: *'on the ball all the time (...) very sociable* [...]' (R.2). She was also hopeful and had plans for the future in terms of further study and getting a great job: *'to sail through the degree (...) get a PhD* […]' (R.8) and '*work in a really great job* [...] '(R.21) suggesting an optimistic and confident self.

She tells us that her present self is irritable and frustrated:

> […] I wouldn't be able to have the same level of patience that I would have when I first came in to college without the depression affecting my life but since it did come in frustration levels would be really high and tolerance levels would be really low […] I'm not really interacting with other people. I'm not listening to what's going on [...] (R.5)

Niamh interprets that her lack of patience is a feature of her depression. Her present self cannot be with others in the way in which she enjoyed before her depression. The present depressed self cannot access her mind and body, and Niamh tells us she is perturbed. This suggests that there is now an almost ever-present awareness of the enormity of the efforts needed to do what she used to be able to do. She describes depression as *coming in*, likening it to an external agent entering her body. The quote tells us that for the present self, there is a disruption of friendship and student involvement: *not really interacting with people* and *not listening to what's going on*.

Whilst Aoife tells us that she was always shy, she conveys she felt comfortable being with other people, but she reveals that changed shortly after she started college:

Now (…) Em (…) like I said my personality has changed (…) I used to be so bubbly before I got depression (…) I notice I still kinda isolate myself. I'd be much more quieter than I used to be em (…) Yeah, quieter (…) I didn't used to worry about what people thought about me but when I started college I began to wonder what other students thought of me 'cause I spent a lot of time on my own (R26).

In this quote Aoife articulates that her personality is now different and communicates that depression is given to account for this: *I used to be so bubbly before I got depression.* Her present, depressed self wants to be on her own, be quiet and is self-conscious. She is anxious about others' opinions of her so she holds back even more. There is a suggestion that she is trying to take an 'outsider perspective' on how she might be considered by other students.

Aoife continues with her account and tells us that her perceived change in her self is bothering her:

Yeah because my whole personality changed where I'd just met these people so they didn't know me before. They didn't know that I was bubbly and fun. They just know me as this person who just sits on their own in class and in the canteen (…) not that they did think like that that's how I think (…) whereas before I would have been the one to go up chatting to people bubbly and em (...) they didn't know me beforehand before the depression (R 49).

This quote suggests that Aoife is expressing that her difficulties concerning being with others is a factor of her depression. There is a sense of sadness when she communicates that her *whole personality changed* suggesting that nothing of her previous self exists and it has been replaced with her present self, who is someone who isolates herself and is different. Her description of herself in the third person: *this person who just sits on their own* suggests a desire to hold her present self at some distance, and her reference to *the depression*, not 'my depression' also suggests that she is keeping it at a distance. She may be an observer commenting on what she sees. She provides a concrete example of how she perceives this change: *I would have been the one to go up chatting to people,* but this 'active' Aoife is no longer, and in its place is a 'passive' isolated Aoife. There seems to be a desire here for Aoife to get back her previous self.

Michael can remember how he was when he started college:

I can see the changes now to like how I used to be when I first started here. I was lots of fun a bit of a messer really. I used to go out a lot and socialise and I used to look forward to things, you know being with friends and my family. I used to be the one messing around and having fun, you know the noisy one ha!ha! Now I feel down a lot of the time and it's harder to get back up. It didn't use to be a struggle. I've got much quieter and more private too (R17).

The previous self seems to be no longer: the messer, sociable, optimistic and noisy self is now low, lethargic and guarded. He even laughs at the memory of a gregarious previous self; the present self is not easy to be with, as now life is a *struggle*. In this quote Michael is also conveying the incremental difficulty he is experiencing: *it's harder to get back up* suggesting a weakening of the present self. The previous self was capable, which contrasts with the present self with no energy. Such is the observed change that Michael tells us later in his interview: *Sometimes it's difficult to remember what it was like before I started college y'know without the depression* (R.34). His previous self is becoming a distant memory so he is looking back at it with a sense of loss. So how will it be for him when he can no longer recall his previous self?

Two participants who are studying sports and leisure give accounts of their present self as lacking the energy or being depleted, in contrast to their previous self, and this makes taking part in their course difficult. Patrick and Ailish tell us how they are experiencing elements of their course currently. Here is Patrick's recollection of a lively, energised previous self:

Like I did a full time job on top of college work in the first and second years and I could keep going. I had worked before I started college and I liked it and I had lots of energy always on the go doing stuff couldn't slow down so I wanted to carry on (…) Now I feel tired a lot of the time and it's so so hard to keep going so I've had to cut right back like with the hours. Like we were swimming today and I was really really tired, still feel tired. It wasn't like that before 'cause I always had energy and I enjoyed all the sports and sometimes I wonder if I'll ever get it back? (R52)

In this quote, we can get a sense of Patrick's previous agency and energy: *full-time job on top of college work.* He conveys that he had so much energy that he wanted to keep going: *couldn't slow down.* His previous self was constantly moving. We can now see the palpable

contrast*: I feel tired a lot of the time….so so hard to keep going.* This suggests a slowing down, almost to a standstill such is the change that has occurred. He can reminisce about his previous, energised self, and contemplates where it has gone: *I wonder if I'll ever get it back?* His present self is depleted and he may never return to his previous self. He seems to be recalling his previous self with regret. Patrick seems to interpret the changes in his motivation and energy to not being his normal, previous self.

Ailish also focuses on the physical changes in her present self, which make her engagement with her course difficult:

> I've literally shied away and I don't have the energy. That's what I look like now. My identity is now is that er I don't want to engage and that's tough as the course is physical. Sometimes I'm just so tired and not interested that I can't be bothered 'cause it's such an effort. That's not how it used to be and I think it's getting worse 'cause I'm really down [...] I was always very happy and I don't like my identity and it's not really me (…) And that was just me I want to be there and I want to participate and I want to have the energy. I wasn't worrying about anything and I was happy and full of energy (R.10).

The quote starts with Ailish telling us that her body is now depleted: *I don't have the energy* and this is affecting her interactions with others. She is isolating herself from others, may be in trying to conserve her energy. But she cannot do this all time because of the nature of her course. She infers that her present, lethargic and isolated self is not her real self: *it's not really me* and she cannot identify with it, suggesting that something has entered her body and has replaced her previous self. It is the image she is presenting to the world: *what I look like now*, so who is she now? There is a sense of loss for the previous self and a sense of worry about her future self: *I think it's getting worse.* The quote finishes with Ailish conveying a longing for her previous self, which seems to be somewhat idealised as it is something that she needs now.

Mary and Eoin give their accounts of their lived experience of depression as something that has been transformative. Unlike the other participants, they do not seem to be looking back at

their previous self with longing. Eoin presents a very different perspective to all other participants when comparing his present and previous self.

Mary's present self is helping her 'to understand' her previous self:

> [...] doing social studies and learning about people's behaviour I can see that I would be very very similar to my mum and this is helping me to understand myself better as it was unclear when I was younger. I guess I couldn't make sense of what was happening. I felt confused a lot of the time as I couldn't express what I was feeling and I was confused about feeling angry or sad but on the course I've had to think about myself and it's helping me to make sense. I'm beginning to accept myself more y'know, really understand myself more [...] (R.16).

This quote communicates that, through her studies, Mary is beginning to contemplate her previous self and there is a revisioning of life before her experience of depression. She gives an account of her previous self through the eyes of her present self. She is looking back at a uninformed and inarticulate previous self: *I felt confused a lot of the time*; *I couldn't express what I was feeling*. This suggests that she could not identify or recognise her emotions, and she suggests that the course may be giving her the vocabulary to help her now. Her present self is perceived as being more informed and empathic.

Eoin, in contrast to the other participants, reflects on his previous self with pity:

> I am a totally different person. I don't recognise the person I was in a lot of ways (ha ha). I feel awful sorry for that person that I was because I don't know how he lived. I genuinely do not know how how he kept going (...) I kept going (…) but that is how distant it feels. Yeah I definitely em for me the diagnosis was not something forced on me. That was the first aspect of me actually taking a bit of responsibility and forcing the issues. Yes I need help and I am going to get it. So I suppose in some ways (...) that literally er that Monday morning in April of 2014 was it (...) everything in my life is before and after that moment. And you know the vast majority after that moment has been positive where the vast majority before was negative. That has had a profound effect on how I see myself since that moment (R18).

In this quote we can witness the transformation that Eoin communicates that he has experienced. The diagnosis, as he revealed earlier, was the beginning of a new 'part' of his life and here he eloquently tells us how his self-image has changed completely since that time: *I am a totally different person*, so his previous self no longer exists; he is changed. There is an impression that he feels dissociated from his previous self in his use of the third person. Eoin has questions for his previous self: how did he live, how did he keep going, how

are you so unrecognisable? The suggestion is that if Eoin were to meet his previous self he would be meeting a stranger. His present self is not passive: *taking responsibility* for his health and doing something about his illness: *forcing the issues*.

Most participants can look back on their previous self with a sense of loss: energy, relationships with others, and possibly the previous self has been idealised. The previous self is recalled as something that was happy and energetic, but it is reflected on with regret. Mary and Eoin convey different accounts of their previous self, which they interpret as being uninformed and pitied unlike their present self, which is empathetic and informed.

4.3.3 The Self as Critical

All participants are critical of themselves in describing their social relationships. They are also critical of themselves when describing the feedback they receive in their academic courses. All participants are self-critical and describe themselves in negative terms, such as Michael's description of his depression as a *weakness*; and Aoife's annoyance and critical self-appraisal of how she 'let herself' develop depression: *How did I let it happen to me?*

Niamh describes herself in harsh terms: *fraud*, *burden* and *nuisance*. A theme that runs through the interview is that Niamh takes a negative stance when describing her social relationships. Here she tells us, quite emphatically:

> […] then on the worst worst days when my mind is like 'No you're a nuisance don't talk to anybody. They're not going to want to talk to you ...you're just in their way. You're a burden (...)' There would be lots of that and I'd really really feel that's what it is (...) I would avoid everyone for fear that being confirmed somehow […] (R5).

The use of the noun 'burden' to describe Niamh's presence among her peers seems highly self -critical. Burden denotes heaviness and weariness, and suggests that her perception of herself is that to be with her would be inconvenient for others. Niamh's interpretation of being with others is that she is not wanted; she is 'out of place' (*nuisance*) and that she

irritates her peers: *They're not going to want to talk to you'*. Her feeling that she will be left alone by others who are annoyed by her is communicated as being worrying for her. She seems to take a very disparaging view of herself and she withdraws from others for fear that her interpretation would be proved correct.

Orla and Eoin seem particularly self-critical. There appears to be a strong expression of disapproval of herself as expressed by Orla:

I get paranoid that I am being a burden em (…) and getting things right can be stressful as I don't think it'll ever be good enough but then em I have a thing like what my psychiatrist says is em my core belief that I am stupid and stuff so it really comes out in those kind of areas like when you have to hand up work and get a mark for it because then I feel really anxious and can get like quite stressed out that I have to er work with others like in group work and they might see how I am and they're better than me (…) and I don't think I'm good enough (R4).

This quote illustrates Orla's low self-esteem: she will never be good enough and she has a name for this: a *core belief.* This suggests that she experiences low self-esteem or never being *good enough*, being *stupid*, as something that is integral to, or the core of, her very self. It goes deep into her body and mind. She seems to be a harsh critic of herself and seems to find voice in areas where she is exposed to external scrutiny. College seems to be providing opportunities to do this: *group work* and assessments. The external indicators of her performance are present: *hand up work and get a mark for it*.

Orla continues:

Even though I got a 2:1 for my ordinary degree I still think I'm stupid. I don't see the degree that I got doesn't change the fact em that I'm stupid box. That box is still big and full (…) You can put as much in as you like and like it's never going to come up. Then with all the feedback for assignments like when you don't do well as you'd hoped (…) more fortune telling like will I get a good enough honours degree? (R39).

Orla's feeling that she is stupid even in the light of contradictory evidence conveys her *core belief,* which she revealed earlier. She is never good enough. There is an impression of a harsh, punitive critic whose standards can never be met. Using a metaphor of a container filled to the brim with her belief that she is stupid: *I'm stupid box…still big and full* there does not seem to be any space left for anything positive. This suggests that Orla is hearing or

tuning into information that affirms her low self-esteem as she does not believe she can achieve success. She provides a concrete example: *feedback for assignments* for which she has expectations, but she cannot measure up: *don't do as well as you'd hoped.*

Eoin describes himself in a very disparaging and self-critical way in the following quote:

> […] I'm not good enough. I'm not good enough. I can't do it. Those old scars don't go away too easily even though they are far easier to deal with and manage but at times if an exam doesn't go well as I'd hoped or a CA comes back and it's not good those little things do seep in again. Even if I do well I don't feel good enough. All I hear is it's not good enough I'm not good enough and that puts me under pressure (…) Every little mistake I beat myself senseless but they all combine together in this perfect storm [...] (R.9)

Eoin's repetition of *not good enough* suggests that he has a 'standard' or 'level' against which he compares himself, and he feels he is just not measuring up. The strong sense of self-flagellation is palpable here when he talks: *I beat myself senseless.* The image of a storm suggests a release of energy much greater than he can manage and which renders him exhausted. Eoin reveals that he started out on his journey with a self-schema that was critical and negative, and he describes himself as being wounded: *those old scars*. Now he finds himself in an environment where these wounds are being opened up by the commentary and feedback he receives from others. He seems to be alert to negative information such as an exam or a CA (continuous assessment) not being as 'good' as he had hoped, and he is focusing on his errors: *every little mistake,* and engages in a self-critical monologue. This is a theme that runs through Eoin's interview, and we see more of his critical self later in his interview:

> […]I see myself as kind of struggling sometimes. And yet no amount of getting good marks or people telling me otherwise changes that. I still would have that feeling that I am just about getting by or I'm just about this or that (…) I never feel that I am excelling in anything (R.12).

The quote begins with Eoin telling us that his perception of his academic work is that it is almost too much for him on occasion: *I see myself as kind of struggling sometimes.* His perception is that he is just about coping. His concrete examples of external markers

reflecting his capabilities: *good marks* and *people telling* [*him] otherwise* are not sufficient or believed, as his self- critical voice tells him that he is not good enough. His expectation is that his work should be reviewed as being highly competent: excellent, suggesting that he is striving for high standards and the work that he is putting in trying to reach these standards is tiring. He articulates a global self-criticism when he states *I never feel I am excelling in anything.*

Most participants talk about how they internalise others' feedback on their work and it is often interpreted as something that induces anxiety or self-doubt:

So being in education and having that belief about yourself doesn't exactly go down easy. All that feedback feeds in to how you feel about yourself (…) The need to pass the exam so that I don't have that more than is more so than the need for other people in the class (Orla, R.21*)*

I feel nervous when I get an assignment back like will I pass so sometimes I don't even want to know (Aoife, R.6)

Sometimes group work is tough as you have to sit and listen to comments about yourself and like if I'm not in good form I try to block it out (Patrick, R.21).

Here we see participants express their worries about how they will be viewed by others and there is a sense here of pessimism and self-doubt. These quotations suggest that being in an academic environment is reinforcing their critical voice: it provides opportunities and an audience. For Orla, it seems as if her low self-esteem is being 'fed' by her interpretation of others' expectations of, or comments on, her work. For Patrick and Aoife, hearing what others have to say about them is uncomfortable, and Patrick, sometimes, cannot even allow himself to hear what others have to say about his work.

Ailish and Mary also express how they interpret feedback on their work:

[...] And that's what makes it so difficult in college and being on this course with all the feedback from lecturers and other students so I have to be good enough at what I do 'cause they'll critique what I'm doing and find problems and that just puts more effort on me (Ailish, R. 4)

Ailish is telling us here that hearing others' views on her work is difficult and she seems to be attending to negative information: *find problems*. The nature of her course is such that she has to engage in a lot of group work and being open to multiple opinions from *lecturers* and *students* is stressful. This suggests that she feels exposed to others and she feels uneasy. She is communicating that she has to put in extra effort to attain her perceived standard: *good enough*. She is anticipating that her work will not be good enough and she will have to rectify it.

Mary also finds multiple opinions on her work difficult to manage:

[...] I think everybody is judging me so being in college doesn't help with that (…) Everybody seems to have an opinion and because we have so many discussions on our course people can challenge you. Sometimes I can't handle that you know and I just pull back (R.8)

Mary starts the quote with conveying her negative self-perception: everyone is *judging* her. Her being in college, and particularly being on her course with all the *discussions*, provides numerous opportunities for her to be subjected to commentary or feedback from others. The impression here is that others' viewpoints are seen as *challenging*: she has to defend herself. The resolution for this is to retreat in order not to be exposed to the voices of other students.

In these excerpts commentary or feedback from others, which is conveyed as being imparted regularly, is interpreted by participants as a negative judgement on their self. It is hard and uncomfortable to hear. This suggests that feedback seems to speak to the participants' self-critical voices and their lack of confidence or low self-esteem.

All participants describe themselves in unfavourable terms, even when they reveal their successes. Feedback from lecturers and other students provides an outsider's view of their perceived abilities. Participants make negative self-evaluations and appear to be attending to negative information in their environment.

In the superordinate theme: *Altered Self* participants reveal the changes to their sense of self that they expressed as taking place during their academic journey. This involves presenting a self that they interpret as being acceptable by the student community; a re-examining of their self, by comparing how they used to perceive their self with how they view their self presently; and a self that is fault-finding and seems to interpret information, negatively, in their world.

4.4 Chapter Summary

In this chapter I have presented the findings from a detailed analysis of the transcripts of the interviews carried out with the eight participants. Three superordinate themes were derived: *Journey through Academia with Depression*; *Managing Depression*; and *Altered Self*. Associated subordinate themes were also derived. Themes are grounded in participants' verbatim accounts, and interpretative analysis is also provided. The themes capture, and illuminate, the participants' lived experience of studying for an undergraduate degree with depression.

Chapter 5 Discussion

This thesis set out to explore mature undergraduate students' experiences of depression. The aim of the research was to gain an understanding of the first hand, lived experiences of depression, from individuals in one institution of Higher Education (HE) in Ireland. In this chapter there is a discussion of the main findings.

Being depressed was not a unitary phenomenon as there was variety across participants, and also changes over time for each individual. In reporting the themes there was convergence and divergence among participants' accounts. The extent of suffering articulated by the participants leaves no uncertainty about the gravity of depression and the implications for their academic experience. Three major themes emerged from participants' interviews, and taking each in turn, I will discuss novel findings, and also how the findings from the study contribute to existing research.

