INTO THE LIGHT:
NARRATIVES OF INDIVIDUALS WHO DIVULGE DEPRESSION DIAGNOSES IN SCHOOLS

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Abstract

This research examines the experiences of 3 students who have depression and chose to disclose that information to peers and/or teachers; it also looks at the supports received or barriers faced within their schools. The use of narrative inquiry ascertains the full experiences of the participants and, by keeping their stories intact, who they are as people. As the stories shared began before school disclosure and continue to the present day, the entire context of the experience is examined and not a specific section of time. Each participant's disclosure was different, but they all had positive experiences: One student spoke to friends, another with friends and teachers, and the third with teachers only. Furthermore, 2 of the participants now do advocacy work, encouraging conversation and acceptance. Ultimately, depression is distinctively personal and cannot begin to be understood without first learning about the person and his or her unique circumstances.

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CHAPTER ONE: ANSWERING THE CALL

Into the Light

Coming into this doctoral program I knew I wanted to move beyond what I had done previously, not just expand on it. In completing my Master's thesis, a self-study narrative investigating my coping mechanisms in the workplace as an individual with major depressive disorder, I underwent a huge shift in my approach to my illness. Speaking openly about my mental health challenges with even the few people involved in my work provided a new sense of control and mastery over my depression. I realized that I was the expert on my illness; I knew what I could and could not handle, and I knew which coping strategies worked and which did not. I had also begun conquering my fear of others learning about my depression. Amazingly, I found that each time I told another person about my illness, I felt stronger, more in control, and less afraid. Despite this, the fear was ever present because I still viewed the diagnosis as a weakness and I was almost ashamed to admit to having depression. The title of my thesis began with "Finding my way in the darkness," and at the very end of the thesis I write, "I wait in my darkness for the day when I can experience what she felt" (Corzine, 2011, p. 98), referring to a story about a woman who openly disclosed and discussed her mental health issues and felt both relief and release in doing so. I felt that the darkness was a safe place where no one could see me clearly and I could hide my faults, weaknesses, and fears. However, beyond that fear was a voice telling me to speak more openly about my struggles, to be more honest about my life, and to take back the power that being fearful and ashamed drained from me.

Then, I heard about adolescents who were standing up in class and talking about

> *their experiences with depression, and I wondered where people half my age were getting the courage to fight back against their illness in this manner. What was causing them to speak out, especially in this age of Facebook, Twitter, and YouTube where any foible can forever be captured for everyone to see? I knew then that this was what I wanted to study for my doctorate. I also wanted to embrace the challenge of moving from self-study narrative inquiry to working with others, specifically young people, to learn about their experiences, their challenges, and their successes and to capture these stories in a piece of research that will move from darkness "into the light."*

Clandinin and Connelly (1991) state:

> Narrative inquirers tend not to begin with a prespecified problem and set of hypotheses. Instead they are inclined to begin with an interest in a particular phenomenon that could be understood narratively . . . and then to try to make sense of the practice from the perspective of the participants, researcher, and practitioner. (p. 274)

In October 2011, a Canadian national television news segment entitled "Teens break the silence" (Roumeliotis) identified an emerging trend of teens in Ottawa, Ontario speaking out about their personal experiences with mental health. Several years later, Mel A. (2015) from London, Ontario created a YouTube video with the title "Joan" outlining her high school experiences as she began the downward spiral into depression. I was intrigued by the phenomenon of youth speaking openly in their classrooms about their experiences with depression and confirmed through anecdotal evidence from colleagues in the education sector that this was indeed happening. In my experience as a teenager during the 1990s, mental health issues were not discussed openly at all in any setting (Corzine, 2011) so I wondered what had changed to bring youth mental health into the light. I found that until about 2006, few people were even talking

about mental health and those who spoke publicly were adults with established reputations such as James Bartleman (Whitnell, 2006), Margaret Trudeau (CanWest News Service, 2006), Shelagh Rogers (White, 2008), Michael Landsberg (Zelkovich, 2010), Bob Rae (CBC, 2010), and Clara Hughes (Bell Canada, 2011).

However, in the last several years, mental health issues have become weekly topics in popular media, and while much of this attention is based on adult experiences, more and more information is surfacing about youth who are also dealing with mental illness. School boards, districts, and Ministries have begun to identify the need to incorporate mental health information into the curriculum and provide supports to students facing challenges with mental health (Mandigo, 2013; Manion, Short, & Ferguson, 2013; Santor, Short, & Ferguson, 2009). In 2011, the Ontario government introduced a new initiative called *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*, a program to address gaps in Ontario's mental health and addiction services with the first three years of the project focused on children and youth (Ontario Ministry of Health and Long-Term Care, 2011). This was followed by the Ontario Ministry of Education (OME; 2013c) creating a resource guide for teachers of children and youth in grades K–12 titled *Supporting Minds: An Educator's Guide to Promoting Students' Mental Health and Well-being* (*Supporting Minds*). According to P. Grogan (personal communication, April 1, 2015), the contact for the guide, it was posted in August of 2013 and a memo was sent to the sector inviting feedback. Thus far, “many schools have begun using the document” (P. Grogan, personal communication, April 1, 2015), and educators and others have responded with feedback. Also, in a Mental Health and Addictions Resources for Educators memorandum (Finlay, 2015) it is stated that “all boards now have a Mental Health Leadership Team and a three-year Mental Health Strategy (and one-year Action Plan) to guide their ongoing

work" and included resources in the form of video guides and a provincial support team.

As someone who has lived with depression for almost 20 years, I am particularly interested in investigating how depression is now being handled and how people are treated. I am also curious to learn what has changed to allow teenagers to tackle the very personal topic of mental health in public spaces such as schools. In this research study, I investigate the school experiences and storied remembrances of adolescents who divulge a diagnosis of depression to classmates and school personnel. I also explore the educational supports these individuals received and the educational barriers they faced both before and after disclosure. To do this, I use narrative inquiry to collect and restory the stories and experiences of three youths.

For the purposes of this research, there are a few definitions to be outlined. First, mental health is taken to mean "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (World Health Organization [WHO], 2014). Mental illness means an absence of mental health. Depression means

> depressed mood, loss of interest and enjoyment, and reduced energy leading to diminished activity for at least two weeks. [Furthermore, the person may] also suffer from anxiety symptoms, disturbed sleep and appetite and may have feelings of guilt or low self-worth, poor concentration and even medically unexplained symptoms (WHO, 2012)

The WHO (2012) also states that depression is not a short-lived response to challenges but rather a health condition that causes people who are affected to function poorly in school, at work, and socially. Seasonal depressive disorder is considered a subset of depression labelled recurrent depressive disorder because the symptoms are the same but the episodes are periodic and

separated by several months when there are no depressive symptoms present (WHO, 2015, sections F33-F33.2). This type of depression is sometimes referred to as seasonal affective disorder (SAD). Ultimately, depression can also lead to suicide.

I have chosen to use the World Health Organization's more general definition of depression instead of a specific definition provided by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., DSM-5; American Psychiatric Association [APA], 2013) because it does not overly restrict the focus of my research. Many research studies reference major depressive disorder (MDD), which is a specific type of depression identified by the APA (2013) and encompasses major depressive episodes but neither manic or hypomanic episodes nor schizophrenic spectrum or other psychotic disorders. It is characterized by "symptoms [that] have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure" (p. 160). In addition, at least four of the following seven symptoms must be cooccurring: weight/appetite changes; sleep disturbances; agitation or restlessness; fatigue; feelings of worthlessness or guilt; difficulty concentrating; and recurrent thoughts of death or suicidal plans. Furthermore, the symptoms must "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning [and] the episode is not attributable to the physiological effects of a substance or to another medical condition" (p. 161). Last, MDD can have specifiers indicating additional features such as anxiety, melancholy, or seasonal patterns (APA, 2013) such as SAD. As is evident, the two definitions are similar enough that there should be little effect on the intents and purposes of my research. In my experience, and in listening to others, it can take several years for a confirmed type of depression to be identified, and youth who have recently been diagnosed may know only that they have

depression and not know which of the several different DSM-5 specifier diagnoses apply to them.

What to Do

In early spring 2013, I voluntarily admitted myself to Psychiatry at my local hospital. The prior months had been quite hard for me to manage, and I was losing control over my depression and anxiety. Thankfully, I had the courage to recognize this shift and, one Wednesday afternoon in late March, I found myself sitting alone on the middle of a sunshine-yellow blanket draped over the stark white sheets of a hospital bed. The nurse who had oriented me to the Psychiatric floor had gone, satisfied that she had adequately welcomed another scared, bewildered, and slightly tearful patient to her realm. Unfortunately, sitting there, I could hardly recall the nurse's name, let alone the rules, recommendations, and daily rhythms of the floor. As I took in my new surroundings, I noticed that two of the beds in the ward were obviously occupied by other women who weren't present at that time and a fourth bed was empty, lying in wait for its next inhabitant.

Neither the bed nor I had to wait long; in walked a young lady, cloistered by her parents, and she started unpacking her several bags of belongings as though she had reached her hotel room while on vacation. After a few moments, they seemed to notice me, shrivelled and frightened on my bed, and engaged me in small talk. When I mentioned the lady's apparent familiarity and comfort, she said in a tone of one wizened, "Oh, I was here last summer. I crashed after a manic episode and I came here so the doctors could get me on the right medication. Now I'm back because I'm so tired all the time that all I can do is sleep. I think it's the medication again." Her parents made a few

> *jokes about the experience, and we all laughed, me a little nervously because I wasn't yet sure how to interact with these newcomers.*
>
> *After a while, the lady's parents left, and I turned to her and asked shyly, "What are we supposed to DO here?"*
>
> *"Come on," she said, jumping down off her bed. "We meet people and talk to them. Let's go see who's here."*
>
> *I spent the following 2 weeks sharing and learning and reliving the stories of the patients (men and women) who came and went from the Psychiatric floor. We laughed, we consoled, we empathized, and we tried to find meaning in our lives and the lives of those around us. Removed from the world and cocooned together, we had only what we brought with us: our stories.* (Doctor of Philosophy in Educational Sustainability coursework, July 21, 2013)

In learning to live with my own diagnosis of depression, I became familiar with many pieces of research, various percentages, and the findings that tell me I am not alone—that what I am feeling, experiencing, and living is not unique to me. However, it was during my stay in hospital that we, the patients, shared so many stories about living with mental health challenges that I finally stopped feeling isolated and unusual. In my Master's thesis, 5 years ago, I said that

> nothing would make me more proud than to say that the process of writing this narrative has eliminated my reluctance to talk about my illness with those around me. However, I cannot; I still harbour a fear of rejection and misunderstanding . . . I still do not have the confidence and trust to make that leap. Perhaps one day soon I will have the conviction in myself to be strong . . . and speak out about mental illness, but that time has not yet come. (Corzine, 2011, p. 98)

Although I cannot say that I have become an outspoken mental health advocate in the intervening years, I can relate that I have been more open with others about my illness since my stay in the hospital. If mental illness comes up in conversation (even with strangers), especially when talking about this dissertation, I do mention that I have depression, which is why I am interested in the topic. I even went so far one day as to stand up for a lady who I knew had anxiety issues and firmly tell the man who was causing her stress to stop what he was doing, which is something I would have never done before. Now, after inquiring into my own story, I am ready to move beyond myself and invite others to share their stories of depression. By conducting this research, I hope to be able to share these stories with others in similar situations and provide them with a sense of community instead of alienation. Sagely, King (2003) points out that "the truth about stories is that that's all we are" (p. 92). This is followed by a quote from Silko (1986)

> I will tell you something about stories,/[he said]/They aren't just entertainment./Don't be fooled./They are all we have, you see,/all we have to fight off/illness and death./You don't have anything/if you don't have the stories. (p. 2)

Life experience stories, by themselves, are informative, but instead of generalizing the issue of depression in adolescents, I wanted to delve into one specific aspect. I believe that in order to keep education relevant and current, we must go beyond books and homework and encompass the individual, including his or her strengths and needs, allowing us to be truly successful in moving forward in the 21st century. Half of the people who will develop a mental health disorder in their lifetime will do so before the age of 14 (Manion, 2013; Manion, et al., 2013), and nearly 20% of youth will experience depression specifically (Adamson, 2010), with an average initial onset age of about 17 years (Minor, Champion, & Gotlib, 2005; Pettit,

Lewinsohn, & Joiner, 2006). With these statistics, it seems important that schools embrace mental health education to provide students and their peers with the support and knowledge needed before symptoms start, while they are occurring, and in reintegration efforts.

It has been only in recent years that researchers have conducted investigations into the supports and barriers faced by students with mental health challenges. While many studies examine depression-based issues from a quantitative or mixed-methods standpoint (De Wit, Karioja, Rye, & Shain, 2011; Flett, Coulter, Hewitt, & Nepon, 2011; Hartman et al., 2013; Mann et al., 2011; Wisdom & Barker, 2006) and fewer using a qualitative lens (Boydell et al., 2006; Woodgate, 2006), little research has been conducted investigating the storied experiences of these adolescents, especially within Canada. O'Mara and Lind (2013) recognize this deficit, identifying that "a major concern . . . is the lack of child and youth views; where are the studies that incorporate their definitions of mental health and coping, and their involvement in planning health promotion initiatives?" (p. 20), and they advocate for additional research. This is not a new observation, as Farmer (2002) notes that there is an inadequate understanding of youth perspectives because there are neither qualitative nor narrative-based studies on this subject. Franklin (2014) speaks to the value of interactive research with youth, as she has observed that they have a lot to say about their mental health experiences in schools including identifying effective supports and maintaining a sense of self within the mental illness. Further encouraging lived experience research are Rudnick, Rofè, Virtzberg-Rofè, and Scotti (2010), who identify people with mental health challenges as the "content experts" (p. 879) and call for firsthand accounts of such people when discussing mental health issues. Likewise, Karp (1996) recognized that the data in most of the research about depression came from people who worked in the mental health care field but never reflected the experiences of people with depression

themselves. He felt that to truly understand the reality of depression, one needed to appreciate the "*subjective point of view of the person undergoing it*" (p. 11). Finally, Crundwell and Killu (2007) confirm that there "currently are no evidence-based depression-specific school interventions for the disorder from which school personnel can draw" (p. 50). When I learned that youth were starting to talk about their depression in school, I decided to focus my research within that vein and look for similarities in their disclosure stories that might indicate the types of school and peer environments that would encourage or discourage openness and the responses, both good and bad, that the participants encountered. My hope is that my research, using the stories shared by individuals who have experience with divulging a diagnosis of depression in school can help build a qualitative and narrative knowledge base for additional study.

In The National (Roumeliotis, 2011) news segment mentioned earlier, the students in the video began speaking out and looking for ways to reduce the stigma surrounding mental illness after a classmate committed suicide. The school (and 14 others in the Ottawa area) introduced a mental health segment to grade 11 and 12 Health and Physical Education classes (Milin & Kutcher, 2011) as "part of the formal curriculum" (Roumeliotis, 2011). In these classes, students learned about mental health, mental illness, the stigma surrounding these issues, and also about talking with others and asking for help. Studying this change, the Royal Ottawa Mental Health Centre investigated the effectiveness of introducing mental health curricula into the schools, intending to learn whether there was a change in people's behaviour, including stigma, about mental health (Milin & Kutcher, 2011; Roumeliotis, 2011). However, it should be noted that Health and Physical Education is an optional class after grade 9 (OME, 2015b).

The Joan (A, 2015) video, however, actually discussed Joan's experiences with trying to

obtain help for her struggles with anxiety and depression. It started in 2008 when she began having panic attacks in math class and encountered less than helpful suggestions from her guidance counsellors, who told her that she should just drop out because her mental health issues were probably affecting her intelligence anyway. Overall, she encountered a lack of understanding about her needs, a lot of stigma, and became a "social pariah" (A, 2015). As time went on, though, a few teachers actually worked with her to develop learning strategies. Halfway through the 4-minute video, she spoke about what would have helped make her experience in high school a more positive one while dealing with her mental illnesses. She outlined changes needed for both the student and teacher populations including stable support, mental health education, and learning strategists. Concluding her video, Joan mentioned that her school had changed a lot in the 2013–2014 school year with regard to mental health issues, and she was left with a sense of hope.

Facing the Fear

> *At the end of my first semester of doctoral classes, there was a colloquium with speakers from various fields. My colleagues and I had lunch with the presenters prior to the event, and I spoke with one lady in particular about my upcoming research as well as my own diagnosis of depression. She was interested in my work and was supportive and kind when I revealed my own struggles with depression. In fact, she was so intrigued with what I was planning to do that during the question and answer period at the colloquium when she was asked the question, "Do you have any examples of good research projects that we can consider?" she answered, "Well, I heard about one at lunch today, and perhaps Lorna would like to come up and tell you about it." I looked around the room at my classmates as well as unknown students, professors, speakers, and staff and quickly*

considered my options. Up to that point, I had been relatively selective about whom I told about my depression and I had never really spoken about my research without linking myself to it through my own experiences; I always found it was the personal connection that really added to the research and its importance. However, since I was being singled out because of the positive possibilities of my research, I decided that it was time to stop being afraid and embrace the research and what it meant to me personally. So, I divulged my own depression to the group and went on to speak about my research. Like the experiences I had had in previous disclosure situations, after I spoke, many people came up to me and told me about their own experiences with depression—whether that be as a friend or family member or their own personal stories. They encouraged me in my research and were extremely positive about my courage in speaking out.

I cannot say that I am coming into this research without some hopes about the outcomes. I would like to learn that the youth experienced the same support and understanding that I have received, that they have increased the knowledge of their classmates, reduced stigma in their school, and received all the supports they need to be successful in their studies. But, unlike teenagers, I do not see daily the people to whom I have divulged my diagnosis. In some cases, I never see them again. If I did, would the supporters outweigh the naysayers in my own life? Would I be able to fight the stigma on a continual basis? Would I be able to help people understand the complexities of the illness of depression? Would I be able to navigate support systems in order to succeed? Or, would I fall back into my grade 10 thoughts that I had to be happy all the time (Corzine, 2011) to prove that I was okay? So, I turn to this research to learn the answers to these questions and more from youth who had the courage to do what I am not sure I

could have done in their place: face the fear of ongoing judgement from my peers.

Summary

Moving forward in this dissertation, I set up my theoretical framework by examining current research in the areas of depression and youth, facilitators and barriers encountered in school, and stigma and stereotyping. I then explain fully the method and methodology used to conduct my research. Next, I present the storied remembrances of the participants and identify themes that connect those experiences. Finally, I discuss my analysis and examine the information provided, in relation to the theoretical framework previously established, to determine if the data can be confirmed or disconfirmed.

CHAPTER TWO: STUDENTS, TEACHERS, AND MENTAL HEALTH

Literature Review

Before beginning this study, I examined the research regarding the school experiences and storied remembrances of individuals who divulge a diagnosis of depression to classmates and school personnel. I wondered how adolescents were empowered to speak about their depression openly and whether the schools themselves provided an outlet and an atmosphere to do so. I was particularly interested in the educational supports the individuals received and the educational barriers they faced both before and after they disclosed their depression. Finally, I wanted to consider how stigma and/or self-stigma might have played a role.