5.1 Superordinate Theme 1: Journey through Academia with Depression

The first superordinate theme: *Journey through Academia with Depression* reported four subordinate themes: *Changing Expectations of Studenthood*; *Struggling to Engage*; *Feeling Disconnected;* and *Paradox of Diagnosis*.

The most difficult features of depression that the participants talked about in relation to their academic life were low mood and the inability to concentrate. It is well recognised that psychological difficulties hinder a student's ability to concentrate in class (Leahy et al, 2010) and place more cognitive demands on a student (Khawaja et al, 2103). An important finding was that for the participants in the current study, who are engaged in a degree that requires a lot of group work and practical assessments, these features (inability to concentrate and low

mood) were revealed as having a great impact and as being extremely hard to manage. Working with other students in practical activities, because of the inability to concentrate and attend to what was going on around them, and experiencing a low mood and the associated feelings of lethargy, was communicated as being especially difficult for participants on the Sports and Leisure degree. Engaging in group work was also communicated as being difficult for the other participants enrolled on the Social Studies degree. Participants' accounts also articulated the feelings of disconnection from others and aloneness. It is reasonable to suggest that the findings from the study highlight that being on a course with a large practical requirement or group work is especially challenging for a student who experiences depression. The experience of disconnection and feelings of aloneness were interpreted as features of the participants' disengagement. These findings, therefore, make a novel contribution to research that has examined the impact of depression on students' engagement in academic work.

A second novel, and important, finding was revealed in the subordinate theme: *Paradox of Diagnosis*. The journey from the initial symptoms to the diagnosis, in which the individuals were given a 'label', took place during their time in Higher Education (HE). It was not until the depression was '*sinking in'* (for example, Niamh) to their college performance and engagement that participants sought a diagnosis. Then they could conceptualise their ill-health as coming about because of their depression. For participants, the diagnosis meant that their depression was named, defined and given a pathological status. This was seen as both limiting, in relation to their professional life; and freeing, in relation to their personal life. Participants communicated that they were concerned that having a clinical diagnosis of depression would not enable them to make full use of their studies inasmuch as they interpreted the diagnosis as a barrier to working with children in the area of social care, for

example. They communicated the concern that they would be seen by others (such as CORU, the governing body for social care workers in Ireland) as a risk or a danger.

Chambers et al (2015) who used IPA to explore how individuals managed their depression report that their participants held ambivalent attitudes towards receiving a formal diagnosis of depression. The sample was drawn from patients from the community, NHS and some university students. Chambers et al (2015) did not report how a formal diagnosis affected participants' feelings about themselves or the impact of their diagnosis on their identity.

In the current study most participants framed their non-disclosure of their depression as having to protect themselves in an environment in which there was little understanding of mental illness. As they highlighted the stigma around depression it is reasonable to infer that seeking a diagnosis must have been very difficult. In addition, studies such as the one carried out by Bond, Jorm, Kitchener & Reavley (2015) document important information about the struggles that students with mental health problems on vocational courses endure, and how these concerns may impact their career prospects. However, few studies have reported on the stigma associated with receiving a diagnosis. The concern about whether to reveal a diagnosis of depression or not was palpable in the participants' accounts, and what was conveyed very strongly was the power invested in that clinical 'label'.

Kosyluk, Al-Khouja, Bink, Buchhloz, Ellefson, Fokuo et al (2016) argue that the individual can experience two types of stigma: perceived stigma, which is one's own beliefs about how members of the community view individuals with mental health illness; and personal stigma, which is one's own endorsement of stereotypes relating to prejudice and discrimination. The authors further elaborate by asserting that 'label avoidance' (p. 326) involves avoiding contexts (for example, a mental health service) that may indicate the label of mental illness, thus exposing the individual to stigma. In the current study, participants' perceived stigma

around their depression was articulated inasmuch as they conveyed that their illness would not be understood by the 'student community', and thus they may experience more isolation. In relation to personal stigma, participants in the current study communicated that they may have difficulties securing employment in their chosen field of study as a consequence of the negative social stereotyping and prejudice against individuals with depression (for example, viewed as a risk to others).

Arguably, a diagnosis of depression for students studying English, for example, may not be interpreted as having the same power to limit future career prospects as a diagnosis for students studying a vocational degree. Pilgrim (2007, p.536) in his analysis of the 'survival' of a psychiatric diagnosis, argues that a psychiatric diagnosis is in a contradictory position as he asserts that 'many consider it to be pseudoscientific and an unhelpful medicalisation'. The diagnosis does not help us to consider the social causes, which may contribute to an individual's misery and the role that professionals play in 'social control'. However, others, and not just confined to medical professionals, consider a diagnosis to be helpful, 'and legitimate' (Pilgrim, 2007, p.536). Certainly, the participants in the current study considered their diagnosis to be a paradox and most were initially reluctant to visit their GP, despite communicating that they had been experiencing some uncomfortable feelings (disturbed sleep patterns, low mood) for some time.

Findings from the current study also make contributions to existing research in the broad area of depression and students in HE. The first subordinate theme: *Changing Expectations of Studenthood* challenges the view that the first year in HE is the most difficult (Buchanan, 2012; Leahy et al, 2010; Parker et al 2004) and that initial pressures placed on students in HE when they are adjusting to a new environment can make depression more likely. A lot of focus has been given to the first year experience of HE and research has often reported data

gathered from traditional students (17 or 18 year olds going straight from second level to third level education) (e.g. Fleming et al, 2010; Leahy et al, 2010; Parker et al, 2004; Rodgers & Tennison, 2009; Shanahan, 2000). Concerns such as moving away from home, managing money and managing an academic workload were often cited as being frequently reported as difficulties. In the current study, participants described that they were experiencing more difficulties as they moved into the higher years of their degree. For all participants, their initial expectations of academia changed over the years on their course. At the time of their interviews they were either in the third or final year of a four-year undergraduate degree.

Some research that has explored the experience of mature students entering HE has drawn attention to individuals being insufficiently prepared for academia (Davis et al, 2016) as they have been out of education for some time. Also, coming back into education was revealed as being something of a culture shock or a sense of not belonging, or trying to balance life between two cultures (Dyson and Renk, 2006). Other studies have highlighted mature students' perceived lack of academic skills (e.g. McGivney, 1996; Shanahan, 2000) and draw attention to mature students being unclear about their expectations of academic writing. In addition, mature students are more likely to lack formal academic qualifications and experience of academic work, further supporting the view that the 'first year experience' is the most difficult for students entering HE. Kevern & Webb (2003) in their investigation of women returning to education noted that their sample conveyed that they could not meet the expectations of the standards of university whilst also addressing the needs of their families. The authors revealed that students' reasons for returning to study were the outcome of a complex set of factors such as improving access to the jobs' market, enhancing self-esteem or a route out of domesticity. Participants reported that they felt different from other students and it was important to find a supportive place among a group of similar self-identified

mature students. In the current study, whilst data were not gathered on the entry route used to secure a place on the courses, no individual vocalised that they had felt unprepared for their academic journey; accounts gave testimony to the initial motivation or longing to be back in education as it was seen as an 'opportunity' or a 'chance' for participants. Nevertheless, participants in the current study might not have been as prepared as they would have liked for their course, as Aoife conveyed that the course was harder than she had thought and Michael said that the quantity of the workload was getting harder to manage.

Fleming and Finnegan (2011) report that mature students often study social science degrees or degrees in the humanities rather that professional programmes as there is scope for choice, opinion and meaning making within the course itself. Relevant prior experience (RPL) was a criterion for acceptance for mature student applicants on to the Social Studies degree in the current study (HEA, 2008; HEA, 2015). The participants in this study did not talk about feeling out of place or feeling different from their younger peers and this was different from some studies that have highlighted the difficulties that mature students seem to have being in an environment with younger students (Fleming et al, 2010; Kevern and Webb, 2003; Shanahan, 2000). Some of the frequently cited difficulties for mature students, such as financial and family worries (Kevern and Webb, 2003; Said et al, 2013) and trying to balance home life with being a student (Dyson and Renk, 2006) were not conveyed in the accounts of the participants in the present study.

In the present study, determination to succeed and gain employment after their course came through strongly, possibly reflecting their desire and impetus for entering and remaining on an academic course, and seeing their journey through to their destination. Mature students bring with them a 'package of experience and values' (Rogers, 2002, p.71) and they enter HE with intentions and expectations about the learning process and their own set of patterns of

learning (Lowell, 1979). As such, for the participants in the current study there was evidence of professional and operational (the acquisition of professional skills) motivation to be back in education.

Research that has reported findings from interviews or questionnaires with medical or nursing undergraduate students on vocational courses (e.g. Bond et al, 2015) have argued that mental health problems among their sample increase in the first year, peak in the second year, followed by a gradual decline during the later years of the degree. Whilst the students in the current study were not on a nursing or a smedical programme, they were still required to do clinical and community based placements with vulnerable individuals, and these placements were an important component of their course. Individuals made references to the difficulties they encountered on their placements in regard to supporting individuals in the community when they could not support themselves. It is reasonable to suggest that undergraduates in the 'helping professions' or on vocational courses are trained to care for others and may well overlook their own need for personal self-care, and may also hold expectations that they should continue working when they are unwell.

The symptomatological features of depression reported in the present study were described in previous studies (e.g. Carton and Goodboy, 2015; Leahy et al, 2010; Khawaja et al, 2013). These were feelings of overwhelming tiredness, impaired concentration and cognition, and relational difficulties. Kangas and Montgomery (2011) write that fatigue is influenced by cognitive and emotional elements in both healthy and unhealthy individuals. Individuals in the current study talked about overwhelming tiredness, and articulated the difficulties involved in engaging with their studies such as trying to catch up on work that they had missed due to not attending classes, or feeling unable to concentrate in class due to fatigue.

As referred to earlier, engaging in group work or practical assessments was communicated as being particularly affected by the physiological effects of depression.

In a discussion of the phenomenology of depression, Ratcliffe (2014) illustrates that most of the experiences in which individuals relate to one another occurs against a backdrop of a shared world. In the study reported here, that shared world is one of academia with its associated behaviours and expectations. When the backdrop is altered as happens when an individual has depression, the result is 'unlike other forms of mundane experiential change' (Ratcliffe, 2014, p. 272). Loss of interpersonal connectedness, which is part of the reported experience of depression, contributes to the experience of the world as static and closed. Indeed, Eoin referred to feeling 'shut out' of the world of others, and all participants talked about feeling isolated and, at times, unable to enter, or occupy, the world of other students. The feelings of disconnection articulated by the participants seemed to be a particularly salient feature of their lived experience of depression. Participants in the current study revealed feeling distrustful of other students and not accepted by them (feeling a burden, a nuisance, a threat) and this is an experience that Ratcliffe (2014) draws attention to as being a fundamental aspect of the lived experience of depression.

All participants in the current study communicated that they felt that depression was stigmatised and this was interpreted as highlighting their experiences of aloneness or disconnection. Interestingly, in the current study, all participants declared that they had wanted to take part in the research because they believed that depression was misunderstood among the student population and they wanted to talk about their experiences. Some, such as Eoin and Mary, also wanted to advocate for other students with depression.

Participants' accounts illustrate that their depression experience involved more than physiological factors such loss of energy, inability to concentrate, low mood. There was a

presence of the fear and worry or rejection about present and future judgements inasmuch as the diagnosis could play an active part in the intensity and disruption of their life plans.

5.2 Superordinate Theme 2: Managing Depression

The second superordinate theme is *Managing Depression*. The two subordinate themes are: *Relationship with Medication* and *Experiencing Control*.

An important and novel finding was revealed in regard to the participants' experiences of taking antidepressant medication. As part of their diagnosis, all participants were prescribed antidepressants. Side effects were communicated as being quite disturbing for participants in the current study, especially around impeding their concentration. Participants on the Sports and Leisure degree (Michael, Patrick and Ailish) talked about their experience of medication as interfering with their ability to react to the practical tasks of their course. This finding is important as these individuals are being assessed on their ability to react to particular situations such as a boat that has overturned or spotting someone who is in difficulty or is distressed. Michael and Patrick, for example, also revealed that they were making comparisons between themselves and their peers, who would be competing for the same jobs once they leave college. Another important finding in relation to using medication to manage depression among students is that the perceived benefits can take some time to take effect. Trial and error of medication was articulated as difficult as participants in the current study recognised that they only spend a certain number of weeks on their course, so they cannot afford 'to miss out' due to trying out medications, which may or may not agree with them. This was communicated as being particularly worrisome for Ailish and Niamh. Essentially, this finding has important implications for students' engagement with their course as the participants' accounts highlighted the impact that effects such as impaired concentration and

slower reflexes can have on students enrolled in studies with a high practical element. Managing depression with medication for a student, as the findings suggest, may not be efficacious or even practical. The participants' experiences of depression suggest that the context and life world of the individual needs to be considered.

Some research such as Gismao et al (2013) and Kramer (1993) have reported that antidepressants helped concentration for their samples. This may have been because trials examining the efficacy of medication have tended to be with older adults (Marcus and Olfson, 2010). Findings from the current study do not support this research.

Even when participants received their diagnosis and a treatment was proposed (antidepressants) this was not the end of their journey. Participants were not satisfied in relying, exclusively, on medication and some questioned the 'medical model' of depression. They sought other treatments, including psychological interventions. In the current study, all participants were engaged in counselling at the Student Counselling services. Participants reported that the use of medication was not seen as unambiguously helpful in their recovery. Most participants perceived that they would only be on the medication for a short time, suggesting that they were taking them to help support them while they studied. They reported that there were some benefits: mood was not as low and seemed to have more energy, so this was considered positive because it helped them to be more present on their course.

Some participants in the current study conveyed that they did not feel like themselves in relation to the effects of his medication, and Eoin was worried that he might not recognise himself because of the side effects of the antidepressants. Karp (2006) explored identity and antidepressant use and writes that individuals are aware of the distance between their perceived 'authentic' and 'real' identity particularly if they are not fully committed to consistent pharmaceutical use. His detailed interviews reveal that being on medication is

complex and confusing. In the participants' accounts in the present study, individuals mentioned not wanting to be like a zombie (Eoin) or fearing that their personality would be completely different (Michael, Patrick, Ailish) suggesting a worry about losing their identity. This fear was communicated by some participants as a reason for taking time to decide whether or not to take medication.

Davis-Berman and Pestello (2005) in their interviews with social work students and practitioners who were taking psychiatric medication, reveal mixed responses in their findings. For some students, medication was providing help that was a defining moment inasmuch as the 'authorities' had now entered the situation and they were now identified as 'disordered'. For other students, medication was viewed as an act of surrender. Participants in the current study also communicated a complicated relationship with medication, and revealed an initial wariness. Like the individuals in Davis-Berman and Pestello (2005) study, participants, nonetheless, suggested that medication was important to their ability to complete their course in spite of the negative side effects. It could be argued that participants recognised that they were struggling to engage with their academic work so by taking medication there was the initial perception they could meet the academic expectations.

While mental health issues in the public domain in Ireland are resourced by community facilities (HSE, 2016) student support services in HE are often the first point of access (Richards and Timaluk, 2013) and consequently the primary care resource accessed by students in HE. Some of the barriers to seeking counselling include times and location of appointments, duration of support, money, misunderstanding the nature of psychological therapies and stigma (Fleming and Finnegan, 2011). Kern et al (2015) note that the single most commonly cited barrier to seeking professional help among their sample of university students was stigma. All participants in the current study talked about their desire or need to

keep their depression secret and, as discussed in the earlier theme: *Journey through Academia with Depression,* individuals referred to a general lack of understanding in the student body around depression. Being in HE is being in a distinct 'community' and whilst being part of that community can be an important aspect of college life (e.g. Arnett, 2000), for students who are perceived as 'different' or who perceive themselves as being different and misunderstood, they cannot fit in. In the current study, not wanting to be seen as different from other students was important and it was communicated as requiring great effort.

Generally, acceptance of their illness was difficult, but once participants seemed to integrate their depression into their sense of identity, they conveyed a sense of agency inasmuch as they began to take control of their lives. Individuals seemed to be moving from a place of not knowing to a greater awareness of what was happening to them: their psychological processes and bodily sensations. In this process, accounts give insight into individuals uncovering qualities about themselves that, arguably, were hidden such as the meaning given to being back in education, and now through a journey of self-awareness and acceptance, participants were beginning to adapt their behaviours in order to manage their depression. They communicated that they were using counselling as a means to gain insight into their thoughts and feelings, and this seemed to help some participants to move away from isolation, which was so much part of some of their earlier experiences of depression.

Similar to Hofmann et al (2010) and Mansell et al (2010) the overall acceptance of a problem and the assimilation of information and personal experience was conveyed as a useful process in managing their depression. Participants in the current study talked about reducing stress, pulling back from commitments, managing sleeping, taking exercise and being outside in nature. There seemed to be a growing sense of coherence, which reflected the participants' abilities to respond to stressful situations through the comprehension of what was happening

to them, and perceiving that they had the resources to manage the situation. Unlike a number of other studies (e.g. MacNeela et al, 2012; Shanahan, 2000) the participants in the current study did not make references to having social supports, although they spoke about the importance of asking for help before their depression became severe. The studies documented findings from younger students (traditional students), so possibly the emphasis on peer help is not really applicable or readily available to the participants in the current study. Also, the experience of depression is such, that being with others is generally difficult, so suggesting that students can be helped by having supportive others around them is particularly challenging.

Marley (2011) documents self-help strategies in her study of individuals (aged 27-60, average age 45 years) experiencing emotional distress. Five themes are noted: structuring the day; empowerment; engaging others to help yourself; physical health and well-being; and spirituality. Although the sample is not students, a number of the themes can be observed in the participants' accounts in the current study. In discussing these themes in relation to the participants' experiences, accounts revealed that they found taking physical exercise was helpful in managing their mood, and referred to being out in nature as being a way of taking their mind off their worries and stresses. Empowerment was revealed in taking control of their behaviour, such as not taking on extra tasks, or stepping back from being a class representative. Help from others was evidenced by a few participants (Orla and Patrick) talking about seeking out other students with whom to study if they had missed classes as a consequence of feeling too ill to attend college. This finding was not like Marley's sample, as the participants in the current study did not report engaging others to help themselves, as the general perception was that depression should be kept hidden. Physical health and well-being was evidenced in participants being aware of physiological changes such as disturbed sleep

patterns or feeling lethargic, so individuals would then step back from doing what they were doing or take some exercise. Marley (2011) also reports the barriers her participants identified as preventing them from engaging in self-help. These were delays in recognising or linking emotional and physical symptoms to a distressing event.