Ideally, I was looking for qualitative research that examined the perceptions of students with depression, why and how they decided to disclose their depression, the supports and barriers they experienced in Ontario schools, and how this affected their education. However, even after eliminating various search parameters in different combinations, I found little research that specifically examined school experiences of students with depression. Conversely, I found much in the way of support and suggestions for teachers when dealing with mental health issues in the classroom. In this chapter, I highlight what I have found from various research sources. The chapter is organized into 10 sections. The first six alternate between student and teacher perspectives of particular aspects of the issues and challenges surrounding mental health in schools. This is followed by a section that looks at the barriers experienced by both students and teachers, a section dedicated to the examination of stigma in general, and ends with the student and teacher aspects of stigma.

Students: Perceptions of their Depression

Hinatsu (2002) looked at adolescent depression using a narrative structure. He worked

with four students, utilizing discussion and therapy to explore their feelings regarding depression. The students' perceptions were typically presented using metaphors, as with one adolescent who described combat-like situations such as stealth, defences, battles, war, armies, vulnerability, and attacks (pp. 75–77). It was noted

> a filter was placed over his eyes and sensory organs. This "filter" was used to screen out all the information that ran counter to his depression. The result was participant A being precluded from seeing any "good things" that were present in his life. (p. 76)

A second student in the study identified depression as an amplifier that intensified the emotions associated with depression, a void that "digested and destroyed" (p. 91) any desire to overcome the depression, and a wall that separated him from the world (pp. 90–92). The other two participants described similar experiences that mirrored the "void" imagery presented by the second adolescent.

In another study, Farmer (2002) found that anger played a significant role in how the adolescents felt about their depression and in the way they expressed their illness to the outside world. In some cases, the anger was physical, but in many instances it was displayed in outbursts or argumentative states. Constant fatigue also plagued the participants, impacting their ability to concentrate and comprehend new information, leading them to a decrease in school performance. They also talked about how fatigue made it difficult to complete normal day-to-day activities (Adamson, 2010; Farmer, 2002). Finally, thoughts of suicide were common among the students; one participant, even though she had attempted suicide previously and received intervention treatment, still felt it was the ultimate escape plan (Farmer, 2002).

In 2004, Wisdom and Green conducted focus groups (seven adolescents) and individual interviews (15 adolescents) with participants who had either a current or recessed diagnosis of

depression. They discussed several stages in aspects of depression, from the lead-up to depression to the end result. Many used weather to describe their feelings, images such as clouds, fog, and rain. They also echoed some of the statements from other researchers above: The students had low energy, wanted to be alone, and were pessimistic, helpless, lost, as well as emotional. Some of the adolescents stated that they wanted to return to the time before they became depressed, a utopia with "the absence of responsibility, future orientation, and stressful experiences" (p. 1231). Some wished to return to childhood, while one 19-year-old wanted to return to high school where she felt she had fewer responsibilities and more social support. Describing the difference between depression and sadness, one conversation started, "*Moderator*: Where do you think your depression comes from? *Participant*: From being unhappy with myself and with other people. . . . When I'm sad, I'm sad about certain things, but when I'm depressed I'm upset about myself" (p. 1232). Similar to my own statement in Chapter One, the students' friends and messages from the media enforced the idea that "everyone should be happy all the time. . . . [This distressed the youth] not just because they were not happy but also because they felt that they were supposed to be happy" (p 1232). One boy stated:

> [Depression can be] addicting, conditioning, 'cause if you're depressed for a long time you might feel happy one day but then it's like you go back to being depressed again and it feels like something's wrong if you're *not* having that sort of feeling. (p. 1235)

Woodgate (2006) also investigated some of the perceptions of depression in adolescents, her findings supporting much of what has previously been discussed. The students used words like "'vortex to hell', 'nightmare', 'tornado', [and] 'devil' . . . [as well as the expression or image of] being on a roller-coaster ride with many ups and downs" (p. 263) to describe their experiences with depression. Again, the adolescents mention fatigue, sadness, anger, loneliness,

and fear, all of which made going to school and completing regular activities difficult. The author identified this as “living in the shadow of fear” (p. 261). Similarly, Friedson (2013) points out that “depression is more of an all-encompassing nightmare or a terrifying monster than it is a mere condition [such as the scientific definitions in Chapter One] that depletes mood, energy, and interest in formerly enjoyable activities” (p. 3).

Overall, the five studies demonstrate several similarities among the adolescents and how they perceive their depression: anger, fatigue, mood swings, and feeling out of touch with the world around them. However, there are also distinct and individualized perceptions such as filters, voids, walls, a need to regress in life, fear, and serious considerations of suicide. Such perceptions emphasize that depression is a very personal and subjective matter that cannot be neatly summarized in figures and graphs and may be more clearly understood through discussion rather than set questions on a survey or questionnaire.

Teachers: Knowledge of Depression

Kovacs (2010) reported that 66% of teachers felt that it was difficult to identify students in distress and only 40% of teachers were confident in helping students with their mental health concerns. The last statistic is supported in a study by Andrews, McCabe, and Wideman-Johnston (2014), who found that just 36% of teachers were confident when dealing with mental health. However, Kovacs did learn that teachers believed that as few as 7% of students would seek help. When teachers were asked to rank their perceptions of 11 emotional health concerns displayed by students in order of importance, the top three issues identified were behavioural (26%), low self-esteem (15.9%), and bullying (16.7%). But, when examining the overall totals without consideration to the rank assigned, depressed mood was actually rated third (14.6%) behind low self-esteem (17.7%) and behaviour problems (16.7%); stress was in sixth place overall, at 8.6%

and anxiety was rated seventh at 5.6%. Further, when teachers were asked which health education topics benefited students most, only 5.5% felt that information about mental illness was necessary, while 5.2% of teachers believed that mental health and well-being were important. Strangely though, 17.4% of teachers felt that mental health issues should be covered in health education courses. With regard to the teachers themselves, only 4.9% received mental health knowledge though in-service education and more relied on their own experiences (17.9%), discussions with colleagues (12.3%), or their own research (9%).

In reviewing Bachelor of Education programs across Canada, Rodger et al. (2014) discovered that few have courses about mental health. Andrews et al. (2014) agree, stating that only 5.3% of preservice teachers had mandatory mental health courses, while 8% revealed that their teacher education programs offered optional mental health courses. Some courses included just the medical aspect such as "how mental illnesses are screened, assessed, and/or diagnosed" (Rodger et al., 2014, p. 11), and even fewer addressed the actual care and support required by a teacher in a classroom when a student does have a mental health issue. All of the interviewed preservice teachers felt they were not adequately prepared for "identifying and addressing the mental health needs that they will see in their classrooms once in the field" (Rodger et al., 2014, p. 17). Andrews, et al. (2014) reported that only 1.3% of new graduates from their Bachelor of Education programs felt prepared to handle mental health issues. One teacher said: "I'm trained to teach math, I'm trained to teach literacy, but I'm not trained for the rest of the stuff that comes with it" (Rodger et al., 2014, p. 21). Similarly, Short, Ferguson, and Santor (2009) quote a teacher as saying: "Educators are minimally prepared. They are well-intentioned but not well-informed. . . . they receive virtually nothing in pre-service education" (p. 14). Their study also noted a lack of evidence-based research about the effectiveness of mental health education for

teachers, both preservice and in-service.

Returning to Andrews et al. (2014), 98.7% of the teachers surveyed believed that mental health issues affected learning. Most (97%) teachers felt they should know how to react and support students, but, as mentioned previously, only 36% of teachers thought they had the knowledge and skills to do so. However, as many as 92% of teachers have had to deal with students with mental health issues. In response to the need for more education, some teachers (17.4%) have resorted to specific Additional Qualification courses to increase their understanding of student mental health. Manion et al. (2013) further support teachers' need for increased knowledge of mental health issues, specifically in the areas of promotion, prevention, and recognition of the signs and symptoms.

Tyler (2014) agreed that teachers lack professional development that focuses on mental health, suggesting that, basically, it was nonexistent. However, the participants in the study believed that teachers would be open to in-service training, with one teacher stating: "I think any kind of training or education or PD [professional development] that would help teachers be more sensitive to mental health issues would be of great value" (p. 35). The participants mentioned that they were aware of online mental health resources offered by their boards but had not used these resources and were unsure what information they contained. Responding more directly to the statements by Andrews et al. (2014) and Rodger et al. (2014), Tyler calls for training at the preservice level, regular professional development, and opportunities for teachers to experience more in-depth training if desired.

The above research identifies several disturbing trends when examining teachers' knowledge about depression. Most feel they lack the knowledge to deal with mental health issues in the classroom, and just as many want to learn more. Teachers have identified that the problem

may begin within their Bachelor of Education programs, where mental health is either not addressed or not prioritized. New teachers then enter the classroom and may be faced with several students who have mental health needs and a lack of additional in-service or professional development opportunities to assist them. Without this support from their schools, teachers turn to other means of learning about mental health and, while this is to be commended, it could also lead to mixed messages from teachers who may have gleaned information from disparate sources.

Students: Empowerment to Disclose and the Social Effects

Interestingly, Hetherington and Stoppard (2002) learned that some students with depression felt they only took notice of, and acknowledged, their symptoms if other people first validated them by asking or stating things like

> 'what's up with you, like you're always depressed' and maybe they'd point it out by continuous situations where its [*sic*] 'well you're always sad, you're always you know pessimistic, you're always down,' like 'I think something's wrong here'. I think that if people bring it to their attention then they'd be 'well, maybe there is' like kind of get them thinking about that' (p. 623).