The participants in the current study did not reveal an explicit trigger for their depression, but described it as something about which they had some awareness for some time. Whilst most participants revealed that they realised that they had been experiencing changes in their mood, concentration and bodily sensations, for some time before they sought their diagnosis, they said that they had waited before going to their GP. One other interesting barrier to self-help that individuals in Marley's study reports was the influence of their core belief in relation to self-esteem. In her study, individuals talked about not feeling good enough and failing to meet others' expectations, for example. Individuals in the current study revealed similar sentiments and worries. Some participants communicated their interpretation of their depression as a weakness and as something that they had 'let happen' to themselves.

Callebaut, Molyneux & Alexander (2017) argue that when an individual is faced with a diagnosis of a perceived chronic health condition, they try to explain why their illness may have occurred and what factors could they have controlled. An individual's prior beliefs about the illness (such as depression), their feelings about themselves and their ability to cope with adversity, affect how they adjust to life with the illness (Lazarus and Folkman, 1984). Feelings of inadequacy (feeling worth less than others or feeling that one has failed) co-occurred with hopelessness and depressed mood in Zah, Lytte, Gethin, Green, William Deakin, & Young's (2015) clinical sample. In this study, the authors examined the role of self-blame and worthlessness in the psychopathology of major depressive disorder in 132 patients. Findings report that feelings of worthlessness and self-blaming emotions were

frequent and bothersome for the participants. Self-blame involves an individual believing that an unwanted event, such as depression, is in some way their fault. In the current study, some participants communicated that stress, as a consequence of doing too much or 'putting themselves under too much pressure', may have contributed to their experiencing depression. If an individual blames themselves for becoming ill, such as 'letting it happen' or that they were not sufficiently strong, then they feel responsible for letting it occur, and thus, they self-blame (Callebaut et al, 2017).

5.3 Superordinate Theme 3: Altered Self

The third superordinate theme is *Altered Self*. The three subordinate themes are: *The Self as Inauthentic*; *Comparing Present Self with Previous Self*; and *The Self as Critical*.

One novel and important finding was that participants conveyed that their experience of receiving feedback on their academic work was stressful and was internalised as a negative and personal critique of their performance (*The Self as Critical*). Accounts communicated the difficulties in receiving feedback on their academic work from lecturers in formal circumstances, and from other students in informal circumstances: class presentations or group work. Feedback was interpreted negatively even when 'evidence' such as good marks or success in previous exams was presented. This finding is important as an increasing part of student assessment takes place in groups, and peers are encouraged to provide feedback on classmates' performances as well as engage in self-assessment as part of the learner experience (e.g. GMIT Strategic Plan 2013-2016).

Markus and Wurf (1987, p.319) argue that 'individuals are generally self-enhancing, meaning that individuals prefer to seek out positive information about themselves' and when feedback is negative, they will selectively interpret information in such a way as to minimise the threat

to their positive self-conceptions. The positive feedback that the participants, such as Orla, Niamh and Eoin, acknowledged that they had received in relation to their academic work, in the current study, seemed to be incongruent with their current self-images, and thus appeared to be filtered through their negative self-schema. Feedback has relevance, argues Street (1988) if it relates to a concept or belief that is meaningful to the individual. It is reasonable to infer that feedback to the participants on their academic work is meaningful and important, and the thoughts of not doing well or not being up to the mark are stressful, as articulated by participants' self-critical assessments.

Feedback was often interpreted as a source of stress as it occurred in an environment that is closely linked to their sense of identity (the learner identity) and self-worth. Hewitt and Flett (1991) argue that when an individual receives social commentary on something that is of utmost value to them, and they have low self-esteem, this can trigger depressive effect. Individuals who are overly concerned with others' perceptions of themselves and who strive to meet the expectations that others place on them, seem to be hypersensitive to perceived failures in achievement domains (Hewitt and Flett, 1991). Therefore, setbacks in achievement related domains, such as an assignment or an exam not going as well as an individual had hoped, are considered to be very distressing. The participants in the current study had made a decision to come back to education, quit what they were doing before and move back into the family home for some. Therefore, it is reasonable to infer that being successful in the new venture in their life is important. Moreover, they all were studying in an area in which they have had practical experience. Arguably, society's emphasis on performance and success does not seem to have scope for the experience of failure or even struggling. For students, who do not see failure as part of the process, their experiencing of difficulties or even failure may well trigger feelings of huge disappointment and shame.

In keeping with research that has described participants' negative self-evaluations (Steiger et al, 2014) and individuals' tendencies to attend to negative information in their environment, whilst simultaneously not attending to neutral or positive information (e.g. Nolen-Hoeksema, 2000; Phillips et al, 2010), the participants in the current study are situated in a context in which they are recipients of continuous feedback and commentary from others. They are in a context in which others' perceptions of their academic performances monitor and assess their ability to engage with their course of study. It is suggested that external values of feedback have been internalised and made personal. Thus, for mature students who have chosen to come back into education and feel related to the material because they have worked in their area of study, it is inferred that they attend to and process feedback differently from younger students. This observation is speculative as only mature students were interviewed in the present study. If individuals demonstrate a negative attribution style that focuses on negative events, they tend to interpret difficulties and failures as global and permanent rather than specific to a particular context/piece of work and temporary (e.g. Steiger et al, 2014)

Feedback provides an academic audience for students and affords them an outsider's view of their activity, and in so doing conveys what the audience values in writing. This was an important finding as it highlights the difficulties that students with depression have in attending to, and receiving, feedback, which is integral to their academic journey. Few studies, to date, except for research investigating the efficacy of different types of feedback in assessment processes (e.g. Burke and Pietrich, 2010; Hattie and Timperley, 2007), have examined the psychological impact of feedback to a student. Weidinger, Spinath & Steinmay (2016) have investigated the association between feedback and motivation among university students. The authors found that students' intrinsic motivation declined after negative feedback and this was mediated by ability self-concept. Ability self-concept (ASC) is a

cognitive representation of one's ability in an academic achievement situation. It is informed by making external comparisons with the performances of others (comparing one's grade for work with those received by other students) and internal comparisons (comparing one's performance in a number of academic tasks over time) (Weidinger et al, 2016). The authors report that if a student held a negative ASC then attainment of the performance goal is unlikely and that this leads to reactions of helplessness. Thus, for participants in the current study who have a propensity to attend to external viewpoints critically, their critical self-assessment and their struggles with motivation because of their depression makes their academic experience especially challenging.

Interestingly, literature that has focused on the mature student experience in HE (e.g. Fleming et al, 2010; Shanahan, 2000) has drawn attention to how students seem to grow in confidence with success and mastery of their academic pursuits. The findings from the current study do not support this as participants' accounts communicated an increasing lack of confidence as they moved into the final years of their degree. Fleming et al (2010) report findings from mature students across a number of courses, none of which were vocational, and no participants explicitly reported depressive symptoms. Shanahan (2000) notes findings from mature students who were training in healthcare, but they did not explicitly report any depressive symptoms. Participants conveyed the pressure to succeed, as did the participants in the current study. However, unlike individuals in the current study, Shanahan (2000) notes that her sample communicated that they were looking forward to entering the workforce after graduation. Participants in the current study communicated self-doubt about securing work after completing their course of study, such was their perception of the stigma of depression.

In the current study participants attended to negative information in their world, which is reported as being common among depressed individuals (e.g. Beck, 2008; Nolen-Hoeksema,

2000; Phillips et al, 2010). Such information was concerned with their academic work and social relationships with their peers. Negative cognitions (including negative self-concept and pessimism) and negative motivation (such as loss of interest in activities) constitute major areas of symptomology of depression (Beck, 1967). It is documented in literature that low self-esteem and a perceived negative view of self-esteem to be associated with a negative view of future events (Hewitt and Fleck, 1991). Individuals who have negative self-schemas conceptualise futures with more negative expectations (Beck et al, 1979.) Individuals who report having high self-esteem express feeling that they are 'good enough'. Findings from the current study support research that has documented negative expectations of future events in individuals who communicate low self-esteem.

According to cognitive theories of depression, individuals possess representations of self-referential information (information about themselves in relation to others and the world) involving theories of failure, hopelessness, worthlessness and rejection (Abramson et al, 1989). When such representations are activated by an environmental trigger such as an event that is considered to be stressful, such as class presentations, exams or essays, as seen in the current study, then self-schemas are believed to generate automatic and systematic biases in information processing (Beck, 2008). This processing results in the individual perceiving that they lack the ability to cope, are weak and are likely to fail. Participants in the current study worried about being good enough and failing exams.

Participants in the current study talked about their faults and failings and some seemed to have extremely high standards and that when these were not met, they engaged in an 'all or none', global negative evaluation of their performance: *I struggle with everything*; *Nothing is good enough*; *I'm never good enough*. Setting very high standards for oneself and engaging in a stringent self-evaluation can generate stress (Hewitt and Flett, 1991). If an individual is

overly concerned with evaluations by others this leads to critical self-evaluations of one's own behaviour and thus there is an inability to derive satisfaction from what they are doing. In the study reported here participants did not express satisfaction in what they were doing, and seemed to be alert to avoiding making mistakes or 'slipping up' either in relation to academic work or social relationships with their peers.

Participants conveyed that they had initial high standards for themselves: first class honours degree (Niamh and Eoin) or further post-graduate study (Niamh). Participants also conveyed that being back in academia was an opportunity or a chance in their life and suggested that they had wanted to do well. Two participants also talked about their interpretation of their family expectations: Niamh referred to being told she had ruined her academic life by having a child when she was young and she set out 'to prove them wrong', and Eoin revealed that he came from a family that he perceived lacked self-confidence. It is suggested that both participants saw being back in education as an opportunity to demonstrate to themselves that they could be successful, or even excel. Hewitt and Flett (1991) argue that individuals, who are overly concerned with meeting the unrealistic high standards they perceive are set by other people, often experience depression. The individual is frequently dissatisfied with their performance and engages in exacting self- evaluation. Also, perfectionists are often concerned with others' evaluations of themselves and feel immense pressure to meet others' imposed standards, highlighting the intra and interpersonal aspects of perfectionism (Hewitt and Flett, 1991). Findings from the current study contribute to this research.

The theme of identity or perception of self was identified in the current research, and findings contribute to previous research, which has analysed depression (Chapman, 2002; Mansell et al, 2010). Comparable findings of an individual's questioning of their identity have been reported elsewhere in research that have inspected chronic illness (Dickson et al, 2008; Smith

and Osborn, 2007). The psychological construct of self has been examined within the personal well-being of individuals with or without illness (e.g. Bury, 1982). Perception of self has been associated with alterations in an individual's behaviour and mood (e.g. Charmaz, 1983). The onset of depression which, to some degree, triggers physical changes (e.g. Beck, 1967; Cannon et al, 2013) may arguably confront the unity and continuity of existing perceptions of self. This confrontation often occurs in tandem with a time in life when the individual is pursuing several personal goals or embarking on a significant life event (e.g. Cole et al, 2006; Eberhart and Hammen, 2009; Friedman, 2000).

Bury (1982) argues that chronic illness is at its most disruptive if it occurs during young or middle adulthood. The participants in the present study had made a decision to come back into education, thus, reflecting a self-defined goal. As alluded to earlier, they were intrinsically motivated with their own learning process (and accounts revealed a strong desire to be successful early in their academic journey) and had defined professional goals. Thus, to be experiencing depression at such a time in their lives may well have challenged their perception of self as they found themselves struggling to engage with their new venture: academia. In situations in which symptoms of depression, such as the inability to concentrate, interfere with, or impair, aspects of the self that are considered to be important to the person (e.g. the academic self) then psychological functioning, such as confidence tends to be affected. Charmez (1983) argues that over time depression (or a chronic illness) has the capacity to wear away many aspects of life considered meaningful to the individual.

Participants in the current study had a view of what a student should be, or how they should present themselves, and did not seem to differentiate the mature from the traditional student. This was captured in the subordinate theme: *The Self as Inauthentic.* This finding has not been reported in other literature that has examined mature students' experiences of the social

aspects of college life (e.g. Said et al, 2013). Not being perceived as a depressed student required a lot of effort and planning and when it became too much individuals retreated rather than tell others how they felt. This was especially difficult for participants who had to work with others in a group as part of their course. As discussed earlier, it is generally well known that stigma around mental illness among the student population exists, and that for individuals to reveal it to others is extremely challenging (e.g. MacNeela et al, 2012; Richards and Timulak, 2013). Findings from the current study contribute to research that has highlighted the effort and difficulties that students with mental health problems endure in order to keep their illness private. This research has extended these findings by reporting the experiences of students engaged in courses with a significant practical component or courses that require group work.

In the theme: *Comparing Present Self with Previous Self*, the ongoing comparisons that participants made in the current study between their previous self (capable, happy, and energetic) and their present ill self (struggling, unhappy and lacking energy) was also reported in research by Smith and Osborn (2007). The authors' study, which used IPA, investigated the experience of chronic pain. Findings highlight the alterations that individuals go through when reflecting on their 'non-ill' self. Charmez (1983) writes that the present ill self seems unrepresentative of the individual's situation, and such as the participants in the current study, almost all reflected on a preferred past or previous self. The participants' experiences of depression were at their most sentient when seen from a relational perspective that concerned the perceived judgements of others in their social world. This perceived gaze and judgement from other students highlighted participants' 'socialness' of their depression. This was conveyed in accounts as being more pertinent for participants on the Sports and Leisure degree.

Most participants had an idealised view of their previous self and there was a sense of loss for what they once had. For some participants, their present depressed self is not their 'normal' self. Whilst they accepted their present ill self, there seemed to be a longing to get back their healthy self. The 'new' self with depression was interpreted as being socially undesirable and there was a longing for the previous, non-depressed self or the 'real me'. Two participants: Eoin and Mary, perceived their present depressed self as an informed self who could help them to revision their previous self, which was misunderstood until they gained knowledge about their depression. This present self could be used to help other depressed students. This finding supports the work of Dickson et al (2008) who suggest that for some individuals, who accept their post-illness identities, there is a readjustment of a more positive sense of self. Sokol and Serper (2017) further report that individuals may also present a more optimistic sense of their future self after journeying through illness. Unlike some of the literature reported earlier on student depression, for Mary and Eoin, they seemed to have acquired self-growth and an understanding of their present ill self through their experiences of depression. There seemed to be an integration of their experience of depression into their present self. Indeed, as Frankl (1959) observes, it is often through suffering that an individual can achieve self-growth. Frankl (1959) and Yalom (1980) argue that it is important for individuals to find or create meaning in their lives and in their experiences. It is suggested that for the two participants who conveyed an experience of a more optimistic present self, they had found meaning in their illness and wanted to use this self-awareness to advocate for other individuals with mental health problems. It is acknowledged that participants were not asked why they had enrolled on a vocational course (Social Studies) and if the research were to be repeated, participants would be invited to talk about what influenced their choice of course.

The transition to HE for traditional students will have, arguably, a 'taken-for-granted' or 'more of the same' experience of examinations and assessments, whereas for mature students, they may not be sure what to expect in terms of standards and of particular types of assessments. As courses are increasingly incorporating group assessments (e.g. HEA, 2015) into course requirements and learning outcomes, students with depression may be disadvantaged. The Irish Survey of Student Engagement (2015, p.88) notes that mature students were 'less likely to work collaboratively with other students, although they would engage in class discussions'. If individuals enter college with low self-esteem and a negative, critical, self-image, then being in an environment in which they receive a lot of external evaluation, seems to be keeping their critical voice active. Not only did participants convey a critical voice and a negative self-concept, they also conveyed low self-efficacy. This finding is important as students are increasingly being asked to work in groups on presentations and group projects, and often this collaborative work forms part of a formal assessment. Thus, this research has drawn attention to a group of individuals for whom working and being assessed in such a way is especially challenging.

Bandura (1977) hypothesised that an individual's expectations of self-efficacy determine whether coping behaviour will be triggered and how much effort and for how long it will be sustained in the face of obstacles or negative experiences. In the context of academia in the reported study, this impacts an individual's perception of their ability to learn and attain an intended level of performance. For the participants in the current study, having depression affected their perceived control over their behaviour, motivation and environment. There is a paucity of research on a mature student's academic self-concept. This may be because attention is given to other components of self-concept such as 'professional', so adult self-concept scales tend to reflect these other dimensions (Messer and Harter, 1986). Whilst the

present study did not focus on self-concept, the unique experience of depression conveyed in the participants' accounts is multifaceted and complex, and has illuminated the reimaging of self, which is interpreted as taking place during their academic journey.

Arguably, students in this study will work in professions that are stressful and vulnerable to professional burnout. The notion that mature students can cope because they have had life experiences and are generally motivated in coming back to education (e.g. HEA, 2008; HEA, 2015; The Irish Survey of Student Engagement, 2015) does not mean that once they have been accepted on to the course they do not have 'needs'. The participants in the current study did not appear to avail of social supports, which research acknowledges is a protective factor (e.g. Chambers et al, 2015; Dunkley et al, 2000; Dyson and Renk, 2006) and the finding suggests that alternative supports are needed for mature students in order to help them to deal more effectively with stress that is associated with studying in HE. Understanding coping behaviours is important because it facilitates a deeper appreciation of how best to support students in difficulty. Social support is therefore important to promote within the HE environment, particularly for those students with low levels of support.

5.4 Methodological Considerations and Strengths and Limitations of the Study

Overall, this study has provided a detailed account of how mature undergraduate students make sense of their experience of depression. A rich description of the experience of depression, of managing it, and the perception of the effects of depression on participants' experiences of studying were revealed. This involved the day-to-day lived experience of depression, which participants articulated as being part of their undergraduate education.

The use of qualitative methodology was a strength of the research as it afforded the opportunity for participants to provide a voice to their experiences. By using Interpretative Phenomenological Analysis (IPA), a rich and detailed description of the participants' experiences was provided. Mature students' experiences of depression have not been explored in Ireland in spite of the increasing number of students with depression and the increasing number of mature students enrolled on undergraduate degree programmes.

As IPA is an idiographic approach that does not seek to ascertain definitive or positive responses, this research does not claim to generalise the findings to other HE institutions. Although mature undergraduate students in other HE institutions may be experiencing depression, it is pertinent to acknowledge that this study has provided a detailed account of the salient features captured by particular participants in a particular context. In addition, although care was taken to be rigorous and transparent throughout the research process, it is important to recognise that the findings presented in this study are the researcher's interpretation and other researchers may have highlighted different features.