Similarly, Farmer (2002), in a discussion of the experience of one student, noted that the student found his friends to be helpful and numerous. They would often notice changes in his behaviour and help him talk through his feelings. In The National news segment by Roumeliotis (2011), one student began speaking with her classmates about her depression and anxiety and found that some of the other students would then express their own struggles with mental health, leading her to truly believe that she was not alone with her illness. Students also felt that people who were "(1) trying to understand; (2) checking in on them; and (3) trying to make a difference in

their lives" (Woodgate, 2006, p. 266) helped them feel connected and as though they belonged. Such sentiments are supported by Hetherington and Stoppard (2002), who learned from adolescents that it is important to talk with others who are truly willing to listen and are trustworthy. Disclosing their emotions and thoughts usually required the building up of courage to approach another person, which can be very difficult, so quite often these confidants are friends because a rapport has already been established. Students also mention turning to family for help, support, understanding, nonjudgemental attitudes, the ability to listen, and a safe environment (Ross, Ali, & Toner, 2003). Gammell (2003) confirms and identifies that people who care about you and "'have the right kind of relationship'" (p. 153) appeal to students when deciding to disclose.

However, one of the challenges in talking about mental health with friends, rather than doctors, parents or teachers, is that students could be given misinformation (American Academy of Child and Adolescent Psychiatry, 2011; Davidson & Manion, n.d.). Students may also turn to the Internet as a resource, and this can also be unreliable (Leahy & Robb, 2013). Luckily, some adolescents, and all of the participants of Hetherington and Stoppard's (2002) study, indicated that their knowledge and ideas about depression came from others who had had depression themselves, be it friends or family. A similar finding is also reported by Wisdom and Barker (2006), where "learning from someone who has 'been there' may be a helpful endeavor" (p. 8). But, some types of help are not always considered good help because "helpful means being supportive, listening, and validating rather than providing advice or suggestions for how to change" (Gammell, 2003, p. 148).

In contrast, not all adolescents find the familial and friendship support mentioned at the beginning of this section. Farmer (2002) also uncovered the negative aspects of disclosure:

Adolescents experienced the defections of close friends, rejection, and humiliation (A, 2015; Farmer, 2002). The affected students then turned to keeping their symptoms, struggles, and difficulties to themselves (Farmer, 2002). Such behaviour is affirmed by Bosacki, Dane, Marini, and YLC-CURA (2007), who learned that disclosure often resulted in social isolation, with friendships negatively impacted, and caused students to suppress their symptoms and struggles. Friedson (2013) talks about her own experience in creating a tombstone under a dark sky for a poster assignment in a mandatory Tolerance and Acceptance high school course. She added a poem that spoke about bullying, lack of support, and eventual suicide. The poster was put on display in the hallway along with her classmates' but was taken down shortly thereafter with an excuse from the principal that Hallowe'en was over. Friedson felt that the principal "decided to hide the symptoms of the pain that [she had] made visible, to throw away the evidence so as to deny it, and in so doing, deny [her]" (p. 3). Alternatively, Hetherington and Stoppard (2002) learned from their participants that cutting off communication "'just hurts you more. Trying to hide it. 'Cause you put more effort into trying to hide it rather than help your problems'" (p. 625).

Friends seem to be the main outlet when someone with depression chooses to disclose his or her illness. These friends, though, seem to come in two groups: those who accept the student's diagnosis and those who distance themselves from the student. Excepting friends who approach the adolescent with sincere concerns about his or her behaviour, one cannot predict the outcome before the disclosure. If positive, the student may be supported and encouraged throughout his or her struggles, offering an outlet for emotions and thoughts. Unfortunately, if the response is negative, this could lead to further issues for the adolescent, such as internalizing, hiding symptoms, and isolation. To encourage disclosure, students with depression clearly need a less

ambiguous outlet.

Teachers: Encouraging Disclosure and the Educational Challenges Faced

While it seems that friends or others who have experience with depression are the main recipients of disclosure, some students do indeed speak with teachers (Wisdom & Barker, 2006). Unfortunately, Wisdom and Barker's (2006) study gave no reasons as to what encouraged the adolescents to disclose to teachers. Similarly, Woodgate (2006) says that teachers can help by offering students "a sense of presence" (p. 266), belonging, or connectedness to the world, also without going into specifics. Overall, very little information is provided to teachers about broaching the topic of depression with students (Crundwell & Killu, 2007). In their article entitled "Understanding and accommodating students with depression in the classroom," two sentences are devoted to monitoring at-risk students and "creating a supportive environment" (p. 49) and neither examples nor techniques are offered. However, there is hope. Lewington (2013) reported that one grade 12 teacher tries to create a safe space for her students by leaving her door open at lunchtime and encouraging students to come in and speak with her if they have questions, concerns, issues, or just need to talk. One adolescent commented: "'It told me that there are teachers out there who care about you and respect you for who[m] you are and do care about everyone fitting in equally. . . . She stood for something'" (p. 39). Surely, if one teacher in Ontario is doing something like this, there are others as well.

The British Columbia Ministry of Education (2001) document recommends that teachers simply note observations, consult with other teachers, and then approach the counsellor and principal. They suggest that the counsellor is likely already aware of the issue and may offer helpful advice to the teacher, and assert that the counsellors and principals are the best people to address the concern. This tactic, though, is frowned upon by students:

> ‘During an anonymous survey at my school I described my issues and [the] negligence I felt from the school. I wanted to die, maybe I still do, but either way, a teacher recognized my handwriting and gave it to another teacher who gave it to a guidance counselor. Low and behold trust is . . . broken, I was called in during the day, thinking it was some routine courses talk, my trust and faith in the decency of my school was violated. How did they expect me to even talk to them if they go behind my back? If that teacher had just talked to me, maybe I would have responded. But how could I now? I walked out of that room in about 3 minutes tears streaming down my face’ (Leahy & Robb, 2013, p. 10)

The actions of the teacher may be justified because of authentic concern for the student or if he or she was thinking of the “duty to report” laws for child abuse (Child and Family Services Act, s. 72. (1), 2014; Ontario College of Teachers, 2015). However, Ontario law for teachers does not address student self-harm. It is left up to individual schools and school boards to implement a structure for these types of incidents (Buchanan, Colton, & Chamberlain, 2011), and this may have been the case in the instance cited here. Regardless, the adolescent’s statement that he might have been more open to help if he had been approached initially by the original teacher is an important one. Tyler (2014) affirms this point by sharing stories of teachers who are reaching out to students. One teacher told a story about a student who had depression and was self-harming. He indicated that he approached the student with his observations and then followed procedures for reporting. He worked with the student by listening and encouraging her to seek professional help. He felt he provided the positive and caring environment needed so the student felt safe. The other teachers in the study agreed that offering this type of support was indeed part of being a teacher. The first student’s story, though, highlights the challenge of encouraging disclosure and how to approach students in the appropriate manner.

In Ontario, Manion et al. (2013) conducted a survey of educators and mental health providers who identified gaps, such as a lack of protocols and agreements outlining procedures for students with mental health issues. Teachers and schools are looking for clarity in their roles and decision-making responsibilities to help these adolescents receive the support required. Likewise, three of the studies previously mentioned (Andrews et al., 2014; Rodger et al., 2014; Tyler, 2014), identified that teachers are not prepared to handle mental health issues in their classrooms. In 2013, two documents with instructions for implementation were made available to schools in Ontario: *Supporting Minds* (OME, 2013c) and *Leading Mentally Healthy Schools* (School Mental Health ASSIST, 2013). These two documents are meant to be used together to help make changes within school boards throughout Ontario with respect to mental health and how such issues are addressed.

Similar to British Columbia, the OME (2013c) recommends that teachers make "several observations of the particular behaviour . . . [and] share these with others who can help develop a plan to manage the behaviour" (p. 20). Importantly though, this document actually addresses talking with students and encouraging conversation. It acknowledges that educators may be important mentors for students and could be the people that students prefer to approach with such issues. There are several suggestions for how a teacher can handle this delicate situation when speaking with a student: finding a safe place to have an open conversation, letting the student know that some issues can not be kept confidential, indicating that he or she is willing to listen to the student, and, in some cases, suggesting that the issue is brought to the attention of someone with more expertise. The last point may also be used if the teacher feels uncomfortable or lacks the information to help the adolescent. However, the document does not mention whether the teacher has to report to someone if the student approaches him or her. It could be

extrapolated that if the teacher indicated that some things cannot be kept confidential, it is also possible to keep the exchange between the student and teacher confidential.

School Mental Health ASSIST (2013) is geared toward school board administrators and provides detailed directions to establish a mental health program within their schools. As of 2013, every board in Ontario has a full-time Mental Health Leader to assist in bringing these changes to the schools. Roles are clarified in a three-tier model which divides mental health programs into three areas: mental health promotion for all students (100%), identifying risk and providing prevention strategies for some students (15–20%), and intervention methods, such as helping the student to access services, for a few students (2–5%). However, as mentioned in Chapter One, 50% of all mental health disorders begin in adolescence (Manion, 2013; Manion et al., 2013), with up to 20% of students affected by depression while in school (Adamson, 2010; Minor et al., 2005; Pettit et al., 2006), so the allocation of resources seems somewhat lacking, especially in the early years of this new program. However, one could argue that not all students with depression require, or want, assistance, as depressive symptoms can range in severity.

Overall, there appears to be a deficiency in information and suggestions for teachers who wish to encourage disclosure among their students. Although programs are now in place and are certainly a definitive step forward in addressing mental health issues in schools, they do not seem to be entirely comprehensive or consistent across Ontario. It appears that individual schools and boards are given some leeway to develop their own policies. While this could be a good thing, especially if the boards work together to determine best practices while also acknowledging the different realities of school districts, it could also lead to inconsistencies regarding reporting responsibilities, supports available to students, and timing of implementation throughout Ontario. Last, it should be noted that the OME (2013c) document mentions that observations should be

shared “with others who can help develop a plan to manage the behaviour” (p. 20). The idea of managing a behaviour could lead one to believe that the mental health issue is somehow bad and needs to be controlled. One would never manage a gay or lesbian student or one with a physical handicap, so why manage a student with a mental illness? Less pejorative statements might be: “help create a plan to support the student” or “help meet the needs of the student.” Wording can be important in official documents as they may influence those who read them, and the text should be approached with a focus on understanding, sensitivity, and inclusiveness.