Caldwell (2008) argues that the theoretical dialogue resulting from IPA studies can contextualise the contribution the research makes to the wider literature. As discussed in **3.7: Assessing Research Validity** Yardley (2000) argues that an important factor in good quality qualitative research is the impact of the study (See **3.7** for an earlier discussion of four criteria suggested for assessing research validity: *Sensitivity to Context*; *Commitment and Rigour*; *Transparency and Coherence;* and *Impact and Importance*). Certainly, the findings from the current study make a valuable contribution to an under-researched area of mature undergraduate students, who have depression. Smith et al (2010) advise IPA researchers to think about theoretical transferability rather than empirical generalisability.

Although IPA recognises the importance of the researcher's perspectives, criticism has been directed at the lack of guidelines in how to integrate reflexivity into the research process, and also to a discussion of how a researcher's perspective can influence analysis. As reflexivity is so important in the process, the researcher kept detailed notes in a reflexive diary and it formed part of the interpretative process. It is worth noting that Smith and Osborn (2008) stress that IPA is an approach rather than a method and suggest that researchers adapt it to accommodate the phenomenon under investigation, and the particular context in which it is examined. The role of language is important in IPA. An interview provides an opportunity for participants to describe a particular experience rather than the experience itself (Willig, 2001). A question that may be asked of IPA is about the participants' abilities to articulate the richness of the phenomenon. It is recognised that some participants may be more able to communicate their experiences than others, and therefore some interviews will seem to be 'richer' in content than others. Also, as depression is often described metaphorically: 'fog', 'black dog', some participants may be more adept at using metaphorical language than others.

A limitation of the research is that respondents were self-selected, and thus, may not be representative of the mature undergraduate student pool. There was a sense that the participants were particularly interested in mental health and therefore, were inclined to be in the study. The experiences of students not choosing to participate may have been quite different. The population from which the sample was drawn represents a homogenous group in terms of nationality and background. Findings may have differed in student populations that were more diverse or even among different cultures. It is also acknowledged that participants may have felt invested in the research project as they knew I was a member of the Institution and they seemed to want me to be aware that depression exists among the

student population. It is reasonable to infer that the 'message' is that depression is not uncommon, and that it impacts academic performance, negatively, as well as individuals' personal relationships. In effect, participants were not only interviewees; they were advocates for other students, who are suffering from depression or other mental health concerns.

The participants' understandings of depression may have been different from that of the researcher. Perhaps the study may have been improved by the application of a formal clinical assessment beforehand. However, this would have compromised the phenomenological stance taken in the research.

Participants were reflecting on their depression so part of the data was concerned with retrospection, and therefore, salience of particular events may have been 'skewed' by memory. Also, part of the interview relied on participants accessing their 'depressed selves' and most conveyed that they were on a 'recovering trajectory'. Having acknowledged this, if participants had been very depressed, it may have been very difficult to conduct interviews as it may have been too painful to articulate their experiences, or individuals may have not been willing to come forward for interview. I had to be mindful of my duty of care to the participants, and also be cognisant that I was not providing therapy. Another limitation was that only one interview was conducted, so accounts were drawn from one particular point in time. However, interviews were full and a range of issues was raised and explored. Further qualitative research could interview students from non-vocational courses or from professional courses as the implications (professional and future) around receiving a diagnosis of depression were strongly conveyed by the participants in the current study. Whilst participants discussed receiving a diagnosis, they were not asked what prompted their seeking a diagnosis. If the research were to be carried out again, that aspect of their experience of depression would be explored.

Whilst all mature undergraduate students, who met the criteria, were invited to take part in the study, participants were only drawn from two undergraduate courses. Thus, it is recognised that the sample was quite narrow, and perhaps students from a business course, for example, may have had very different lived experiences of being a student with depression.

5.5 Implications for Counselling Psychology

Findings from the study have practice and academic implications. Student counselling services have an important role to play in HE institutions and are, to varying degrees, part of the fabric of the institution. Counselling psychologists are often employed in counselling services.

Counselling psychology emphasises the subjective experiences of the individual, 'seeking to understand their inner worlds and constructs of reality' (Strawbridge and Woolfe, 2010, p.10). Counselling psychologists can help the individual in examining their emotions through the therapeutic relationship. As counselling psychology holds a humanistic value base, the aim is 'to reduce psychological distress and to promote wellbeing in the individual, by focusing on their subjective experience as it unfolds in their interaction with physical, social, cultural and spiritual dimension of living' (B.P.S., 2018, p.5).

In relation to the participants in this study, their expressions of psychological suffering are articulated as taking place in a particular context with its social expectations and practices. For a counselling psychologist, all knowledge represents an interpretation of human experience, so what an individual expresses is valid and meaningful to them. As the individual is considered to be self-conscious and reflective, with capacity for choice and responsibility (Strawbridge and Woolfe, 2010), a counselling psychologist, using knowledge

of various psychological theories and therapeutic practices, can help the individual to reflect on their life choices such as behaviour and relationships. Strawbridge and Woolfe (2010, p.11) stress that counselling psychology 'still explores and evaluates the strengths and limitations of psychology, critically.' Being familiar with research concerned with self-esteem and how a chronic illness can contribute to disruptions to sense of self (e.g. Bury, 2002) is helpful when working with students who communicate low-self-esteem and depression. Also, research that has examined diathesis-stress models, in which negative self-referential biases are thought to lie dormant until triggered by relevant environmental cues (e.g. Beck et al, 1979) can help therapists to understand the impact of experiencing a perceived stressful event, such as an exam, can have on a student. Whilst the individual subjective experience is given priority, theoretical explanations may help to provide a framework for assisting the individual in understanding their experience.

The subjective experience of depression is explored with each individual, and a counselling psychologist should retain a position of curiosity and openness. In therapy, the individual's particular experience, rather than a diagnostic label of depression, or indeed its symptom check-list, is prioritised. An appreciation of the individual's uniqueness is very important, so depression is not seen as something that is universal, and that all mature students will experience it similarly.

The participants in this study, as mature students, have a particular identity, which is expressed in a specific context. The context for these individuals is an academic institution, in which they are students in a more youthful environment (undergraduate mature students are a minority within the Institution). Coming into college as a mature student means that there was not a direct transition from Second Level education to Third Level education, so their reality is that they are entering college from the workplace. Their lived experience is that they

are mature students with work experience entering a more youthful context, as most students are aged between 18 and 21 years (e.g. HEA, 2016).

Individuals' narratives communicate that they felt different from others in that context, and that this 'difference' was interpreted as a mental disorder. Spinelli (2014) reminds us that we cannot make adequate sense of human beings (or ourselves) on their own or in isolation. We are always in-relation to others, observes Ratcliffe (2014). Therefore, an individual's problems that they bring to therapy are considered expressions of their relatedness to others. For the participants in this study, their experiences of depression may have arisen from their 'lack of fit' between how they perceive they should be (a competent, mature student) versus their actual experiencing of being (an incapable, struggling student). In relation to Erikson's life span theory of development, the participants' sense of identity and identity formation, which provides a young adult with a sense of where they are going in their life (Erikson, 1965; 1968) is being tested, as accounts communicate the participants' difficulties, and disappointments with their new, or developing, academic identity. Feedback on academic tasks is challenging their academic identity.

As a trainee counselling psychologist, I endeavour to try to understand individuals' reality as they experience it. IPA is an appropriate approach in order to do so, as it attempts to explore individuals' positions in life and contextual nuances of their lived experience.

Findings revealed the stigma around depression, the distinct dynamic among mature students in relation to why they have come back into education, the difficulties in engaging in group work for individuals who experience depression, feeling isolated or disconnected, the challenges of receiving feedback on academic work, and the self-critical voice that participants conveyed in their accounts. These findings reveal the perception of the academic process for the participants in the current study.

Supporting students through student counselling services can be challenging because of the stigma of mental health issues and also because of a sense of community that being part of a HE institute invokes; that is, students may not come forward for counselling for fear of being different to the perceived 'in group'. Findings from the current research reveal that mature students seemed to want to 'fit in' with the student population and not be perceived as different or 'the depressed student'. Therefore, if internal and external services were promoted then students would be presented with a choice. On-line therapy for depression (e.g. Richards and Timaluk, 2013) has been shown to be effective for students in HE, and this is an approach that counselling psychologists could consider implementing or suggesting that students engage in such support. For mature students, who often live off campus, one barrier to seeking therapy is location, so offering an alternative to face-to-face counselling could be useful.

For students who feel they do not have anyone to talk to and feel disconnected from others, counselling can offer a supportive and accepting therapeutic relationship. It can help students explore stages of their distress and bring into awareness their already self-help strategies or preferred ways of managing stress and depression. It is important to recognise that each student has different needs and different ways of coping.

Counsellors need to be cognisant that mature students are always 'in transition' and that they have various needs from an education programme as well as different ways of learning. I would argue that it is important to have counsellors who understand non-traditional student needs and desires, and are instrumental in their integration into life in HE and in the successful completion of their degrees.

It is reasonable to argue that mature students come back into education for a variety of reasons and, therefore, their expectations of the experience of academia will differ. Some of

these perceived expectations may be enhancing, challenging (e.g. Arrnett, 2000) or disappointing. For the mature students in this study, experiences of academia were communicated as being challenging and psychologically uncomfortable. Some participants questioned why they had returned to academia. Therapy can help individuals to find meaning in their psychological discomfort, as people with lower levels of meaning in life seem to have greater levels of distress and lower levels of life satisfaction (Frankl, 1959). Managing past disappointments as well as present disappointments may well help individuals to come to terms with their psychological distress. Sokol and Serper (2017) suggest that one goal for working with individuals with depression is to foster a sense of unity between present and future selves, and discuss how current life decisions may impact a future self. Counselling psychologists could focus on helping the individual to derive meaning from their current life difficulties, as Frankl (1959) considers finding meaning is important in personal growth.

Ideals are often powerful in depression and are often unrealistic (Cooper, 2017). Participants in the study talked about how they believed students should present themselves to the world and also how, as mature students, they should be able to manage stress and their workload. Some individuals also reflected on being in college as an opportunity or a chance they thought had eluded them in their life. It is reasonable to argue that human beings are 'future oriented' (Cooper, 2017) and that our ideals match some internal standards or a template (e.g. Hewitt and Flett, 1991) and, arguably, these are the sources of our 'shoulds', 'oughts' and 'musts'. The participants in the study seemed to be putting themselves under great pressure to achieve their goal and the source of their 'musts' became increasingly more challenging as they moved through academia with depression. It is suggested that their strong ideals seemed to activate disappointment when they did not achieve them, such as grades not being what

they had hoped, or not being able to retain information in class. Receiving feedback on academic work seemed to be particularly challenging.

Disappointment in itself, argue Hewitt and Flett (1991), need not be a problem if it does not elicit self-criticism or other self-attacking beliefs. As revealed in the study, disappointment seemed to be a trigger for bigger fears of rejection, criticism and feedback from others. A counselling psychologist can help an individual to become 'more present' in themselves and overcome resistances or 'blockages' to reality (Cooper, 2017). Counselling psychologists can work with students to manage their self-critical perfectionism, which may contribute to a similar reduction in depressive symptoms and vice versa. Acceptance and commitment therapy (e.g. Hayes, 2004) is an approach which may be beneficial to students with perfectionist concerns as, rather than challenging existing thoughts, a therapist can help individuals to treat their thoughts as events to be observed and accepted. If an individual can foster 'present-centred' awareness (Hayes, 2004) mindfulness-based cognitive therapy may help to move the focus from dwelling on past events to the present. Chambers et al (2015) report that having a positive self-identity was an important aspect of coping with depression, and this involved self-acceptance and self-compassion in order to combat self-criticism and negative comparisons to others. A counselling psychologist can help a student reflect on their strengths and help them, sensitively, to acknowledge their perceived mistakes in a compassionate way.

Assessing the nature of students' experiences and designing relevant interventions to help them to manage stress and adversity may make an important contribution to stemming the tide of depression among students in HE. In the current study, all participants said they came forward for interview because they wanted to contribute to research in the area of student mental health. They also drew attention to a general lack of awareness, throughout the

Institution, of students' struggles with depression and the impact that this has had on their academic work. They articulated that they believed that mental health difficulties were not uncommon among the student population. Participants conveyed that lecturers are not as cognisant of the mental health problems as they would have hoped, and inferred that the counsellor should 'educate' academic staff members. If this is the case, then counselling psychologists could involve students, such as the participants in the current study, in developing workshops or putting together information that can illuminate the impact of depression on the academic, as well as personal, life of students.

When working with an individual experiencing depression, it is important to be cognisant of the demands of academia and the importance of the individual's aims and expectations from life and their way of living. It is essential to put aside assumptions or stereotypes of depression as a general 'thing' as the current study has illuminated the nuances and complexities of the lived experience of depression. Most of the depression scales are clinical in nature (e.g. Beck's Depression Inventory,1996) and identify depressive symptoms (e.g. sleep and appetite disturbances), which are appropriate for clinical populations, but may not be as appropriate for students.

Findings from the current study suggest that when carrying out an assessment a counselling psychologist should not assume that they know what depression is like for the student, but it may be more beneficial if they were to adopt a more phenomenological stance, which explores an individual's full range of experiences. In so doing, an in-depth discussion of the nature of the individual's experience can lead to a fuller and more integrated picture of what is happening for the individual.

I would argue that it is reasonable to suggest that trainee counselling psychologists, who are often mature students, can benefit from being aware of the literature which suggests that

individuals who experience intense negative emotions often engage in high levels of self-criticism. Individuals who engage in high levels of self-criticism often report less positive responses to, or engagement with, psychotherapy (e.g. Cooper, 2017). As such, when working with a client, who communicates such emotions, a counselling psychologist may need to develop their own methods of managing their own self-criticisms should they surface.

5.6 Critical Reflection

Reflexivity in qualitative research is crucial in thinking about how the researcher's own values and assumptions influence the process. I would argue that reflexivity is an inherent aspect of the phenomenological reduction. Smith et al (2010) in drawing on Husserl, argue that bracketing, or the attempt at bracketing, is seen by researchers in IPA as an important part of the research process. The authors state that each reduction 'is intended to lead the inquirer away from the distraction and misdirection of their own assumptions and preconceptions, and back towards the essence of the experience' (Smith et al, 2010, p.14). Part of my critical reflection involved a level of reduction inasmuch as I had to bracket my own experiences in order to bring the phenomenon of the participants' depression to light. For example, I needed to set aside the assumption that depression is a 'thing' and that there are a set of symptoms that are described in DSM V (APA, 2013).

In light of my reading about diagnosis, an example being how it can be an imprecise tool, and how a 'disorder' should be considered in the context of the life of the individual, I was curious about what it meant for an individual. There appears to be a social implication to receiving a diagnosis, and I did not really appreciate this until I interviewed the participants. The feelings of being 'disordered' and different from peers because a professional had told you that you had a 'disorder', really resonated with me as I have 'put my faith' in medical

professionals in the past. I, too, did not really question their knowledge, as I perceived them to be an expert. I was curious that participants, although they communicated that they did not agree with the diagnosis, and subsequent prescribing of medication, still went along with what they were advised. I wish that I had explored this further as it would have provided some important insight into an individual's perceived sense of agency, or perceived lack of autonomy over their own body. Pilgrim (2007) writes that there is the presumption that the disorder exists 'out there' and is independent of its diagnosticians. However, participants' accounts articulated the contextual and subjective nature of their experience of depression. Fatigue was communicated as being experienced by all participants, but the meanings afforded to it were different, as were the feelings of disconnection. Pilgrim (2007, p. 540) makes an interesting observation when he writes that 'The body is potentially explicable in physical terms, whereas human conduct can only be understood meaningfully via interpretative methods'. Depression is also concerned with how individuals perceive it and how they describe it. The participants in this study articulated nuanced experiences of depression, which, I would argue would get 'lost' or cannot be located, in a check list of symptoms. Having carried out this research, I gained a deeper understanding of the importance of the context of the illness as well as the communicated symptoms.

I also needed to set aside previous assumptions that I had held about mature students, generally, being able to cope with the pressure of academic work as they had had often demonstrated (for example, talking about their experiences in class sessions) being able 'to juggle' home and college life. I was struck by the level of negativity communicated in participants' self –descriptions, and how a 'low grade' allocated to an assignment was interpreted as a personal failure, and its impact would linger in the mind of the individual. I had under-appreciated the meaning assigned to their academic progress, as reflected in

academic feedback. I wish that I had explored the reasons for coming back into education, but I was concerned that parts of the interview may have been retrospective. However, I acknowledge that this may have contributed to participants' sense making and the meanings afforded to being back in education as a mature student.

The analysis process is not entirely inductive. I was struck by how participants talked about receiving feedback on their academic work, and consulted literature in the area. Smith (1999) acknowledges that he consulted literature in his study of transition to motherhood. I was aware that I was interested in how participants managed depression, and how they handled the difficulties of their course, if they communicated that particular elements were impediments. Thus, in my endeavour not to prioritise certain themes over others, I made a conscious attempt 'to bracket' certain preconceptions to ensure that interpretations were grounded in participants' data. I made sure that my analysis was scrutinised by my supervisors and discussed potential preconceptions with them and at IPA group meetings.

Throughout the process, I kept a reflexive diary in which I recorded my thoughts and ideas as the research progressed. I also found it helpful to discuss my ideas and thoughts with my supervisors and with colleagues at IPA meetings. Before I began the research, I realised that I would have difficulties in seeing myself as a researcher and not as a therapist or even as a member of the lecturing staff. I had made some initial assumptions about participants' abilities to reflect on their experiences of depression and to be self-aware. This was seen in my providing more prompts in the first two interviews. Also, in these earlier interviews I did not provide sufficient time for participants to ponder on the question. This was also a result of being nervous and being worried that there would be lengthy pauses in the interview, and I acknowledge that this was part of my inexperience with conducting qualitative interviews.

I was also cognisant that I worked in the Institution and that there was a power imbalance. I tried to address this by recruiting participants from a campus that is 75km from where I work, and in which distinct courses are offered. The probability of my teaching the participants was low at the time of the research. However, with a topic as sensitive as mental health, I contemplated how open participants would be with me as I was a member of the lecturing staff. I initially wondered if they would 'filter' their narrative inasmuch as if it were perceived that a particular course or lecturing staff exacerbated their depression, they would not want to bring this up in their interviews.

I was particularly moved by the ways in which participants talked about the struggles involved in coming in to college and how they did not want to be seen as different from the younger students. I had made assumptions that mature students were self-sufficient and that, because they had had 'life experiences' before coming back into education, they would be resilient. I was moved by the insight that they demonstrated about the impact that their depression has had on their relationships and how they experienced themselves. All participants told me that they had been glad that they had taken part in the research. They also conveyed, during the interview, they had talked about their experiences in ways that were different from how they communicated during therapy. Some participants commented that they had learned more about themselves by reflecting on how they see themselves and the meanings that they were making. Participants articulated that this new insight was important to them.