Students: Supports Experienced in School

Although mentioned previously in this chapter, the following statement also applies to this section: Woodgate (2006) learned from students that teachers provided support “by trying to understand them, checking in on them during difficult periods and by making a difference in their lives” (p. 264). Two other examples that bear repeating come from the teacher in Lewington’s (2013) study who provides a safe space to talk and Tyler’s (2014) research that identified a teacher who took the initiative to approach a student who demonstrated need. As a student, Joan’s (A, 2015) experience in high school was mostly negative. However, she did say that the few teachers who made an effort to talk with her about a learning plan made a huge difference in her motivation to continue with schooling. Furthermore, Farmer (2002) points out that depending on who is involved in the circle of care for the student, teachers can have a larger role in the overall supports a student receives. In one case she studied, the parents were included in that circle and the teacher would call them and let them know their teen was performing well in class. This can motivate the student and reassure the parents that, despite the illness, the adolescent is learning to cope. Unfortunately, when De Wit et al. (2011) discuss that adolescents may feel that some of their needs are being met by supportive teachers, they do not indicate in

what ways those needs are being met.

While not specifically related to depression, Leahy and Robb (2013) mention a conundrum a student with generalized anxiety disorder faced in class. The student had difficulty staying awake, and when the class was asked to read an article, she approached her teacher to see if she could walk in the hallway as she read to help her stay awake. The teacher allowed this, and when the student returned to class she was finishing her reading just as her classmates were, something that had not happened before. She said:

> 'In that moment I realized that I could achieve the same level of success as anyone else. I just might need to get there a different way. . . . And it was that teacher, with her willingness to listen to my idea and accommodate, simply by saying yes!' (p. 13)

In the research reviewed here, there were very few studies that investigated student experiences with school supports. Some articles spoke of supports found through friends, parents, doctors, and the general community, but none looked explicitly at the support students with depression received at school. In one metasynthesis by Dundon (2006), qualitative studies investigating adolescent depression were examined. Between the years 1970 and 2005, she found only six studies and, even then, "because of the very limited number of studies available, studies were included in which some or all of the participants were not necessarily diagnosed with depression" (p. 385). Of the six studies, only three were based solely on students with depression, and these have already been referenced several times in this chapter: Farmer (2002), Hinatsu (2002), and Wisdom and Green (2004). In fact, Wisdom and Green stated that, "although there is literature about adults' experiences of depression, little research has focused on teenagers' experiences" (p. 1227). Studies by Oliver et al. (2008), O'Mara and Lind (2013), and Woodgate (2006) also identified a lack of student perspectives. Finally, even in contacting

Canadian Dr. Stanley Kutcher (personal communication, July 22, 2013), a world-renowned psychiatrist, researcher, and scholar of adolescent- and school-based mental health initiatives, he said he was unaware of any research that investigated student experiences with supports and barriers in a school environment.

Clearly, research is needed in the area of student experiences with school supports. As will be demonstrated below, many recommended supports will be listed for teachers to utilize, but no one has asked the students with depression if those supports help, are available, are implemented, or even if they are offered. Perhaps, in light of the new OME (2013c) document outlining a province-wide strategy for school mental health, studies will be conducted over the next few years to determine the success of this initiative. However, to truly understand the effectiveness of the new guidelines, it seems evident that some of this research should include the viewpoints of students with depression. Only then can we begin to move forward in developing the strategies needed to ensure students with depression can achieve their maximum level of success in school.

Teachers: Recommended Supports in School

Evidence-based resources for teachers to use in supporting students with depression are difficult to uncover. Leahy and Robb (2013) conducted surveys and focus groups with adolescents, and although the participants were not all diagnosed with depression, they made three recommendations to support students: provide a quiet space within the school for students to deal with their mental health issues in a nonjudgemental environment, place posters and use morning announcements to inform students of in-school mental health counsellors, and leave pamphlets and other mental health materials in a private space so as to avoid drawing attention to students looking for information. While not specific to depression, but still within the “mood

disorders" category, Lofthouse and Fristad (2006) identify that "no research-supported, school-based interventions currently exist" (p. 219). Calling for an investment in determining evidence-based mental health initiatives, Manion et al. (2013) urge more effort be put into identifying best practices. Teachers also recognize this lack of information and are specifically asking for "development, testing and promotion of promising evidence-based practices within [Ontario]" (Short et al., 2009, p. 33).

In the OME (2013c) document, there is a substantial list of approaches for assisting students with depression. This list contains 25 separate strategies for teachers to consider and implement. These include developing a schedule which promotes student attendance, helping the student set goals and assisting with organization, modifying the student's workload, allowing extra time to complete tests and exams, and providing positive feedback to the student. While many of the supports that were mentioned appear sound and promising, and on reflection are good teaching practices, it is important to realize that this information, while referenced from Anjum and Rashid (n.d.), Buchanan et al. (2011), and Calear (2012), is not supported by research. However, it is critical that these practices be in place to help students who do have depression. It should also be noted that in Calear's recommendations, she is actually referencing Crundwell and Killu (2007) for the strategies.

Other documents not only mentioned some of the strategies above but also provided additional ideas for supports such as being good listeners (British Columbia Ministry of Education, 2001; Canadian Mental Health Association (CMHA, n.d.b), identifying someone within the school who may already have a supportive relationship with the student (School Mental Health ASSIST, 2013), providing a safe space within the school and using a code word so the student can leave the classroom to go to that space (CMHA, n.d.b), providing photocopies of

another student's notes (CMHA, n.d.a), and considering different formats for exams depending on the preferences of the student (CMHA, n.d.a). Again, none of these suggestions are based on research.

The only evidence-based information about supportive strategies was in Tyler's (2014) work. Tyler interviewed several teachers about the approaches used to help accommodate students with mental health difficulties in their classrooms. Teachers identified that they value being able to make students feel that they are approachable and welcome in their classrooms, not just those with difficulties but all their students. The teachers also agreed that it was important to practice active listening. When talking about accommodations, Matthew, a teacher in the study, says, "You make sort of accommodations without it being specified in a legal document, you make your own accommodations . . . I'm sure over the years I've looked to find ways to make life easier for kids that are going through rough times" (p. 39). In general, the teachers said that observations helped a lot. They would greet the students or scan their faces, observing their mood and interaction with classmates. If a relationship has already been built by their initial work in making students feel comfortable in their classrooms, they felt they are more likely to get a truthful response to "questions like 'what's up' or 'are you okay'" (p. 39). The teachers believed that offering the students choices was important, choices ranging from how they do their work to where they choose to sit. It was emphasized that the teachers would do these things for any of their students because a medical diagnosis does not mean you have the exclusive rights to difficult days. Finally, Matthew suggests:

> Is it letting kids off the hook? You know, you could construe it that way, but I think it can also be construed as compassion to someone who is so overwhelmed by life that you don't, that you want to kind of take away from the performance anxiety or whatever and

make things a little easier. (p. 41)

It seems that most of the recommendations put forth by many organizations and various researchers have not been studied. They appear to be based on conjecture. As we saw with students, teachers have generally not been consulted for suggestions regarding approaches with which they have had success in their classrooms. This again indicates that one of the most important sources for developing ways to help students with depression in the classroom is being overlooked. Teachers may provide a wealth of information and can certainly be easily identified and contacted to complete surveys or interviews about the effectiveness and use of supports in their classrooms. The teachers in Tyler's (2014) research indicated several times that they try to treat all students as individuals with individual needs. This is not a new notion, as the book *Curriculum Considerations in Inclusive Classrooms: Facilitating Learning for All Students* looks at many important approaches to inclusive education, such as creating safe classrooms, giving the student choices (Ford, Davern, & Schnorr, 1992), having flexible learning objectives and outcomes, using a team approach (Stainback, Stainback, & Moravec, 1992), and practicing problem-solving (Graden & Bauer, 1992). Interestingly, these general principles are reflected in many of the supports listed in this section. Perhaps it is only a matter of time before additional research is completed and used to enhance the current recommendations. Meanwhile, though, students and teachers are relying on guesswork. The present study has the potential to provide evidence-based practice.

Students and Teachers: Barriers Experienced by Both

When students are diagnosed with depression, the barriers discussed again and again in the research are stigma and self-stigma. Stigma appears so often that it will be discussed independently of this section concerning other barriers.

Farmer's (2002) discussions with students showed that they were all excellent scholars with above-average grades but experienced problems with motivation with regard to homework. One student, "*Sue*, embarrassed about her inability to handle the workload stated: 'I'm not dumb enough to be in special ed so I'm in special ed for an emotional disability. I don't want to be in special ed.'" (p. 574). Ferguson et al. (2005) noted that depression often interfered with a student's engagement in school. One student related that

> it's very, very easy to become depressed, to stop liking yourself, liking who you are . . . it spreads to other areas of your life . . . need to address these issues at the beginning before they balloon. And it's so difficult to do because so many of the symptoms or whatnot are invisible. (p. 34)

Some students, especially those with other risk factors (such as home life, drugs, learning disabilities), felt a lack of connection with the school. They experienced poor grades, which led to skipped classes, then suspensions, and ultimately to failed courses. Some adolescents reported strict rules within the school which offered no leniency and often compounded the issues. These students fell behind in their progression and were either "asked to leave or [left] on their own" (p. 34).

The You Tube video produced by A (2015) detailed many of the barriers Joan encountered in high school. Joan mentioned that she graduated three years ago, so she would have begun high school in approximately 2008. Immediately she noted that, "as a student, I was looked at as my flaws, and as my issues. To my teachers, I was a problem" (time stamp 0:11). She felt her panic attacks and school time missed due to depression made her a nuisance, especially for those teachers who "didn't believe that mental health is an actual thing" (time stamp 2:10). Her high school provided no support, but she also recognized that they did not have

the resources to do so. There were no programs or services in place, and the school psychologist was never there. When she experienced ongoing panic attacks in her grade 9 math class, her guidance counsellor recommended that she drop out of school, arguing that her panic attacks would affect her intelligence and capabilities, which Joan knew was not true. After her conversation with the guidance counsellor, Joan found that she was treated differently by other teachers and staff throughout her high school career. Furthermore, she believed that teachers, among others, eventually leaked information, because her peers became aware of her conditions and she felt like a "social pariah" (time stamp 1:45). Ultimately, near the end of the video, Joan stated: "I am not a problem. I am an individual. I am complex. And I deserve to be listened to" (time stamp 3:17).

Leahy and Robb (2013) learned that students with mental health issues identified the lack of a "designated safe space" (p. 4), where they can go when they are overwhelmed by their depression (tearfulness or anxiety, for instance), as the top barrier in their schools. This safe space would be open to all those who needed a private place to go, somewhere they would not be judged. To take this point one step further, the students felt that an on-site counsellor should be available at all times because a situation where the student may need assistance or guidance "cannot be scheduled or predicted" (p. 11; Lewington, 2013; Nabors, Reynolds, & Weist, 2000). A youth in Rodger et al.'s (2014) study explained this well:

> Or like a lot of times they'll say, you know, on Monday the mental health nurse is here. And you're like, oh, good, I'll try to plan my crisis for Monday. Okay, every Monday morning. That be it. Like, yeah. (p. 38)

Leahy and Robb noted that the placement of information for students with mental health issues was also a barrier. One student mentioned:

> There are brochures and flyers concerning mental health, suicides hotlines, etc. for people to take. But they're in the front foyer, so everyone can see if you take one, which sucks. No one wants everyone to know if they're struggling. (p. 12)

Other barriers include teacher reactions to such symptoms of depression as stress (viewed as defiance), poor mood (thought of as an adolescent phase), and inappropriate behaviour (regarded as acting out). Feeling as though one is being judged by the teacher, rather than being shown true concern, was also identified as an issue. The students "explained that there appears to be a double standard when it comes to the behaviour of youth with a mental health or addiction issue, compared to a student with a physical illness" (p. 8). Students were also wary of counsellors due to confidentiality issues. They felt that the counsellor might contact their parents. Overall, there is no clear definition of what can and cannot be kept confidential by the counsellor, which creates a barrier for the students receiving help (Kovacs, 2010; Leahy & Robb, 2013; O'Mara & Lind, 2013). Leahy and Robb (2013) recommend that more effort should be placed on understanding the legal rights of each party with regard to confidentiality, as was discussed previously.

Another obstacle identified by Leahy and Robb (2013) is the lack of understanding and acknowledgement of mental health issues in schools. More than a quarter (28.2%) of students said that the school curriculum did not cover mental health issues, and about a third (35.9%) mentioned that it was discussed once in one course. Mandigo (2013) noted that the Ontario curriculum did not cover mental health until grades 11 and 12, and then only in optional physical education classes (Milin & Kutcher, 2011; Roumeliotis, 2011). This excludes the vast majority of students who do not pursue physical education past grade 9 as only one course in this subject is a graduation requirement (OME, 2015b). Furthermore, mental health is addressed as an illness or

disease (Mandigo, 2013). In examining these two statements made by Mandigo, I scanned current curriculum documents for grade 9 subjects and discovered that only four subjects had been updated in the last 5 years: Canadian and World Studies (OME, 2013a), French as a Second Language (OME, 2014), Health and Physical Education (OME, 2015a), and Social Sciences and Humanities (OME, 2013b). While all four had a preface paragraph about mental health, only Health and Physical Education required integration of mental health information in the curriculum for grade 9 students; Canadian and World Studies required no integration, French as a Second Language provided mental health information in some (optional) grade 11 and 12 university preparation courses, and Social Sciences and Humanities discussed mental health only in three (optional) subjects in grade 11 but did so in all destination streams (open, college preparation, and university preparation).

Interestingly, a close review of *Supporting Minds* (OME, 2013c) reveals that the document only vaguely mentions that teachers may want to integrate mental health awareness in their classrooms. It emphasizes positive classroom management by addressing acceptable behaviours, management of emotions, coping skills, and problem-solving skills. As was discussed earlier, it does provide information about possible supports for students with identified needs but, other than specific cases, it does not cover broaching the subject of mental health with all students. Disappointingly, the document has a four-paragraph section called “Causes of Problems” (p. 11) which stresses environmental factors that may contribute to a decrease in mental health but has only a few words about the genetic or biological causes of mental health issues. The section referenced only one source, Ries Merikangas, Nakamura, and Kessler (2009), who actually cited 13 sources in their overview of “Risk factors for mental disorders in youth” (pp. 13–14). While both Ries Merikangas et al. and Rodger (2014) agree that some mental health

issues may be initially caused or exacerbated by environmental (community, school, social, etc.) or family factors (family structure, relationships, violence, neglect, etc.), it is important to remember that "one of the most consistent and potent risk factors for the development of mental disorders in children is a parental history of mental disorders" (Ries Merikangas et al., 2009, p. 13). This is supported by Sullivan, Neale, and Kendler (2000) who indicate that if a family member has major depression, other members are 2.8 times more likely to have depression as well. They also state that depression has up to a 42% chance of being inherited. Teachers' classroom management strategies may help some students learn to recognize and address their mental health issues but could unwittingly cause other students to hide their difficulties if these were manifested in ways that were contrary to expected behavioural norms in the classroom.

School Mental Health ASSIST (2013) and Rodger (2014) provided identical suggestions for teachers when working with parents of students with mental health challenges. However, these suggestions also work as a short list of barriers to avoid when working with students with depression: Do not judge the student, do not forget to update yourself about the student and his or her needs and diagnosis, do not act as an opponent, and do not dislike the student. Similarly, Joan (A, 2015) breaks down the best supports one can provide a student: learn, listen, and love. She was particularly adamant about the listening aspect and said it was important to: (a) let students talk; (b) just listen, do not involve yourself, it is not about you; and (c) repeat. She also reminds teachers and guidance counsellors that it is not supportive to tell students to drop out or simply provide resources to help. Finally, she found that a lack of reintegration assistance after a mental health episode, such as a panic attack, caused difficulties.

The CMHA (n.d.b) suggested that teachers not be discouraged when a student experiences a setback despite accommodations. Setbacks can happen for a variety of reasons,

and it is important to be prepared and willing to continue helping the student. Tyler (2014) mentioned a specific situation in which this could occur: when teachers get frustrated with "students who become disengaged" (p. 41). Disengagement may be the result of the student's symptoms distracting him or her and occupying his or her mind, leading to a loss of concentration in the classroom. This situation can then create difficulties in assessing the abilities of the student, make relationship-building challenging, and cause problems in determining the supports that are required. By recognizing and acknowledging setbacks or disengagement, teachers may have to work a bit harder to attain the original goals of the accommodations, but some of the suggestions made previously could help. However, Manion, et al. (2013) remind us that a teacher's time is also a barrier, as is the lack of understanding about protocols which may be established. Adding to this, O'Mara and Lind (2013) state that there is little knowledge about the services available to both students and teachers. Learning to accept that student needs often stray outside their academic role, teachers may be able to view the time spent with students who have mental health needs as educational, possibly for both parties. Understanding school protocols and services may offer additional solutions such as directing students to guidance counsellors or mental health workers that may be on site.

It appears that students with mental health issues report far more barriers than supports. Yet again, the problem seems to lie in the lack of enquiry done with adolescents; only seven researchers had any information on educational barriers, and only two of those (one being a student video) provided any depth or detail. Regarding teachers, addressing some of the barriers they may experience sheds light on the need for further research, education, and knowledge about services available in their own schools. This section provides a place to begin correcting current practices and implementing objectives that will help both students and teachers succeed

when dealing with mental health issues.

Stigma, Self-Stigma, and Discrimination

Stigma, self-stigma, and discrimination are not unique to depression. Rather, these experiences affect people throughout the world in a variety of circumstances: race, sex, religion, social status, and many other identifiers, both big and small. In this study, I am using the following definitions:

> **Stigma** is defined as negative, disrespectful and untrue judgments about you based on what people think they know about you – and your situation.
>
> In contrast, **discrimination** involves negative and disrespectful actions against you.
>
> **Self-stigma** occurs when you begin to believe the negative opinions about you and start to think that you deserve to be called names and denied opportunities.
>
> **Stigma and discrimination by association** involves negative judgments about – and disrespectful actions against – family members, caregivers and mental health professionals. (Everett, 2009, p. 5)

Dovidio, Major, and Crocker (2000) explain stigma in a slightly different way, indicating that it must involve "at least two fundamental components: (1) the recognition of difference based on some distinguishing characteristic or 'mark'; and (2) a consequent devaluation of the person" (p. 3). Chodos, Mulvale, Bartram, and Lapierre (2009) identify "that stigma and discrimination frequently have at least as great an effect on people as does their mental health problem or illness itself" (p. 90). To deal with both a mental health illness and the stigma around it can have an extremely negative effect on a person's quality of life. In a study conducted by Rose, Thornicroft, Pinfold, and Kassam (2007), adolescents indicated the words they used to describe people with mental health issues. A total of 250 words were documented, and the top 10 were:

disturbed, nuts, confused, psycho, spastic, crazy, depression, disabled, mad, and unpredictable. These derogatory, stigmatizing terms would be some of the words whispered behind the backs of, or even directly to, students experiencing mental health issues.