The overall experience has taught me a lot about carrying out qualitative research and the importance of engaging with phenomenological enquiry. I have learned to be more patient and to try not to find solutions to individuals' dilemmas, or to try to find a cause. I have also learned that it is important to appreciate that experiences of depression are unique, and thus,

to approach each individual with an openness and a willingness to stay with the phenomenological method. I would argue that this has most definitely helped me to become a better practitioner.

5.7 Chapter Summary

In this chapter I have discussed findings from the study in light of pertinent research in the areas of depression and mature students in HE. In so doing I have highlighted novel findings, and also how findings from the current study have made a contribution to existing research. Important findings are related to: the perceived impact of experiencing depression on participants' difficulties engaging in group work and in courses with high practical components; the negative side effects of medication; the meaning of a diagnosis of depression for mature students; and how feedback on academic work is perceived and internalised. I also discussed methodological considerations, and presented a discussion of the implications of the findings for counselling psychologists.

Chapter 6: Conclusion

The research in this thesis presents a detailed idiographic analysis of the lived experience of eight mature undergraduate students who experience depression. The work utilised an Interpretative Phenomenological Analysis (IPA) approach, which was informed by Smith et al (2010). Data were collected using semi-structured interviews, which were transcribed verbatim. IPA was an appropriate methodology as it permitted a rich examination of the life world of individuals who experience depression. This experience could be expressed in its own terms, rather than according to a pre-defined category system (Smith, 2004). The study highlights the importance of a qualitative approach to depression, as it focuses on the narrative of personal experience, and emphasises the importance of the context of the participants' life worlds. This is in contrast to a positive approach, which is characterised by a medical model mentality, which considers depression to be a disease that is situated within the individual, outside of their social context (Granek, 2006). DSM V (APA, 2013), for example, presents symptoms of depression, which are out of context. Thus, such classification systems do not take into account the relational aspects of some of the participants' experiences such as self-criticism, which was conveyed as being particularly sentient.

Importantly, while much research, such as studies referred to in **Chapter 2**, provide valuable information about how depression is disabling for an individual and the impact of the side effects of medication taken to manage depression, much of the research does not communicate the personal and nuanced experience of depression for the individual. It is acknowledged that while the aetiology of an illness is important so is the psychosocial experience of that illness (Ogden, 2002).

This study provides a detailed examination of a particular group of individuals within a specific context. It contributes to existing research on depression and students; specifically, mature undergraduate students. The findings illuminate the participants' struggles with depression as they journey through their undergraduate degree in one Institution of Higher Education. Participants' accounts highlight the feelings of disconnection from others in their student community, and the difficulties they encountered when having to work with other students on group or practical tasks as part of their programme of study. Findings also illuminate participants' 'making sense' of their depression, and how their sense of self altered during their journey. Findings also highlight the ways in which participants were managing their depression, such as taking antidepressant medication and engaging in counselling. Individuals also conveyed accepting that they were experiencing depression seemed to be helping them to regain some control in their lives.

The participants are a distinctive group. Their age profile (twenty-six to fifty years) is different from the usual age profile (generally eighteen –twenty-one years) in research that has explored undergraduate students and depression. Also, the participants may have been experiencing depression before they began college, but it had never been diagnosed. They may have been suffering from depression for some time, and, arguably, as adults (age twenty-six years and older, and had been in the workplace), they would have developed coping resources, such as avoidance or procrastination. The participants in this study are distinctive in how they react to their academic challenges as they communicate a lack of self-efficacy, possibly because it has been some time since they were in a formal educational environment, and perceive that they lack academic skills. It is reasonable to suggest there is a mis-match between how they may have coped with problems before entering college (e.g. avoidance) and presently as mature undergraduate students, as the nature of the context (being in

academia) is such that avoidance is not efficacious. The meaning and context of the participants' experiences of depression are articulated as being precipitated and maintained by 'what they are doing'. The participants, in this study, vocalise that they interpret their experience of college in a different way from their younger peers and this is inferred as being brought about by a 'person-environment' interaction. The findings of this study draw attention to the ways in which this particular, distinctive, group of individuals, express their lived experience of depression.

Recommendations from the study are that depression among mature undergraduate students needs to be recognised as a problem within HE, and that once the student has secured entry on to a course, the support should not end there. Support services, in order to assist mature students, need to be tailored to their needs: psychological and academic. A multi-faceted approach is needed, which includes support staff, students and academics.

The research reported in this thesis is an important step towards understanding the lived experiences of mature undergraduate students with depression. By using IPA I have been able to highlight their shared and divergent experiences. I have also highlighted the need to understand the context of these life experiences. Findings also suggest a number of implications for helping students to re-examine aspects of their lived world and their relational world in an attempt to help them to understand or even to find meaning in their college experience.

It is my hope that this research, and future research in this area, will help to contribute to supporting and improving the lives of mature undergraduate students with depression in Ireland.

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APPENDICES

APPENDIX 1 Participant Information Sheet

Mature Students' Experiences of Studying for an Undergraduate Degree with a Diagnosis of Depression

Researcher: *Marie English;* as a requirement for a DPsych Counselling Psychology from NSPC and Middlesex University

NSPC Ltd
Existential Academy
61-63 Fortune Green Road
London
NW6 1DR
Middlesex University
The Burroughs
London NW4 4BT

30th July, 2016

Participant Information Sheet

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part. You should only agree to take part in this study when you feel that you have understood what is being asked of you and you have had sufficient time to think about your decision.

This study is being carried out as part of my Doctoral studies at New School of Psychotherapy and Counselling and Middlesex University, UK.

I work as a lecturer in psychology in Castlebar and I teach students on different courses, so you may know me through this. However, in the research interview I am not in the role of lecturer, but simply wanting to learn about your own experiences.

What is the purpose of the study?

I am interested in learning about your experience of studying for an undergraduate degree with a diagnosis of depression. I want to know about your thoughts, feelings and experiences of being a student. I will also ask you to talk about your experience of taking antidepressants. I am interested in

hearing undergraduate students' voices and the best way to do this is through interviews. Eight students aged 23 and over will be invited to part in the study.

What will happen to me if I take part?

You are being asked to participate because you replied to my flyer inviting interested students to contact me and then we had a phone conversation about the study, in which you expressed interest in taking part. You will be interviewed once at a convenient time for you. I will be recording the interview on a digital recorder. It is expected that the interview will take about an hour and will take place in the Dublin Rd. Campus, Galway. I will transcribe the data myself. I will not use your name. If there is anything you are not clear about, I will be happy to explain it to you.

What will you do with the information that I provide?

I will transfer the data to an encrypted USB for storage, deleting the file from the recorder. All the information that you provide to me will be identified only with a project code, and will be stored in a locked filing cabinet. I will keep the key that links your details to a project code in a locked filing cabinet. The information will be kept for five years after I have graduated, and will be treated as confidential. After that it will be destroyed. I will ensure that neither your name nor any identifying details are included. If quotations from your interview are used in a published article, I will ensure that I will not include any identifying information. Data will be stored according to the British Psychological Society's Code of Ethics (2009) and the Data Protection Act (1998). I will be supplying a short report to the university about my findings. Data will be collated and anonymised. All identifiers will be removed.

What are the possible disadvantages of taking part?

It may be that talking about your experiences during the interview will upset you. I invite you to alert me to any distress or discomfort which may emerge at any stage in the interview process and we can bring the interview to a close and I will turn off the recorder.

If you want to talk more about some of the things covered in the interview, I invite you to discuss this with me. If you feel you want to discuss your thoughts further, then I can discuss the details of organisations that can support you.

Confidentiality

Your privacy is important to me. However, if I am concerned that you are at risk to yourself or to another person I will have to inform a counsellor at Student Counselling Services. For example, if you tell me that you have made plans to hurt yourself seriously or hurt someone else seriously then I will have to tell the counsellor. Also, under the Children's Act (2004) I am obliged to report information, which indicates that a child is at risk. Under the Terrorism Act (2000), if you give me information that associates you with terrorist activities, I must report this. My academic supervisor may request to see the data before it is anonymised. NSPC may require sight of the data as part of an audit. No other individuals will be able to do so before it is published. Otherwise, whatever you tell me in our interview will be confidential.

Excerpts from data may be published verbatim in the final thesis but details that could identify you will not be used. The only people who will have sight of the transcripts will be my supervisor, Dr. Jacqui Farrants and myself.

Consent

You will be given a copy of this Information Sheet for your personal records. If you agree to take part in the study, you will be asked to sign the attached Consent Form before the interview begins.

Participation in this study is completely voluntary. You do not have to take part if you do not wish to do so. If you do decide to take part you may withdraw at any time, even once the interview has started. You do not need to give a reason for withdrawing. Non participation will not affect your studies in any way.

Who is organising and funding the research?

As this study is self funded, there will be no payment made to you for your participation.

Who has reviewed the study?

All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The NSPC research sub-committee have approved this study.

Thank you for reading this Information Sheet. If you have any further questions you can reach me at:

Marie English
New School of Psychotherapy and Counselling
61-63 Fortune Green Rd.
London.
NW6 1DR
Britain.
Email: me495@mdx.ac.uk
Ph: 0858445591

If you have any concerns about the conduct of the study you may contact my supervisor:

Dr. Jacqui Farrants
The Old Chapel,
33, Church Street,
Coggeshall,
Essex,
CO6 1TX
UK.
jacquifarrants@hotmail.com; ph: 0044 (0) 7850 082160

APPENDIX 2: Debriefing Sheet

Mature Students' Experiences of Studying for an Undergraduate Degree with a Diagnosis of Depression.
Researcher: *Marie English;* as a requirement for: DPsych Counselling Psychology from NSPC and Middlesex University

NSPC
Existential Academy
61-63 Fortune Green Rd.
London.
NW6 1DR
Middlesex University
The Burroughs
London NW4 4BT
30th July, 2016

Debriefing Sheet

Thank you for taking part in the study.

This study was an investigation into mature students' experiences of studying for an undergraduate degree with a diagnosis of depression.

Research published by AWARE (www.aware.ie, accessed on 11.3.2016) tells us that approximately 450,000 people currently experience depression in Ireland and that 1 in 10 adults are taking anti-depressant medication (Drugnet Ireland, 2016). There is lack of information about students in Third Level education, in the Irish context, so the study seeks to explore mature students' experiences of studying with a diagnosis of depression, and their experiences of taking antidepressant medication. Today you have kindly shared your experiences with me. It is hoped that the study will highlight the issues associated with being an undergraduate student with depression. It is hoped that the project will help to raise awareness of these issues in the mental health field.

Sometimes talking about your experiences can bring up thoughts and feelings that can make you feel uncomfortable. If you decide that you would like to talk about your thoughts and feelings at a later stage then there are a number of professionals and organisations who you can contact. Their names

and contact details are at the *end* of this sheet. Even after a couple of days, if you want to clarify anything that was discussed in the interview or you decide to withdraw from the project, that is fine and I will dispose of your interview material. This, in no way, will affect your studies.

All information collected today is confidential and there will be no way of recognising your responses and your identity when I write up the findings. I aim to interview 8 students.

This study has received ethical approval from Middlesex University, UK.

If you are interested in finding out more about the study please contact me and on completion of the project, I can make a summary available to you.

Thank you again for your participation.

If you have any questions regarding the study please contact

Marie English me495@mdx.ac.uk Ph: 0858445591 *OR*
Dr. Jacqui Farrants (Supervisor): jacquifarrants@hotmail.com Ph: 0044 (0)7850 082160

Organisations who can offer you support

GMIT Counselling Services: 091-742563 pauline.clancy@gmit.ie OR renagh.linnane@gmit.ie

chaplaincbar@gmit.ie: 0949043150 or 0868492552

Dr. Stephen Patten: 094 9021999

Jigsaw: 091-549252 galway@jigsaw.ie

Samaritans: 091-561222 OR 116 123 (free call)

APPENDIX 3 Interview Schedule

1. **Please can you tell me what it is like to be a student with depression?**

   Prompts: What's it like being depressed – do any words or images come to mind? How do you manage your studying? What is your week like? Can you describe the actual experience? Can you talk about what is going on for you? What are the difficult things about experiencing depression? Can you talk about what it is like for you on any given day?

2. **How do you make sense of your depression?**

   Prompts: what does it feel like? What is it like? Do any images or word come to mind?

3. **What was it like to get a diagnosis of depression?**

   Prompts: What did it feel like? What does it feel like now? What are your thoughts on hearing you needed medication? Has having a diagnosis of depression made a difference to how you see yourself?

4. **Can you talk about your experience of taking anti-depressant medication while studying?**

   Prompts: How are you managing? How do you feel about being prescribed medication? Has anything changed for you? How does it feel being on medication?

5. **How do you see yourself?**

   Prompts: How would you describe yourself? What sort of a person are you?

6. **How do you see your future?**

   Prompts: what do you see for yourself after your studies? What do you see yourself doing next year?

APPENDIX 4 Transcript of Interview with Niamh

I1: Thank you very much er to agreeing to being interviewed. Em what I'd like to do just to start off with (.. .) I'd like to hear a little bit about what made you interested in participating in this research.

R1:Ok em(…)so I suppose firstly as a student (...)research just is an area of interest for me I like I suppose the idea of using people's experiences to to understand you know a phenomenon or a concept. Em I particularly like when when I can relate to the area that's being researched or if I can contribute you know by using my experiences. I guess it's the only way that things can be understood is if people are willing to talk about their experiences so I suppose for me that was one of the main reasons and then secondly em I suppose as a wider em reason em is that my opinion is that there are a lot of students out there that are(...)struggling with kind of mental health issues and without studying it, without researching the effects of like living with the the mental health struggle (...) or with the medication that is used for the mental health struggle lecturers and staff in colleges and institutions just as a whole will em never really know what the student is going through outside of the academics so(…) em. They don't understand how performance is affected why attendance is affected you know and just I suppose what's happening right in front of them and so for me I think contributing to the topic gives a wider understanding for everybody and I suppose it just makes life easier for everybody, so that's really why I wanted to do it.

I2: Em..Well this is very generous of you, very generous of you. So do you think you could em tell me about your own experience of being a third level student with a diagnosis of depression?

R2: Well em I suppose depression would would something would really affect my experience as a student in that before before it I was highly functioning, highly performing, really you know on the ball all the time well able very sociable em but you know now you know on the worst days on the very worst days I don't care I couldn't care about the work. I couldn't care about the consequences of not doing the work. I don't care about what people think about me. I don't care about my interactions with them. I don't see the point in studying at all because you know it's hard to see the point in life as as a whole but that's the worst days (ha ha) that's not always. Mostly it's a struggle between knowing I should be em attending something or listening to something or interacting in a particular way(....)and then not having the energy or the motivation or the confidence to do it and em. Em then (...)having to I suppose deal then with the anxiety of not doing it (...) and then there are other days that you know I'd feel that no matter what I produce it will never be enough and even though my logical brain will tell me that I'm still well able to produce very, very good things and I will still get back really, really good results. When I'm trying to do it I have this huge fear that it will never be good enough so then I just don't do it and then I have to ask for extensions or defer my exams and then em...having (…) doing things like that then makes me feel like I suppose em a failure in a way because I can't keep up with my counterparts and the same way like they don't crumble under the pressure the same way that I would, so I suppose that's depression how how it kind of comes in lots of different ways but it would really affect my experiences as a student.

I3: Would you be able to say a little more about what some of the days are like where it's very difficult maybe to concentrate on your studies and could you tell me what's going on for you on those days?

R3: Yeah so I guess em (...) I guess (…) em (…) it's a bit of just not really caring and like ok so maybe that's not even the best word. I do care about it obviously that's why I get up and go in and I try but when I get there and I'm listening to (…) you know whatever is being said be it a law or a policy or something about government and I have to listen listen (…) to something like that and in my head (…) you know I have all this just fog and it's just really hard to concentrate. It really is hard to listen to stuff that's seems so not real if that makes sense like it's not real to me. It doesn't apply to me and my life and it doesn't fix anything for me so em (…)I mean that it's hard to listen to those things and then em I'm part of a course that would look at different I suppose suppose parts of human suffering so that doesn't help matters you know because you have your own misery then you have to listen to other people people about people's misery then sometimes and then some of the things that we are learning about are ways to I suppose interact with other people and the different things they are going through so maybe someone is telling you that the best way to deal with

someone with depression is xyz and you are sitting there and you're like 'no that's not real (ha ha)' I find I have a lot of that going on and I would think about it. I would get stuck then on a point and miss the rest of the class because I'm thinking about (…) something so (…) I guess em my point being so rambly is an example of my thoughts when I'm trying to concentrate on one thing my mind goes off on a hundred different things that is is really really difficult to focus so my answer in of itself is an example of that of how that happens (ha ha). Those are the hard days but it's not always like that (…) There are better days too.

I4: What is like for you coming into college on those sorts of days (…)the better days?

R4: There there are days where I wouldn't feel it all maybe it's sunny outside or we know that the Easter holidays are coming or just something good a class has been cancelled is always (…)wonderful you know. Someone wants to go for a walk something like this (…) something a bit different and em (…) on those days it's good on those days. I'm em excited. I want to I suppose the good part about college when you're struggling with this is other people and having a chance to em socialise and to experience things and to talk about anything from the weather to something ridiculous on television or something more serious. But I suppose that's the part I like about college. On other days it's the worst part about college but it's the thing I suppose that that keeps me most sane in here (ha). Yeah, people help (…) on good days.

I5: So is this about interaction with other people? Could you say more please?

R5: Yeah I guess (...) That can either be I don't know how would you describe your interactions with the students. Then in some of these moments. So I guess I guess then on the better days which are less frequent but on the better days em interactions with students are you know the thing that keeps me there in that (…) the conversations like I said and a lot of the time it's just having connection. Connection is huge like em I think without that without that I think that's what we are built for but then on the worst days I want to punch everybody in the face. On the worst days people are just annoying and you know there would be questions that might be asked that would kind of kind of...I suppose distract the lecturer from what they were talking about and maybe the lecturer would get into the conversation with them em (…) and I wouldn't be able to have the same level of patience that I would have when I first came in to college without the depression affecting my life but since it did come in frustration levels would be really high and tolerance levels would be really low and so when those moments happen where be it a student distracts someone or a lecturer goes off on a completely random tangent and ... we don't get the thing done I'd find it really difficult to em to concentrate and I suppose (…)and (…)another thought that I had on interactions with others is em then on the worst worst days where I'm not really interacting with other people I'm not really listening to what's going on and I feel I should talk to somebody about how I feel. They're the days when my mind is like 'No you're a nuisance don't talk to anybody. They're not going to want to talk to you ...you're just in their way. You're a burden.' There would be lots of that and I'd really really feel that's what it is. I would avoid everybody for fear that being confirmed somehow so em yeah.

I6: Can you say a bit more about that that you feel..about that (…) to use your words: 'you're a burden'?

R6: Yeah I don't em let me just think em I suppose I just (…) When I look around and I see people doing their own thing. They're doing their study and they're doing their lecture and whatever it is they are doing and I'm there thinking all of this stuff. You know I might be really upset by something or whatever it is and you know my having worked in the area of mental health for for a few years before coming in here I know that it's a good thing to do is talk to somebody about it (…) and yet at the same time my mind is saying to me 'No don't do that don't (…) they're not going to want to hear you. They are doing their own thing leave them. They're happy they're comfortable (…) if you go to talk to them now (…) you're disrupting their day you're disrupting their comfort they're going to dread seeing you coming' (…)This kind of em I don't know. I suppose there is a real insecurity about where where I'm placed in the world or how others see me and it's a funny kind of thing because em people would describe me you know as strong and resilient and intelligent, easy going ... These are some of the words that em I get all the time, you're very strong and capable all of the time and I win things. I win awards and scholarships and I get brilliant grades but at the same time when I go home and the door is closed, the makeup is off and the pyjamas are on, that's when I'm like nope you're a fraudand you know I really believe that. I really believe that I'm on a em I've been put on (…) I'm on a pedestal and I don't deserve to be on it and then you know I think it's the image that I have created for my own self anyway. I've

created an image of I'm fine I'm fine I'm coping just fine (…) but then when I'm not coping and I need someone to talk to and I ask for it I'm asking people who believe that I'm really strong and I'm really resilient and intelligent and so they don't (…) they can't meet me at the level. They want me to be what they think I am which is strong and resilient and intelligent so they tell me you'll be fine. You'll be grand aren't you great aren't you perfect. They can't come to that level (…) it's lonesome. It's a lonely kind of image I've created for myself and now I can't come out of it so on those days that's where I feel like a nuisance or burden or fraud.

I7: Could you say a little bit more about how you see yourself?

R7: Em well I guess that's really, that's really it. I see myself as the opposite of what those people would see me as. I would see myself as you know em em. The words that I've just used there strong and all that em. I don't know weak or I don't know (…) yeah identity would be something I'd really struggle with that in that there is the image that I've created for myself which is a strong resilient coping type and yet at the same time I'm a bag of nerves most of the time. I think most of it that I put on is a mask like a coping kind of thing. I'm fine. I'm great. I'm perfect. Don't notice that I'm not and em so then and then I have to come back away from all of that and when I close my door it's a different story and I I suppose that's the part where I struggle with the identity so I don't know who I am. I suppose that's em that's difficult.

I8: If you can could you say a little bit more about putting on a mask?

R8: Yes just for me. I suppose for me personally and the different situations I have going on in my life. I have a young child and it's just us and when I was pregnant with him em initially everyone(…) well the biggest thing for me I wanted to come to college. I I always wanted to go to college be here getting my degree get my post gradget even up to PhD level. This was my biggest dream and then I got pregnant and the response to that was (…) You've ruined your life. You've ruined all your plans. You're never going to reach your dreams. You'll never get to college. You'll never get your exams. You'll never manage that (…) not going to be able to manage it all. That's what I was getting all the time so I think I I wanted to prove them wrong or something (…) I wanted them to be wrong. I wanted em them to be wrong. I wanted to continue with my plan. So then I did it em and I did quite well up until recently and I was managing you know to to juggle parenthood and a household and my student life em and then I guess I put myself under too much pressure to do it all and be superwoman of some description and then I had to succumb to the pressure of it all (…) But because I was doing so well with all of that and I'm this amazing superwoman and I'm managing my household. Here I am with my little house my little car my little boy all my awards all my scholarships amn't I great in college with all my distinctions. So I created this and everyone was so proud. 'You really did it. Well done for proving us all wrong' (…) and they had me on this great pedestal and I didn't mind being on it initially and then I guess I started to drop something. It was like being a juggling show (…) juggling you know and I was doing a really good job and I was starting to drop some things as I was getting tired. I was getting tired. I em em suppose sleep is the big thing and tiredness is a big thing for me so once I started losing a bit of sleep and started to get a bit tired anddropping.. things. So I might not be able to I might still be able to continue with college (...) and something would fall at home or I'd be trying to get something done at home and or I wouldn't keep up with college work and as I started to drop some of those balls as in the juggling metaphor that I'm using. The people around me almost couldn't see that I was dropping it because they were so used to seeing me managing it that they didn't notice the one or two that were falling (...) And I would panic and say 'Help I'm really struggling here' but everyone would not em everyone that was around me and the people that were there for the image that I'd created had a real real difficulty in accepting that that it was a problem. They kept em encouraging me to keep going and I couldn't let my guard down. I couldn't stop so I was stuck in this constant show: panicking dropping things all over the place asking for help and (…) So I guess that's that's what it was about so eventually I dropped it all. Ahh so em I can't do it anymore put my hands up so you could see that would turn into a bit of a bit of a mess from there.

I9: So the people em the people in your life. Could you tell me a little bit more about how you see other people in your life?

R9: Em em mostly it's what I said about about the nuisance. I really feel that I am a nuisance to them em I would be the type that would be over. I would comprise everything for the convenience of others. I would be afraid to be in their space. I'd be afraid to be to ask for help. I'd be afraid to ask for time. Let's say for example there (…) struggling between parenting and workload. I still wouldn't ask for help. I still wouldn't ask someone to mind him while I got an assignment done so because I felt like a nuisance (…) it really came down to how it came down to (…) my interpretation of the relationship because you know I know really that if I do ask I'm em and I'm starting to learn that now that if I do ask for help it's there but my interpretation of where I stand in relation with others is that I'm a nuisance and that people would rather not help me. And that even when they do say yes they are doing it unwillingly or em I don't know what the word is that they they would rather not kind of thing. I suppose then there's that other side of me that thinks that most people just haven't a clue they just don't know they just don't understand em really so when I hear things like just think positively or em what is the other one that really annoys me (…) em you know just things like if you just get up now and just do it just start and that will make it better or go for a run go get your eight glasses of water or you know just things like that em it bothers me in that em it just it sounds awful but there's part of me that just thinks em you just don't know what you are talking about I'd really almost put them down in my own mind and I would kind of little bit lose respect a tiny bit for their understanding of reality almost yeah (…) you know so yeah.

I10: So do you feel as though others don't understand your depression? Could you tell me about this please?

R10: Yeah oh absolutely absolutely we have come a long way as society in talking about mental health and kind of understanding it a little bit more. I think the majority of people see it as this you know as this sadness that just came from somewhere and it can be fixed (…) it really is not like that and I don't know how to explain it but it isn't just a sadness that comes out of nowhere. It's more of em a darkness that that affects everything not just sadness it affects everything and it everything becomes a fog and nothing really seems to matter almost. Nothing is clear and it's all such an effort (…) So I guess em most people it's very well intended. Don't get me wrong this attempt to fix it these all these all ... get up and exercise eight glasses of water and five a day fruit and all this craic and you know em just talk about it it's that easy just talk about it and em Then I think that it's very it's very (…) it's much more complicated than that and I think that the general people unless they have been there really won't understand what it is em. It's so personal too (…)

I11: Could you say more about depression being more complicated than just feeling sad?

R11: Yeah (…) well as I said it's more than feeling sad. Everything is an effort and I don't care and yet I force myself to do things (…) I guess that's my personality…keep going don't give up. So I guess from the outside I look fine em but inside I feel such a fraud can't be honest with people(...) but as I said, not all days are like that. Some days I can put on a smile and sort of mean it you know (…) but those days are few. People don't really know em (…) what's going on inside. As I said before they see me as strong capable and intelligent so how can she be em. feeling depressed? Mostly life seems like a fog. I'm trying to make sense of what I have to do but I also don't really care (…) em nothing seems clear (…) yeah nothing seems clear em (…)

I12: You mentioned earlier that people perceive you as being strong and capable. Could you say more about what that means for you?

R12: So yeah like that like I said it gives me a lot of anxiety being on that pedestal because I feel like I can't come off it. I feel like I've a right to come it because I'm struggling and I feel like I should be able to come down and say 'I'm not well'. And I I don't like to say that depression is a sickness but I would like to be able to come down and say that I'm not well or I'm unwell or I'm sick. I'd like to be able to say that and for it to be fine. So yeah I mean em I would like to come down and for it to be okay but it's not and I'm (…) I'm still stuck there. Even though we have been going through this for months people still have me there on this pedestal (…) Can't come down off it so yeah it's hard.It's tiring. It's hard to try and convince people that It's hard to convince people the opposite of what I've been trying to convince them for so many years (…)

I13: Which is?

R13: I've been trying to convince them for so long that I'm coping that I'm fine. I'm great and that I'm wonderful and all of this and now I have to try and convince them that I'm not. I'm not coping. I'm not wonderful (…) em get me down off the pedestal. Let me down from it. I just don't like the pressure. It's a lot of pressure being up there and a lot of pressure so that's really exhausting so em yeah.

I14: If you can could you say a little bit more about the sort of pressure you're experiencing?

R14: It's that (…) it's it's the pressure to be strong to be resilient to be to continue the image that they want me (…) they want me to be (…) that strong resilient person and they just want it because it's comforting to them in some ways (…) They don't like that I'm struggling they just they don't like the idea that they were right almost (…) and I guess (…)

I15: Who are they they? (…) When you say they who comes to mind?

R15: So I suppose (…) support system eh friends and family em (…) even lecturers to a point. So when I'm struggling say at home or you know with my health or whatever it is it's friends and family but if say if I struggle with college work it's staff. You know when I came in here in first year I blew lots of things out of the water in that I created em I started really well. I did really good exams really good assignments and contributed well to my classes and now that continued through first year and second year and by the time I got to third year and I was really really starting to struggle with everything but mostly mental health (…) that started to sink into my em abilities in the classroom. It was really difficult to (…) I suppose to just let go of the whole I need to have a distinction. I need em. Actually it's really coming to me now. Em I had thought about it during the year but I didn't think about it today in relation to this interview but I actually hold a lot of my worth in my college performance so em. So even though in third year one of the support staff here really strongly recommended that I took a year out and I wouldn't let it go because I was afraid that if I came out and I wasn't studying and I wasn't performing and I wasn't getting this kind of validation for the pressure I was putting myself under I needed em I knew that the pressure was making me sick but I needed to know that it was for something. So as long as I was getting good results you know … feedback it was validated in that I don't know if that makes sense?

I16: Yes yes it does make sense

R16: So that that was really (…) I just found it hard to let go of that and to ask for help and even asking for extensions or ... deferring my exams I was afraid to tell my lectures as though they cared (ha ha). They didn't. They had how many hundreds of other students and yet I was so certain that if I told them that they would be so disappointed in me (…) that they would see as less of a student and that they'd see me less. I don't know and that was one time I realised that I'd weighed that I'd put so much of my worth into how I do things in college because it's one of those things I can control. Life was so crazy and my mental health was so unpredictable that college was something that I could control. I can control what I write control what I'll get control all of that. I think that just yeah I didn't really think about that until now em but (…) yeah.

I17: You talked about your distinctions and things like that, all of that and that not wanting to have a break from College and managing to keep going for a couple of years (…) and things then changed. Could you say a little bit about your experiences of taking anti-depressants during this whole em your college life?

R17: So I guess em they didn't really suit me em antidepressants. We figured that out after trying a couple of different ones. So the first ones had annoying physiological effects on me in that they would make me sleepy and sick, so that affected my college em attendance and performance but although I would be there in the building because there was something about being here that kept me grounded because again it was my worth (ha ha) but at the same time (…) I would be asleep across the desk or I would be asleep in the corridors, just to sleep and there would be students passing me by. I could be there for hours. It just made me sleepy and I'd sleep on tables and I'd miss lectures and that was those ones. And then the second ones were I suppose the worst ones. They really affected my ability to like (…) really affected say emotional control and really heightened things like suicidal ideation kind of stuff you know. I had some really crazy thoughts that didn't really have a place but (…) It was really exacerbated by this medication. When I went back to my GP about it she realised it probably wasn't really the best idea for me to be on them. There had been reported

side effects that for people people under 30. Maybe she she just didn't think about that. So then I suppose the latest one have less of a physiological effect and it doesn't make sick or sleepy and it doesn't affect the thinking as much, but would affect things like concentration and the ability to em you know absorb information. So like em I think I mentioned before I could sit in a lecture and there could be really informative em presentation something really really interesting and I would only hear or really really hear or absorb one sentence or one piece. And if for example a lecturer or a facilitator at the end of the session said 'Can you tell me one thing that you can take away from today?' I would really struggle with recalling what I actually heard recalling any of it, so I would have to rely on really really good notes because I wouldn't have heard what was said. So if I didn't write it down I'd really hope that somebody else did or that the person would have hand outs at least or some sort of on line stuff and that's really unsettling for me because again I'm the type of student that likes to soak up things and em would really take something ponder it and give back something and em . Then I suppose since all that changed it's it's really unsettling. It's unsettling to know that's more than likely because of this medication and my awareness of the change is I suppose like if I wasn't aware of it then it probably wouldn't bother me as much but I am aware of it. I can recall a time when I was highly functioning and this wasn't an issue and now I can see the difference and how it's affecting my ability to perform and like I said already (…) The performance is so linked in with my worth it becomes a cycle that em just exacerbates the feelings of uselessness and all of that (…) so it's a cycle.

I18: So how are you managing all of this then? How are managing managing your medication? Could you tell me about this please?

R18: Well right now I am actually speaking to the GP about not just not being on medication because I don't feel it's a chemical for me although I have the diagnosis of depression. For me I don't feel like it's a chemical imbalance. I think lots of people like I said earlier... I think people think it's a sadness that came out of nowhere but I know that (…) there is a huge belief in particularly in mental health .. medical kind of arena that depression is is just a chemical imbalance and that's that's all it is and that once you right that imbalance all will be well which is why we have this surge of em medication. But I would be of the belief that that's in some cases it may be true but not all cases and I think that with my circumstances it's not like a chemical imbalance. It's a result of years of pressure and exhaustion (…) and you know just the pressure and you can only be under so much pressure for so long. But how you can say that's fixed by medication when you think about it it doesn't really make sense. So em we 're looking at that as an option to go down a talk therapy route rather than a medical route. It isn't doing well for me and it's really affected my college and like I said because it's affecting (…) it's not em like I said it's affecting my feelings of worthfulness usefulness and you know it it is becoming a vicious cycle. So I suppose if we remove the medication and (…) In my opinion if we remove the medication and replace it with a talking thing then I suppose and taking some of the pressure off and just I suppose managing time and all of that and maybe taking some of the worth out of college then maybe it may be easier. I don't know.

I19: Could you talk about maybe having a diagnosis of depression has made a difference to how you see yourself?

R19: Well like I said before I worked in the area of mental health before coming into college, so I guess I knew that the diagnosis was coming. I recognised it ... I recognised what was happening. I recognised all of the symptoms. I knew that when I got that diagnosis wasn't surprised. It didn't change my life that much. It kind of validated the some of the feelings that I was having in a way. But then there was that other part of that (…) that was really dread provoking. It meant that this wasn't a phase. It meant that this was something that could potentially follow me forever and if the medical model is right and it is… what if it is something to do with me and my brain and my makeup then will this be (…) Will this feature in my life forever? Will this continuously be a thing? So there is a fear and dread around that. What if it is a thing to do with (…) what if it is you know a medical thing rather than you know just a difficult phase that can be worked through. So I guess there is that em. Also with the medication (…) I I suppose being told that I need that to regulate myself is a little bit em em difficult because firstly I don't think that I do and em I do think I need to think lift the pressure a bit. Em and have more support around you know managing things. I I really don't know if I really believe that it's a medical imbalance or something (…) whatever it is that people continue to say that it is (…) what it is yeah em. I guess it's hard to have that say on my medical record. You know I do worry a lot about things you know. I did one of my placements in social work and I know that say if a family wanted to em foster a child or get involved

in that kind of you know thing their medical history is looked at and mental health is considered really important, so if you have a history of any mental health difficulty it is weighed up against and even used against you years down the line. So I worry about things like that you know. I'd like to think at some stage this will be something to look back on and that it won't be it (…) feature in my life forever but it would still be there on my medical record. It will still be something that's used to used to define me and something that's used to assess whether I'm a risk of some sort you know, so I worry about things like that. I don't know whether it will affect my ability to emigrate down the line things like that or get life insurance just little things. I do wonder, yeah. I do worry about the fact that it is on my medical record as part of a diagnosis

I20: Is this part of how you are making sense of the whole experience?

R20: Yeah yeah I guess. I don't really know how much I ponder on it. They are just some of my worries in terms of when I do see a going forward point, but most of the time (…) I can't see forward. I can't see future. It's just fog. I'm not saying I don't have a future. I'm not saying that that I see an end. I see fog and I don't see it so em so on the good days I'm imagining all these great things and then I worry about that the diagnosis because it was a diagnosis which means it was medically diagnosed it means that it will follow me. It will be always on my record somewhere and there will always be someone who thinks that it means xy z whatever (…) and will use it to assess whether or not I'm good enough for whatever it is be it a job be it a volunteer role be it emigration or to foster a child or whatever it is that I decide to do down the line. So em I don't really know how I try to make sense of it but they're some worries about the future and having that (…) yeah on my record (…) yeah.

I21: So thinking about em what you've just said (…) so how do you see your future?

R21: Yeah I mean like I said right now it's foggy. It's something I don't know whether what's in it you know. I just don't know. I used to have this very clear idea that I was going to you know sail through my undergrad. I was going to do a post grad and hopefully closer to the city as in Dublin and I would work in a really great job there. You know I I sometimes look up the different jobs that are going and some of these dreams jobs for me (…) and I used to have those were so clear. And now I don't even know if I will get through the undergrad. I'm just (…) I'm struggling so much so I guess I don't really know what I see the future as but it's not something that I'm excited about anymore. It's more something I'm dreadful for and I'd like to be able to put a hold on time (haha)for a while to stop it from going forward so I guessI don't really know how I see my future. Yeah. That's it really (…)

I22: I've really appreciated em how open you've been in this interview and how much you've shared your personal experience with me. So em I'd just like to know how you've experienced the interview and if there is anything else you'd like to say or mention that we haven't talked about before we finish?