Self-stigma, Snyder (2014) finds, can be just as harmful as stigma to a person with a mental health issue. In one study, patients in a psychiatric ward were paired with outside persons to complete a game; half of the patients were told that the other person knew about their medical history and half were told that the other person knew nothing. In reality, the partner had no knowledge of any medical issues. The patients who thought their partner was aware of their medical situation became anxious and tense, had difficulty with the game, and were socially awkward. The patients stigmatized themselves by acting in a way that emphasized the stigmas they thought the other people had attributed to them.

Stereotypes and attribution theory complement the information about stigma, self-stigma, and discrimination. Stereotypes are formed when a stigma can be assigned to "a definable group" (Biernat & Dovidio, 2000, p. 92), and negative stereotypes tend to develop from stigmas that are thought to be controllable. Stereotypes influence three things: what people think, their attitudes, and discriminatory actions. Interestingly, the underlying aspects in the stereotyping of people with mental health issues are very similar to those associated with race. In applying these notions to depression, a stigma like "you're crazy if you go to the counsellor's office" can be expanded into a stereotype that encompasses other people, such as "all crazy people need to be locked up in the psych ward". Janes (1996) uses attribution theory to explain that a teacher's expectation of a student's achievement can influence the level of achievement that student actually attains (Jussim, 1989; see also Rosenthal, 2002). Teacher expectations are often influenced by stereotypes, labels, and stigmas (Janes, 1996; Riley, 2009). A teacher can impact a student's

likelihood of success with the type of feedback (positive or negative) provided and the amount of time spent with the student, among other things (Janes, 1996). This can have a very real effect on students with mental health issues.

Finally, to provide additional context about the impact of mental health stigma on human development, Millon (2004) reviewed approaches to mental health issues that have been used throughout human history. For over 10,000 years, people have believed that others who showed signs of mental health difficulties were possessed by evil spirits and should be feared, shunned, and made to release the spirit: In the Stone Age, trephining, or the boring of a hole in the skull, was used to relieve psychotic behaviours; primitive and ancient civilizations used torture to release the person from possession; in the 6th century B.C., the person was flogged; the early medieval and medieval eras brought church-sanctified exorcisms, witch hunters (who flogged, starved, and then burned their victims), and the use of other more torturous devices; by the Renaissance, people were locked in institutions meant for isolation and not for treatment; and in the 1800s people were confined to "'lunatic boxes'" (p. 82). While the people in these eras were trying to understand and help those with illnesses, their first and foremost reaction was fear, followed by the idea that those with mental health issues needed to be cured in whatever way possible. However, it should be noted that not all civilizations treated people this way. Ancient China valued science and medicine and believed in treating people with (what we now call) psychotherapy, medications, and acupuncture, as well as providing places where the ill could receive care. Also, many people over the centuries (starting with Socrates, Plato, and Aristotle around 500 B.C.) have been adding to the cumulative knowledge that psychiatrists use today. In general, stigma is thought to be a social construction which may exist at one point in time but not in another (Dovidio et al., 2000). As Millon (2004) demonstrates though, stigma about mental

health has been around since humans first appeared. Any consideration of mental health issues must take into account the reality of the potential (negative) impact of stigmas and stereotypes.

Students: Stigma and Self-Stigma Experienced

In studies previously mentioned, many students also identified stigmas they experienced in high school. Words like rejection, defection of friends, humiliation, exclusion from peer groups, teasing, and ostracism, noted by Farmer (2002), are echoed throughout the research. Almost half of students identified stigma, while 17.5% cited fear of physical attacks, as the reasons they did not seek help for their mental health issues (Leahy & Robb, 2013). Joan (A, 2015) explained that she was "ditched" by her friends because she was "emo" and no longer fun to be around (time stamp 2:00). She experienced self-stigma in feeling ashamed that she needed supports, which were not even available. However, she believed that integrating mental health information into the curriculum would lead to less stigma and fewer difficulties in school. Self-stigma is also mentioned by the CMHA (n.d.a) who learned that students are often afraid teachers will treat them differently or think them unable to complete coursework if they seek help.

Not surprisingly, students did not want to be labelled, "given the stigma associated with feelings of depression and the fear of being judged" (Dundon, 2006, p. 390; Ross et al., 2003; Roumeliotis, 2011). Judgements, though, can be both external and internal. The Mental Health Commission of Canada (MHCC, 2012) You Tube video found that students with mental health issues felt judged by others in the way they coped (cutting, for instance) or if they asked for help, but they also judged themselves (self-stigma) when they started to believe what peers said about them or held a fear of what others would think. Self-stigma can also be an issue if one already believes in the stereotypes about depression, such as being crazy or abnormal, and then develops

the mental health issue itself (Ross, et al., 2003). One student in Lewington's (2013) research was rejected by her friends because they thought they would be infected by her illness, and several studies identified the peer-held notion that one was crazy if he or she had to see the school mental health worker (Kovacs, 2010; Lewington, 2013; MHCC, 2012; Nabors et al., 2000; Ross et al., 2003).

Like most people, students with depression "did not want to be seen as different from their peers, but it was not uncommon for them to feel stigmatized and like 'outcasts'" (Woodgate, 2006, p. 266). One participant in Gammel's (2003) research was influenced by self-stigma and mentioned that "a lot of time you're depressed, you don't know why, you just think you're crazy, you have no idea what's going on . . . So I don't think you'd be likely to open up with that" (p. 90). Young adults spoke further to the MHCC (2012) about their experiences with mental health issues in high school. One young lady said that she was so embarrassed (Kovacs, 2010; MHCC, 2012) and ashamed of her difficulties that she created a fake persona, a way of "hiding who [she] really was" (MHCC, 2012, time stamp 2:32). Psychiatrist Dr. David Goldbloom explains that this is not uncommon: "that happy me that people saw before was a sham. That successful, productive me was fake. The silence that surrounds that person . . . among friends only confirms that self-perception" (Abraham, 2008, p. 2).

One of the more alarming effects of stigma is its impact on the student's willingness to seek help. While Hartman et al. (2013) state that more than 12% of students with mental health issues will not discuss their struggles with anyone, Adamson's (2010) research puts that number at 25%, and Leahy and Robb (2013) found that 46.4% of students will not seek help due to stigma. There is clearly much variation in the understanding of help-seeking behaviour among adolescents, but the problem remains: students are not receiving the help and support they need

due to what they believe others may think. Overall, stigma is hurtful and damaging to students, especially as they may be at their lowest and most vulnerable state. It also often leads to self-stigma which makes dealing with the symptoms of depression (and other mental health issues) that much more difficult.

Teachers: Dealing with Stigma in the Classroom

Santor et al. (2009) believe that before teachers can even begin educating students about mental health, they must first confront the stigma that surrounds the issue. *Supporting Minds* (OME, 2013c) states:

> Children, young people, and adults all agree that one of the major barriers to seeking help for mental health problems is fear of being stigmatized or negatively perceived by others. Educators have a unique opportunity to influence all students' perceptions and understanding of mental health problems. Teachers can help reduce the stigma associated with mental health problems by discussing mental health issues in class and helping students to find and use reliable, in-depth information on the topic. (p. 19)

Kirby (2013) provided an example from Australia of how stigma can successfully be eliminated in youth. The Australians have included mental health and stigma curriculum designed to inform and change attitudes in their grade 5 classes for the past 15 years. Research now shows that the positive attitudes instilled in preteens have remained and they have not reverted to old stigmas and stereotypes. Unfortunately, this type of success has yet to be realized in Canada.

There is little practical information provided to teachers about how to approach stigma in the classroom: School Mental Health ASSIST (2013) suggests implementing and getting involved in antistigma school campaigns throughout the year. Short et al. (2009) recommend bringing in speakers who have had difficulties with mental health, especially younger adult

speakers who may invoke a stronger connection with the students. This latter point is affirmed by young adults in the MHCC (2012) video who believed that this type of speaker would present an opportunity for open conversation within the class. A study conducted by Hartman et al. (2013) examined self-stigma and the importance of addressing this issue in the classroom in addition to stigma and mental health. They found that presentations made by those who have received mental health care can help reduce the self-stigma, especially shame and self-consciousness, students may feel when considering approaching people for help. Moving beyond utilizing outside speakers, Tyler's (2014) research identified one teacher who worked to remove any victimization of her students: "'I still want the student to feel like I see them as a student and not a victim or you poor thing'" (p. 31). The teachers also recognized that the language they use in the classroom can either reinforce or undermine stigmas which may be held by students. However, students' language is also important. By listening for, addressing, and eliminating stigmatizing statements, stereotypes, and offensive language, the classroom becomes a safer space for all students. Finally, Kutcher and Wei (2015) developed a resource that can be used in the classroom to address the stigma of mental health issues in high school. Research results from the use of this resource have shown a decrease, for both teachers and students, in the stigma surrounding mental health issues (Kutcher & Wei, 2015; Kutcher, Wei, McLuckie, & Bullock, 2013).

Despite the strong statement in *Supporting Minds* (OME, 2013c) cited above, classroom curriculum guides provide little to no information about mental health or antistigma strategies. Of the four courses identified—Canadian and World Studies (OME, 2013a), French as a Second Language (OME, 2014), Health and Physical Education (OME, 2015a), and Social Sciences and Humanities (OME, 2013b)—only Health and Physical Education contained any curriculum

information about mental health stigma, and this was limited to grade 11 open and college preparation classes. Again, while each curriculum guide had a preface that mentioned mental health, each one only passed over the word stigma.