R22: No I don't think there is anything additional em. I'm glad to have had the opportunity to talk about mental health and student hood because I don't think it's really everything when people think about college students and they think about third level you know they say college is the best years of your life and you know I've read research recently. I read a piece that said you know 63% of students reported that their performance and their attendance has been affected significantly by the mental health. That's a massive amount and I don't think enough research is done and I definitely don't think that college is given enough weight. I think that a lot of the time we are assessed on how we do on one day in the middle of May and it doesn't really matter about what you're going through or what your year has been like or what's going on in your mind or how you do (…) so that two hours that morning in May really determines so much. And I don't think things like mental health are considered. A bereavement maybe considered and physical illness might be considered but em you know what goes on in your mind really (…) they don't see it as important you know. I hate that term 'mind over matter' but you know ,so I think that research like this is very important for that and I'd hope that the more students that are the more I suppose that it's researched the more understanding we can have and a cultural change can happen around students and how institutions can interact with those students. And I suppose the other thing that I found interesting with this interview for me in particular was thinking about identity. I don't think I've ever really thought about how depression changes how you see yourself (…) yeah how I see myself. As I said: capable and strong and yet I'm I'm not really (…) In interviews it's usually it is just questions. It's just an interesting one. It definitely needs to be asked a little bit more because it

does change your whole identity or it does make you question it so I guess that was good. Yeah It was an interesting aspect of it (…) So I don't know if I have anything more to say, em (…) no no more to say. Thanks.

I23: Well I'd just like to say thank you very much. Thank you.

APPENDIX 5 Example of Exploratory Coding (Niamh)

Participant 1: Niamh	*Exploratory coding*
I2: Em..Well this is very generous of you, very generous of you. So do you think you could em tell me about your own experience of being a third level student with a diagnosis of depression?	
R2: Well em I suppose depression would would something would really affect my experience as a student in that before before it I was highly functioning, highly performing, really you know on the ball all the time, well able very sociable em but you know now you know on the worst days on the very worst days I don't care I couldn't care about the work. I couldn't care about the consequences of not doing the work. I don't care about what people think about me. I don't care about my interactions with them. I don't see the point in studying at all because you know it's hard to see the point in life as as a whole, but that's the worst days (ha ha) that's not always. Mostly it's a struggle between knowing I should be em attending something or listening to something or interacting in a particular way(…) and then not having the energy or the motivation or the confidence to do it and em. Em then (…)having to I suppose deal then with the anxiety of not doing it .... and then there are other days that you know I'd feel that no matter what I produce it will never be enough and even though my logical brain will tell me that I'm still well able to produce very, very good things and I will still get back really, really good results. When I'm trying to do it I have this huge fear that it will never be good enough so then I just don't do it and then I have to ask for extensions or defer my exams and then em(…) having doing things like that then makes me feel like I suppose em a failure in a way because I can't keep up with my counterparts and the same way like they don't crumble under the pressure the same way that I would, so I suppose that's depression how how it kind of comes in lots of different ways but it would really affect my experiences as a student.	Uses her experience to educate or advocate for others. Is she trying to educate me; I'm wondering here how she sees me? She seems really committed to the area of mental health. Depression is a struggle (repeats) Impact of depression on students; lecturers don't understand – impact on academic performance and attendance. If depression is understood, it would make life easier for students and lecturers. Is she trying to educate me here? Contrasts life as a student before becoming depressed with how she is now: Beginning of her course- highly functioning, high performance, very sociable: very positive Last year or so – on worst days –doesn't care as there's no point in doing anything such as college work or socialising Laughs when she says that not all days are as bad as this. Sounds like college is a 'hell' for her - unrelenting, repetition of 'struggle' A real heaviness in her voice - it's like she is living her depression, now, as she tells me her story. Life is a struggle (repeats this numerous times) – knows she should attend classes but can't as no energy, motivation or confidence to do so. I'm getting a sense of her struggle and wonder how she coped with getting in to college at all? Logical brain is telling her she can still function as a successful student, so part of her brain is still working for her. Sounds scared of failure and not being good enough.
I3: Would you be able to say a little more about what some of the days are like where it's very difficult maybe to concentrate on your studies and could you tell me what's going on for you on those days?	Compares herself with other students who don't need to ask for extensions; sees herself as a failure for not keeping up. Repeats – pressure to keep going. This is a very strong image for me: failure, never good enough, crumbling under pressure
R3: Yeah so I guess em. (…) I guess .....em (…) it's a bit of just not really caring and like ok so maybe that's not even the best word. I do care about it obviously that's why I get up and go in and I try but when I get there and I'm listening	I picked up that concentrating is difficult and frustrating for her so I ask for more information.

to (…) you know whatever is being said be it a law or a policy or something about government and I have to listen listen... to something like that and in my head (…) you know I have all this just fog and it's just really hard to concentrate. It really is hard to listen to stuff that seems so not real if that make sense, like it's not real to me. It doesn't apply to me and my life and it doesn't fix anything for me so em...I mean that it's hard to listen to those things and then em.. I'm part of a course that would look at different I suppose suppose parts of human suffering so that doesn't help matters you know because you have your own misery then you have to listen to other people people about people's misery then sometimes and then some of the things that we are learning about are ways to I suppose interact with other people and the different things they are going through so maybe someone is telling you that the best way to deal with someone with depression is xyz and you are sitting there and you're like 'no that's not real (ha ha)' I find I have a lot of that going on and I would think about it. I would get stuck then on a point and miss the rest of the class because I'm thinking about (…)something so (...) I guess em my point being so rambly is an example of my thoughts when I'm trying to concentrate on one thing my mind goes off on a hundred different things that is is really really difficult to focus so my answer in of itself is an example of that of how that happens (ha ha). Those are the hard days but it's not always like that. There are better days too. I4: What is like for you coming into college on those sorts of days the better days? R4: There there are days where I wouldn't feel it all maybe it's sunny outside or we know that the Easter holidays are coming or just something good a class has been cancelled is always (…)wonderful you know. Someone wants to go for a walk, something like this (…) something a bit different and em... on those days it's good on those days. I'm em excited. I want to I suppose the good part about college when you're struggling with this is other people and having a chance to em socialise and to experience things and to talk about anything from the weather to something ridiculous on television or something more serious. But I suppose that's the part I like about college. On other days it's the worst part about college but it's the thing I suppose that that keeps me most sane in here (ha). Yeah, people help(…)on good days.	Days when it is hard to concentrate:- It's more than not just being able to pay attention to what's happening in lectures - not really caring about college; tries to motivate herself to go in, but it's difficult – like a struggle. She can remember specific examples of when she couldn't concentrate. It all sounds such an effort for her. Taking pauses to gather her thoughts? In classes listening to topics but mind is a fog; it's not clear for her. The image of a fog is like you know something is there, but you can't see it. It must be frustrating for her. Can't relate to topics under discussion – seem abstract. If it's not real to her – what is her reality? Hard, heavy and seemingly pointless being in class, but she still forces herself to come in. What's the point of it all? She's studying topics that relate to human suffering – content resonates with her and she questions herself. It's pointless and depressing and it makes her think about herself, but she still gets up and goes in to college. Wonders how can she listen to the misery others face when she can't deal with her own suffering. Other content doesn't seem real – when lecturers talk about depression she questions this: not how it is for her. It's not real and doesn't apply to her. Wonder if she 'switches off' during these lectures? Must make the effort to stay with the topic really hard. Gets stuck on a point in class and misses other aspects of class. Laughs when she says that her response to my question is indicative of not being able to be concise, but is 'rambly'. Differentiates between bad days and better days as depression isn't the same every day, so that must be hard as it sounds unpredictable. The breaks from college work are great. Better days: more energised; things don't seem so flat Connecting with others is important and keeps her going, but can cause frustrations too. Repeats that having depression is a struggle – Laughs when commenting that people 'keep me sane' – quite dismissive of her own feelings. Is this part of her coping? On good days having people around her helps but on the bad days having people around her is the worst part of college.

APPENDIX 6 Example of Coding Using IPA (Niamh)

Themes	Transcript	Underlined: description and content *italics: thinking about language use* **bold: conceptual and interrogative use.**
Impact of depression on student performance Depression is misunderstood by lecturers Impact of depression is not understood Depression is common among student population	I1: Thank you very much er to agreeing to being interviewed. Em what I'd like to do just to start off with (...) I'd like to hear a little bit about what made you interested in participating in this research. R1: Ok em… so I suppose firstly as a student (…)research just is an area of interest for me I like I suppose the idea of using people's experiences to to understand you know a phenomenon or a concept. Em I particularly like when when I can relate to the area that's being researched or if I can contribute you know by using my experiences. I guess it's the only way that things can be understood is if people are willing to talk about their experiences so I suppose for me that was one of the main reasons and then secondly em I suppose as a wider em reason em is that my opinion is that there are a lot of students out there that are (…)struggling with kind of mental health issues and without studying it, without researching the effects of like living with the the mental health struggle (…) or with the medication that is used for the mental health struggle lecturers and staff in colleges and institutions just as a whole will em never really know what the student is going through outside of the academics so. em. They don't understand how performance is affected, why attendance is affected you know and just I suppose what's happening right in front of them and so for me I think contributing to the topic gives a wider understanding for everybody and I suppose it just	Uses her experience to educate or advocate for others. **Wants to contribute by using her experience. Relates to other students struggling with their depression.** **Is she letting me know (as I am a lecturer) that depression is not uncommon among students – is she educating me?** *Depression is a struggle (repeats)* **Impact of depression on students; lecturers don't understand – impact on academic performance and attendance. If depression is understood, it would make life easier for students and lecturers.**

	makes life easier for everybody, so that's really why I wanted to do it. I2: Em..Well this is very generous of you, very generous of you. So do you think you could em tell me about your own experience of being a third level student with a diagnosis of depression? R2: Well em I suppose depression would would something would	
Compares present self with self before depression Challenges of studying Changing image of student Changing relationships with other students Overwhelming tiredness Depression is a struggle Can't engage with studies Lacks motivation; doesn't care Heaviness of depression Changing image as a student Overwhelming tiredness Can't engage with studies Highly self-critical Loss of self esteem Depression is overwhelming Loss of confidence Self-critical	really affect my experience as a student in that before before it I was highly functioning, highly performing, really you know on the ball all the time (…)well able very sociable em but you know now you know on the worst days on the very worst days I don't care I couldn't care about the work. I couldn't care about the consequences of not doing the work. I don't care about what people think about me. I don't care about my interactions with them. I don't see the point in studying at all because you know it's hard to see the point in life as as a whole but that's the worst days (ha ha) that's not always. Mostly it's a struggle between knowing I should be em attending something or listening to something or interacting in a particular way (…) and then not having the energy or the motivation or the confidence to do it and em. Em then (…)having to I suppose deal then with the anxiety of not doing it (…)and then there are other days that you know I'd feel that no matter what I produce it will never be enough and even though my logical brain will tell me that I'm still well able to produce very, very good things and I will still get back really, really good results. When I'm trying to do it I have this huge fear that it will never be good enough so then I just don't do it and then I have to ask for extensions or defer my exams and then em...having... doing things like that then makes me feel like I suppose em a failure	<u>Contrasts life as a student before becoming depressed with how she is now:</u> **past– highly functioning, high performance, very sociable: very positive** **present – on worst days –doesn't care as there's no point in doing anything such as college work or socialising. Looking back on an idealised self?** *Laughs when she says that not all days are as bad as this: Using humour to deflect from content.* *Life is a struggle (repeats this numerous times)* – <u>knows she should attend classes but can't as no energy, motivation or confidence to do so.</u> <u>Low self-esteem and low confidence:</u> **Shows lots of self-awareness** **Logical brain tells her that she can still attain high grades and that she's a good student, but she tells herself that she's fearful that she'll never be good enough: self=critical voice** <u>How she sees herself in relation to other students:</u> **Compares herself with other students who don't need to ask for extensions; sees herself as a failure for not keeping up.** *Repeats – pressure to keep going.* **Sees herself as a failure: very harsh self-assessment**

Self as weak Challenges of studying Unable to engage with the material in lectures	in a way because I can't keep up with my counterparts and the same way like they don't crumble under the pressure the same way that I would, so I suppose that's depression how how it kind of comes in lots of different ways but it would really affect my experiences as a student.	**Making social comparisons** **Very harsh self-assessment here**
	I3: Would you be able to say a little more about what some of the days are like, where it's very difficult maybe to concentrate on your studies and could you tell me what's going on for you on those days?	
Questioning self Depression is overwhelming Can't engage with studies Depression is not understood Challenges of studying Ruminating Can't engage with studies Can't engage with studies Depression is misunderstood	R3: Yeah so I guess em (…)I guess (…) em it's a bit of just not really caring and like ok so maybe that's not even the best word. I do care about it obviously that's why I get up and go in and I try but when I get there and I'm listening to....you know whatever is being said be it a law or a policy or something about government and I have to listen listen (…)to something like that and in my head (…) you know I have all this just fog and it's just really hard to concentrate. It really is hard to listen to stuff that's seems so not real if that make sense, like it's not real to me. It doesn't apply to me and my life and it doesn't fix anything for me so em...I mean that it's hard to listen to those things and then em.. I'm part of a course that would look at different I suppose suppose parts of human suffering so that doesn't help matters you know because you have your own misery then you have to listen to other people people about people's misery then sometimes and then some of the things that we are learning about are ways to I suppose interact with other people and the different things they are going through so maybe someone is telling you that the best way to deal with someone with depression is xyz and you are sitting there and you're like 'no	*Pauses reflect struggle to articulate her feelings* Managing her college life Days when it is hard to concentrate: **Not really caring about college; tries to motivate herself to go in, but it's difficult** – like *a struggle.* **In classes listening to topics but** *mind is a fog*; **it's not clear for her.** **Can't relate to topics under discussion – seem abstract. Can't find meaning in her studies any more. Changing image of herself as a student.** **She's studying topics that relate to human suffering – content resonates with her and she questions herself.** Can't link theory with her personal experience of depression Course content really seems to resonate with her: **Does this make her feel better or worse about her own suffering?**

Rumination Can't engage with studies Depression is inconsistent Being with others is important Depression is inconsistent Difficult to be with others Paradox of being with others Can't be with other students: has to withdraw Relational self	that's not real (ha ha)' I find I have a lot of that going on and I would think about it. I would get stuck then on a point and miss the rest of the class because I'm thinking about (…) something so (...) I guess em my point being so rambly is an example of my thoughts when I'm trying to concentrate on one thing my mind goes off on a hundred different things that is is really really difficult to focus so my answer in of itself is an example of that of how that happens (ha ha). Those are the hard days but it's not always like that…There are better days too. I4: What is like for you coming into college on those sorts of days (…) the better days? R4: There there are days where I wouldn't feel it all maybe it's sunny outside or we know that the Easter holidays are coming or just something good a class has been cancelled is always (…) wonderful you know. Someone wants to go for a walk, something like this .. something a bit different and em... on those days it's good on those days. I'm em excited. I want to I suppose the good part about college when you're struggling with this is other people and having a chance to em socialise and to experience things and to talk about anything from the weather to something ridiculous on television or something more serious. But I suppose that's the part I like about college. On other days it's the worst part about college but it's the thing I suppose that that keeps me most sane in here (ha). Yeah, people help (…) on good days.	<u>Questioning herself – how can she listen to the misery others face when she can't deal with her own suffering?</u> **Frustration. Other content doesn't seem real – when lecturers talk about depression she questions this: not how it is for her.** **What's happening during these classes for her?** *Laughs –she seems dismissive: uses humour to deflect from content* **Gets stuck on a point in class and misses other aspects of class. Laughs when she says that her response to my question is indicative of not being able to be concise, but is 'rambly'.** <u>Not every day is the same on her journey through depression.</u> **Clear awareness of differences in good and bad days.** <u>Better days:</u> **Environment – sun, being outside going for a walk** **College – coming up to a holiday and/or classes cancelled.** **Feels different on good days – excited. Some energy there.** **Can be sociable.** *Repeats that having depression is a struggle – Laughs when commenting that people 'keep me sane' – quite dismissive of her feelings.* **On bad days having people around her make depression worse; relational aspect of depression is evident here.** *Use of the word sane is interesting here.*

APPENDIX 7 Examples of Themes from the Whole Group

Superordinate Themes	Subordinate Themes	Quotes
Journey through Academia with Depression	Changing Expectations of Studenthood	*I used to have this very clear idea that I was going to you know sail through my undergrad […]And now I don't even know if I will get through the undergrad (ll309-312); I'm just (…) I'm struggling so much so I guess I don't really know what I see the future as but it's not something that I'm excited about anymore (Niamh, ll 212-313)* [...] *coming back as a mature student is a chance in college that I never thought I would get again […]* (*Eoin ll62-64)* *I thought about what else could I do and I've wanted to come to college for years and now I have the opportunity and I'm struggling to manage it (Patrick ll70-73).* *[…]I wasn't sure I could stay on the course and that was bad as I wanted to do the degree. I suppose I didn't really think em that depression would affect me so much (…) yeah (…) em when you think about it.it's it's gonna have some impact (Orla, ll 16-17)* *[…] It's really hard because like that's why I came to college when everything was okay […](Aoife, ll21-22)* *[…] To be honest the course isn't really what I expected […]* (ll 281*); It's just that I thought it would be different somehow (…) y'know that I could use my experience y'know as I'm quite a bit older […] (Mary, ll283)*
	Struggling to Engage	*I'd feel like a ton of bricks and my mood would go down. But also I'd feel really lethargic (…) I'd feel like somebody is pushing me down physically* (*Mary, ll 93-94).* *Sometimes it feels like trying to walk up a river against the tide or something like that (…) It's that kind of tiring everything*

		is tiring (…) (Eoin, ll 46-47) *[…]trying to get essays and exams done (…) concentrating on all that stuff. It took ages to write my ideas down and then I couldn't study […] (Aoife, ll 72-73)* *[…] you know I have all this just fog and it's just really hard to concentrate(…) I would get stuck then on a point and miss the rest of the class because I'm thinking about (…)something (Niamh, ll41-43)* *You need to be able to concentrate. So one day you could have a week of sitting at a computer screen and staring at it and not writing anything. It's more your mood […] your mood you're not in the humour for doing any assignments (Michael, ll 86-88).* *[…] It's not staying in my head it's quite hard […] (Patrick, ll186).*
	Feeling Disconnected	*[…] then it's like a light switch. One minute I am (…) the light is on and I'm friendly I'm enjoying myself em (…) up for anything and I can socialise with other students in my house. Next minute the switch comes off and you are down in the dumps again. You don't want to do anything. You isolate yourself and can't be with others so that varies day to day[…] (Patrick, 298-300)* *[…] it's so hard to relate to others sometimes (…) even there today I had to sit at the front of the bus on my own and that nearly killed me […] (Ailish, 190-191).* *[…] I had to be up at the front (…) em (…)that was hard as I didn't feel like it(…) em but I had to do it (…) em so I tried like I didn't want to be there 'cause I wasn't in good form[…] (Michael, 105-107).* *[…] I was just isolating myself I found it really hard to make friends so that was em (…) […] (Aoife, ll 19-20)* *Because like I said the day before I might have made a plan say to meet up after class and I would be looking forward to it and then when the time would come I just wouldn't be able to […] (Mary, ll30-31).*

		[…] If you are feeling anyways down it's very easy to withdraw it's very easy to hide away [...] (Eoin, l10).
	Paradox of Diagnosis	*With the diagnosis I now see that it is not all in my head that someone does believe that it's there's something is wrong. It's not just me being a hypochondriac or something, which was something that I thought for a long time (Orla, ll 371-372).* *Yeah like it is something real not just in my imagination. It was important to me to have that em diagnosis. It is real so I need to get on with it (Ailish, ll 251-252)* *I guess with the diagnosis I know now there's something wrong with me so it's not just a feeling (Aoife, l12).* *[..]It meant that this wasn't a phase. It meant that this was something that could potentially follow me forever and if the medical model is right and it is (…) what if it is something to do with me and my brain and my makeup then will this be (...) Will this feature in my life forever? Will this continuously be a thing? So there is a fear and dread around that […](Niamh, ll 278-281).* *[…]At that moment and in the days immediately following it it was the beginning of me doing something about it. I had known now looking back […] (Eoin, l80).* *[..] so if you have a history of any mental health difficulty it is weighed up against and even used against you years down the line. I'd like to think at some stage this will be something to look back on and that it won't be it (...) feature in my life forever but it would still be there on my medical record. It will still be something that's used to used to define me and something that's used to assess whether I'm a risk of some sort you know, so I worry about things like that […] (Niamh, ll290-294).*
Managing Depression	Relationship with Medication	*I didn't go to the doctor for ages because I knew that I would be kind of put on medication and didn't know how it would affect my study. I didn't want to become*

		dependent on it (Aoife, ll175-177) *Em it took me a while to get on the tablets the anti-depressants because I didn't know what the consequences would be and I didn't want to take the risk and become dependent on them (Patrick ll185-186)* *I always had this fear before taking them of the zombie effect and you know (...) em that it would change me completely as in I wouldn't know myself* (*Eoin, ll 113-114).* *[…]So the first ones had annoying physiological effects on me in that they would make me sleepy and sick, so that affected my college em attendance and performance […] (Niamh, ll 233-234)* *[…]They [antidepressants]had a positive effect. They are really working on me(…) didn't really help with the studying or concentration but my mood really lifted [. ..] (Aoife ll 186-187)* *[…] I question why I get it[depression] (…) why other people don't get it and why can't I not live without medication 'cause I've tried several times and it never works and it really makes me question why I have it and then I try to think of it as if I was a diabetic then I would have to take insulin the whole time[…] (Orla, ll 55-58)* *[…] Well another one of the side effects is that I have constantly for the last year is that I have a tremor in my hands constantly[…] (Orla, ll 72-73)* *[…] You miss quite a lot of college if you waited for the effects of medication to just go away (Orla, ll84-85)* *[…] I don't really want to be on anti-depressants. I don't think they are any way beneficial at all for me at all y'know […] (Ailish, l 289).* *[…]You can take away their college career like the whole lot by giving them this one tablet that completely destroys[…] (Ailish l 293).* *[…] Yeah (…) but you are even slower at thinking […] (Michael, l63)*

		[…] Em the antidepressants kind of em mess with em it [emotions] it works on your mind as in like you are not as worried as you should be. It kind of blocks out that er stress so I can get stuff done without over thinking like I do em when I'm feeling under pressure […] (Michael, ll 309-311) *[…] you're trying to(...) you're taking this tablet to help you feel the way you think everyone else should feel. So it takes that independence away from you. You have to depend on a tablet to feel better[…] (Michael, ll350-352)* *[…]You'd say you're not on the ball as you take a more relaxed approach. I think it does numb er your personal feelings and I need to be able to react quickly (Patrick, ll25-27).*
	Experiencing Control	*[..] You know I'm a mature student so I should know how to manage. But then I've learned now through counselling and the counsellor in the college is fantastic er she is really helpful. I've learned it's better to speak up and ask for help earlier rather than waiting until it goes completely down […] (Orla, ll 116-118)* *[..]And then you just have to learn that not asking for help and going for the supports that are out there because you are afraid someone will see you is just going to be as noticeable in the long run as actually asking for them because if you don't ask for them you are going to get so sick that people will notice something is wrong anyways (Orla, ll199-203)* *[…] I love the outdoors so when I am outside I'd rather be outside than inside(...) you are walking around a lake er there is nobody there to annoy you (...)you're just em listening to nature around you and it's very therapeutic[…] (Michael, ll47-50).* *Well I find [name of counsellor] the college counsellor is fantastic. Talking about what is going on for me and how I can manage college as well as daily life is keeping me going, keeping me here to be honest (Mary, ll299-301).* *I'm better at knowing when it's gonna hit me now (Ailish, l 233))*

		[…] It's changing my thoughts of what I think depression is. It's more of an understanding but that's been hard to be honest […] (Michael, ll83-85). *[…] I do think I need to take a little bit more control of my illness rather than just accept (…) Maybe accept that I have it em to recognise the triggers and then use the healthy mechanisms now like bringing in more stuff and hopefully lead to more confidence and self-esteem so I can bring back friendships […] (Mary, ll 140-143)*
Altered Self	The Self as Inauthentic	*[…] I don't want to share how I feel with other students 'cause they wouldn't understand. (…) It's like a stigma put on people. So it's that fear you don't want to be different from anybody else. You just want to fit in[…] (Michael, ll395-397)* *I think most of it that I put on is a mask like a coping kind of thing: I'm fine (…) I'm great(…) I'm perfect(...) Don't notice that I'm not* (*Niamh, ll111-112).* *For my friends I always have a smile on my face. I always come in and I'm looking happy.... like a false face. So that's a pressure in itself. Just to try and hide it Even though they wouldn't know that I would be crippled inside (Michael, ll 281-283).* *[..] I can't talk about it in college say as students don't understand and they think I'm making it up or something because like I don't look depressed so I won't say anything (Ailish, ll203-204).* *[…] my personal self when I'm not pretending to be someone else I would be quite shy depressed and fearful. [..]Like you are fearful of how other people treat you. You don't want to be treated special because you have a mental illness you still want to be treated the same.[..] (Patrick, ll. 306-308).* *It might not be the real you but you were selling yourself basically. It's what the public want to see but it's not what I'm feeling. So I suppose that would be my face for I am the depressed nervous wreck behind it the false face (Mary, ll20-23).*

		[…] I have to pretend I'm ok and 'cause my course is very practical. I gotta work with other students (Ailish, ll332-333). *[…]am I the person who acts like this so nobody knows what it's like or am I the depressed horrible person that I think I am so you don't know really know who you are? It's like I'm lost (...) I don't know (Orla, ll 318-319)* *[..]yeah identity would be something I'd really struggle with that in that there is the image that I've created for myself which is a strong resilient coping type and yet at the same time I'm a bag of nerves most of the time (Niamh, ll 119-111).* *[..]and it's a funny kind of thing because em people would describe me you know as strong and resilient and intelligent, easy going (...).These are some of the words that em I get all the time you're very strong and capable all of the time and I win things. I win awards and scholarships and I get brilliant grades but at the same time when I go home and the door is closed the makeup is off and the pyjamas are on that's when I'm like (…) nope you're a fraud and you know I really believe that [...] (Niamh, ll. 93-98)*
	Comparing Present Self with Previous Self	*[..] You know when I came in here in first year … I blew lots of things out of the water in that I created em I started really well. I did really good exams really good assignments and contributed well to my classes and now that continued through first year and second year and by the time I got to third year and I was really really starting to struggle with everything but mostly mental health [...] (Niamh, ll. 206-209)* *[..]I find it really hard to make friends because before I had depression I was a really really bubbly person em(...) like (…) I was shy (…) but once I got talking to people I was really bubbly but then when I got depression I felt that my whole personality changed. [..] (Aoife, ll. 102-104)*

		[…] I can see the changes now to like how I used to be when I first started here. I was lots of fun a bit of a messer really.[…] (Michael, ll285-286)[…]*Now I feel down a lot of the time and it's harder to get back up. It didn't use to be a struggle. I've got much quieter and more private too (Michael, ll287-289)* *[…] Like we were swimming today and I was really really tired, still feel tired. It wasn't like that before 'cause I always had energy and I enjoyed all the sports and sometimes I wonder if I'll ever get it back? (Patrick, ll. 396-399).* *[…] Sometimes I'm just so tired and not interested that I can't be bothered 'cause it's such an effort. That's not how it used to be and I think it's getting worse 'cause I'm really down [...] I was always very happy and I don't like my identity and it's not really me (Ailish, ll. 158-160)* *[…] I felt confused a lot of the time as I couldn't express what I was feeling and I was confused about feeling angry or sad but on the course I've had to think about myself and it's helping me to make sense. I'm beginning to accept myself more y'know, really understand myself more [...] (Mary, ll. 170-172)* *[…] I am a totally different person. I don't recognise the person I was in a lot of ways (ha ha). I feel awful sorry for that person that I was because I don't know how he lived. I genuinely do not know how how he kept going (...) I kept going (…) but that is how distant it feels (Eoin, ll.246-249)*
	The Self as Critical	*[..]I really feel that I am a nuisance to them em I would be the type that would be over (…) I would comprise everything for the convenience of others. I would be afraid to be in their space. I'd be afraid to be to ask for help. I'd be afraid to ask for time. Let's say for example there (…) struggling between parenting and workload. I still wouldn't ask for help. I still wouldn't ask someone to mind him while I got an assignment done so because I felt like a nuisance [..] (Niamh,*

		ll. 147-151) *[…] I get paranoid that I am being a burden em (…) and getting things right can be stressful as I don't think it'll ever be good enough but then em I have a thing like what my psychiatrist says is em my core belief that I am stupid […] (Orla, ll. 51-52)* *[…] then on the worst worst days when my mind is like 'No you're a nuisance don't talk to anybody. They're not going to want to talk to you ...you're just in their way. You're a burden (...)' There would be lots of that and I'd really really feel that's what it is (...) I would avoid everyone for fear that being confirmed somehow […] (Niamh, ll. 80-83).* *[…] Even though I got a 2:1 for my ordinary degree I still think I'm stupid. I don't see the degree that I got doesn't change the fact em that I'm stupid box. That box is still big and full (…) You can put as much in as you like and like it's never going to come up. Then with all the feedback for assignments like when you don't do well as you'd hoped (…) more fortune telling like will I get a good enough honours degree? (Orla, ll. 498-501)* *[…] I'm not good enough. I'm not good enough. I can't do it. Those old scars don't go away too easily even though they are far easier to deal with and manage but at times if an exam doesn't go well as I'd hoped or a CA comes back and it's not good those little things do seep in again […] (Eoin, ll. 147-150)* *[…] I never feel that I am excelling in anything (Eoin, l182)* *So being in education and having that belief about yourself doesn't exactly go down easy. All that feedback feeds in to how you feel about yourself (…) The need to pass the exam so that I don't have that more than is more so than the need for other people in the class* (Orla, ll 308-310*)* *[…] And that's what makes it so difficult in college and being on this course with all the feedback from lecturers and other students so I have to be good enough at*

		what I do 'cause they'll critique what I'm doing and find problems and that just puts more effort on me (Ailish, ll.21-23) *[...] I think everybody is judging me so being in college doesn't help with that (...) Everybody seems to have an opinion and because we have so many discussions on our course people can challenge you. Sometimes I can't handle that you know and I just pull back (Mary, ll. 117-119)* *Em (....) yeah 'cause when it first started I was having the thoughts about how could I help other people if I can't help myself? […] (Aoife, ll. 33-34).* *[…] I when I used to hear about people having depression I always thought I would never let my mind go to that level but you can't control it [...] (Aoife, ll. 140-141).* *[…]I see everybody else and think they must be normal because they are surviving. I need medication to keep going[...] (Orla, ll60-61)* *[…] They [other students]are able to come in and get what they need to be done done and deal with crises of life that happen outside of college which mature students seem to fall into regularly. But they seem to be able to cope with it whereas I'm like 'I can't deal with that and deal with this' […] (Orla, ll68-71).* *[…]'Depression is only a mental thing. It's not physical so why is it hard for me?' […] (Michael, l30)* *[…] like I said its embarrassing it's like a weakness that shouldn't be there […] (Michael, l 288)*

APPENDIX 8 Themes Across the Whole Group

	Niamh	Aoife	Orla	Michael	Patrick	Ailish	Eoin	Mary
Superordinate Theme 1								
Changing expectations of studenthood	Y	Y	N	Y	Y	Y	Y	N
Struggling to engage	Y	Y	Y	Y	Y	Y	Y	Y
Feeling disconnected	Y	Y	Y	Y	Y	Y	Y	Y
Paradox of diagnosis	Y	N	Y	Y	Y	Y	N	N
Superordinate Theme 2								
Relationship with medication	Y	N	Y	Y	Y	Y	Y	Y
Experiencing control	Y	Y	Y	Y	Y	Y	Y	Y
Superordinate Theme 3								
The self as inauthentic	Y	Y	Y	Y	Y	Y	N	Y
Comparing Present Self with Previous Self	Y	Y	N	Y	Y	Y	Y	Y
The self as critical	Y	Y	Y	Y	Y	Y	Y	Y

APPENDIX 9 FLYER

ARE YOU AN UNDERGRADUATE STUDENT AGED 23 YEARS OR OLDER?

DO YOU HAVE A DIAGNOSIS OF DEPRESSION AND ARE TAKING ANTIDEPRESSANT MEDICATION?

IF SO

YOU ARE INVITED TO TAKE PART IN A PROJECT WHICH AIMS TO INVESTIGATE WHAT IT IS LIKE TO BE A MATURE STUDENT WITH DEPRESSION

Studying for an undergraduate degree can be very stressful. There are a number of stressors such as: academic requirements of your course, financial pressures, pressures of family and pressures of a social life. All of these factors can impact your experiences of being at college. Depression among college students is a growing problem and increasing numbers of students are receiving a diagnosis of depression.

If you have depression then I would like to know more about your thoughts, feelings and experiences of studying for your degree.

- Aged 23 years or older
- Received a diagnosis of depression by a doctor during your time at college and are taking antidepressant medication
- Studying for an undergraduate degree

INFORMATION FOR PARTICIPANTS

- If you agree to take part, you will be invited to take part in *one* face-to-face interview of up to one hour. This will be at a time and date that is convenient to you in order to talk about your experiences. Interviews will take place in a seminar room adjacent to Student Services.

This study is a final part of a Doctoral Programme in Counselling Psychology undertaken at the New School of Psychotherapy and Counselling, London. The research conducted by **Marie English** has full ethical approval from Middlesex University. The project is being supervised by Dr. Jacqui Farrants.

If you are interested in participating, please contact me on*: 085 8445591* or *ME496 @mdx.ac.uk.* You can leave a text or voice message and I will get back to you.

APPENDIX 10 Consent Form

Mature Students' Experiences of Studying for an Undergraduate Degree with a Diagnosis of Depression
Researcher: *Marie English;*
as a requirement for: DPsych Counselling Psychology from NSPC and Middlesex University

In partnership with Middlesex University London

NSPC Ltd
Existential Academy
61-63 Fortune Green Road
London
NW6 1DR
Middlesex University
The Burroughs
London NW4 4BT
30th July, 2016

CONSENT FORM

Participant Identification No: _____

Title of Project: *Mature Students' Experiences of Studying for an Undergraduate Degree with a Diagnosis of Depression*

Name of Researcher: *Marie English*

Please tick the boxes

1. I have read and understood the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my data will be treated confidentially and any publication resulting from this study will not report data that can identify me. ☐
3. I understand that participation is voluntary and that I am free to withdraw at any time, without providing a reason and without my legal rights being affected. ☐
4. I agree to take part in the above study. ☐

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Researcher Date Signature

APPENDIX 11 Extract from Reflexive Diary

Niamh could not make the first two scheduled times for the interview: first attempt -the friend who was going to look after her son could not make the arrangement; second attempt – her son was sick and she had to collect him from school and take him home, and there was no-one to look after him as it was short notice. I began to think that the interview would not go ahead and felt anxious about this. I felt that this must be what it is like for Niamh to try to fit college life around family commitments, and it's possible that this must happen to a number of mature students who have children. When the interview was re-scheduled for the third time I was not sure that it would go ahead and was prepared to re-schedule it again.

I was mindful that I was not in the role of lecturer, but as interviewer, and I would have to allow myself to be guided by Niamh. I realised that this interview would test those skills for me. I had to be alert to this, as I didn't want my assumptions such as students with children have to balance home and college life, to guide the interview. My training in counselling definitely helped me to follow Niamh's narrative and I was fairly relaxed in being led, and comfortable in coming back in to ask her questions. I also hoped that she would be open with me and not feel constrained because of my role in the Institute.

During the interview Niamh spoke eloquently and I experienced, at the beginning, that she wanted to educate me and to let me know that depression was not uncommon among students. Whilst I did not feel uncomfortable at this point, I did wonder if she perceived that lecturers were lacking in awareness of the plight of students with mental health concerns and that this was something that really concerned her. Initially, I was wondering what she thought this interview would be like, and what I would be like?

There was a real sense of heaviness in the room as the interview progressed. The weightiness of her experience of depression was evident in the way she was sitting: slumped forward at times, so I had to move the recorder closer to her so that I could capture her voice. She also looked down at the table often as she spoke and I felt the struggle that she has to endure in formulating her ideas. We smiled at one another when she commented that she was 'rambly' in her answer pertaining to the difficulties she experiences being a student. I found myself feeling quite emotional when she described herself in such negative terms: burden and nuisance, and had to hold back from trying to reassure her, as I was aware that it was not a counselling session. I experienced a sense of real sadness at times during the interview when Niamh described how she had tried really hard to keep going with her studies and how she associated academic success with her self-esteem. I would have felt this, myself, when I was an undergraduate, and the 'chasing' of the first class degree was vivid in my mind.