Although there are few suggestions to help teachers address, and hopefully eliminate, stigma about mental health issues through classroom education, there is always hope. More researchers are looking at the effects of stigma on adolescents, and a few are actually talking to the students themselves. In addition, videos from MHCC (2012), individual students such as Joan (A, 2015), the students in Roumeliotis's (2011) news report, and students who create videos for the Children's Mental Health Ontario "Change the View" (2015) contest (which received 230 videos in 2015, its 6th year running) continue to promote antistigma actions in Ontario high schools. Together, these efforts may provide teachers with the means to broach the topic of mental health stigma in the classroom to eliminate myths and begin the change from rejection to acceptance.

Summary

As has been demonstrated in this review of literature, there are many barriers, both for students with depression and for teachers, surrounding the complex issue of mental health. However, there are also suggested supports for these students. The main concern, though, is the lack of evidence-based practices. The voices of students with mental health issues must be examined to determine what they require to succeed in high school. The present study examines the experiences of students with depression—their perceptions of depression, the effects of disclosure, the supports they received, the barriers they faced, and the stigma they encountered—to gain some insight into what might constitute best practices in mental health education and accommodations.

CHAPTER THREE: CAPTURING LIVED EXPERIENCES

Choice of Research Design

As identified in Chapter One, my research examines the school experiences and storied remembrances of adolescents who divulged a diagnosis of depression to classmates and school personnel. I also investigate the educational supports and barriers these individuals encountered both before and after disclosure. Dewey (1965) speaks directly to this connection between education and experience: "Education in order to accomplish its ends both for the individual learner and for society must be based upon experience – which is always the actual life-experience of some individual" (p. 89).

According to Guba (1990), one's research methodology can be viewed as the answer to the question: "How should the inquirer go about finding out knowledge?" (p. 18) The answer is therefore dependent on the purpose of the research. If one is interested in understanding human action, a qualitative route may be more suitable (Pinnegar & Daynes, 2007). Furthermore, I believe "people live storied lives . . . and their information brings researchers closer to the actual practice of education" (Creswell, 2008, p. 511). I also support Atkinson's (2007) view that "we think in story form, speak in story form, and bring meaning to our lives through stories" (p. 224).

To investigate the research phenomena and capture the students' lived experiences, I use narrative inquiry, which "describes human experience as it unfolds through time" (Clandinin & Rosiek, 2007, p. 40). Creswell (2008) and Polkinghorne (1988) agree that narrative research is best used when stories have a chronology: a past, present, and future. Narrative inquiry allows me to gather information about the students' whole stories with regard to their experiences with depression, both broadly and school focused. As a narrative inquirer, I "stay attentive to experience with no clear outcome beyond a deeper understanding of the experience" (Clandinin

et al., 2015, p. 24). Without being held within the borders of direct questions with direct answers, narrative inquiry captures the nuances of a person's experience with depression which, as discussed in the literature review, is lacking in current research, especially with adolescents. For true learning to occur, individually and within society, it is important that the reader become immersed in an experience, either through firsthand participation or by "the reader understand[ing] enough of the participants' experiences so that the reader can share something of what the experience might have been for the participants" (Clandinin & Connelly, 1991, p. 277). One way to capture these details is through story by using narrative inquiry. In this way the experiences themselves are not limited to an individual but rather available to society as a whole.

In this chapter I outline narrative methodology and method, as well as my complete process for conducting the research. The detailed steps taken include ethics requirements and considerations, selection of participants, participant portraits, setting, interviewing, interview questions, transcribing, restorying, voice, analysis, validity, reflexivity, and limitations.

The Theory of Narrative Inquiry

> "Narrative" can refer to the process of making a story, to the cognitive scheme of the story, or to the result of the process – also called "stories," "tales," or "histories." I [am] using "narrative" and its cognates to refer to both the process and the results. (Polkinghorne, 1988, p. 13)

Narrative research is used to help understand our culture (Johnson & Christensen, 2012) with the goals being to create an accurate account of an individual's experiences and make meaning of these experiences by examining past, present, and future implications (Polkinghorne, 1988). Likewise, Connelly and Clandinin (1990) state that "the past conveys significance, the present conveys value, and the future conveys intention" (p. 9). As the participants in this study are high

school graduates, I asked them to reflect in the present about their prior experiences in high school and to examine the impact their actions have had, currently have, and will continue to have on their futures.

Creswell (2008) identifies narrative methodology as a framework that consists of "three dimensions of interaction, continuity, and situation [to] create a 'metaphorical' inquiry space that defines narrative study" (p. 519). The first dimension, interaction, consists of both the personal (looking inward to feelings and hopes) and the social (looking outward to the environment and other people's intentions and purposes). Continuity includes looking backward into the past for remembered stories and experiences, examining current stories related to actions or events, and projecting forward into the future for possible outcomes and plot lines. The third, situation, examines context, time, and place or setting for intentions, purposes, and points of view (Clandinin & Connelly, 1994, 2000; Creswell, 2008). These ideas are neatly summed up by Clandinin and Connelly (1994), who state that "the study of personal experience [is] simultaneously focused in four directions: inward and outward, backward and forward. . . . To experience an experience is to experience it simultaneously in these four ways and to ask questions pointing each way" (p. 417).

These four directions can be easily identified in the research: inward, the personal experiences of the participants; outward, the reactions of classmates and school personnel as well as the supports received and barriers faced; backward, the experiences that have already happened and are therefore remembered narratives, told as stories; and forward, how these experiences influence the participants now and into the future. The situation, or context, is also evident as the research is an investigation into school and educational experiences. However, the telling of personal stories means that the events happened in the past, whether yesterday or 10

years ago. Clandinin and Connelly (1994) ask: “Is it the adult interpreting the childhood experience, in which case it is the adult speaking?” (p. 424) As memories are recalled, they are influenced by events that may have happened in the intervening time between occurrence and being told or shared. Shields (2005) says: “A story remembered must be revisited and reconstructed using our own life experience across the intervening years” (p. 180). Therefore, the story is reinterpreted due to present knowledge, but the power and purpose of that story are not diminished over time.

Use of Narrative Inquiry

> Connelly and Clandinin (1990) discuss that narrative is both methodology and method: It is equally correct to say “inquiry into narrative” as it is “narrative inquiry.” By this we mean that narrative is both phenomenon and method. Narrative names the structured quality of experience to be studied, and it names the patterns of inquiry for its study. . . . Thus, we say that people by nature lead storied lives and tell stories of those lives, whereas narrative researchers describe such lives, collect and tell stories of them, and write narratives of experience. (p. 2)

Narratives can be written or oral, with oral recollections being obtained through interviews, conversations, or fieldwork. They can recount a short, specific event, tell a longer story about an important life aspect (such as schooling or illness), or be an entire life history (Chase, 2005). In my work examining the experiences of students, I looked for longer stories from participants outlining the events leading up to their disclosure of depression, the event itself, and any after-effects.

Unexpected Community

Stories are not always easy to share. In fact, one of the ladies in my four-bed room

in the Psychiatric ward shared so little that all I really knew about her was her name and the number of children she had, and we lived for 10 days within 20 feet of each other! Another lady shared her story the night before she was discharged, and I think that was more due to fear and a need to talk rather than actually wanting to discuss anything about herself. Even innocuous stories, those of family and friends, of work and play, came with great difficulty for some people. We didn't necessarily talk about our actual illnesses or how we ended up in Psychiatry—some people skimmed around it, others avoided the topic—but many did share stories of how their illness has affected them and those around them. No matter which diagnosis each individual had (depression, schizophrenia, mania, dementia, or drug addiction for example), I discovered that we shared bits of the same world and could relate on levels others may not understand. We each had our own mixture of psychiatrists, medications, side effects, mood swings, and confusion, but through it all, a thread of similarity, of sameness, could be felt among us. Even if we hadn't had the same experiences, we sincerely tried to empathize with each other more so than I usually felt in the outside world.

I thought it strange, at the time, that there were no group counselling sessions offered. I had presumed there would be—we were a captive audience of sorts, without the excuses of transportation difficulties, other commitments, or forgetfulness. But, looking back, I see now that we organized our own informal group and peer counselling opportunities at the times of the day and week we needed them, not at a time prescribed to us. And it was better. No one was forced to sit and talk when they didn't feel like sitting and talking. No one had to wait and bottle up all their thoughts and feelings for one specific time. We were encouraged to live and share naturally and spontaneously, talking

> *over a breakfast of boiled or scrambled eggs, chatting during a walk outside in the drizzling April air, conversing over a puzzle of minute pieces, or even whispering at night after lights out. There was a sense of shared community—that we were all in this together—and together we would find the way free.* (Doctor of Philosophy in Educational Sustainability coursework, July 21, 2013)

Ethics Requirements and Considerations

Before beginning any research, I applied for ethics approval at Nipissing University. My research was approved for one year and was subsequently extended for another year. I was also required to obtain ethics approval from the North Bay Regional Health Centre before I could recruit participants at that location.

This study could have posed some risk to the participants due to the psychological discomfort of recalling and sharing stories about divulging a diagnosis of depression. However, these risks were not likely to be any greater than those presented in daily life, because the participants had already divulged a diagnosis to the public and had opened that part of their lives to scrutiny. Regardless, participants were reminded that they need only answer those questions which they felt comfortable discussing and could stop a story at any time without penalty. As a safeguard, participants were provided with a local 24-hour mental health help line number in case psychological support was needed. While I am guaranteeing confidentiality and the identities of the participants are known only to me, due to the nature of the research and the descriptive stories, I am not able to guarantee anonymity. The participants were offered the option of using pseudonyms; however, it may still be possible that the participants could be identified by others reading the study, who may recognize specific contextual details.

A final ethical consideration is that our lives are not solitary; other people are almost

always involved, and my research questions specifically ask about the participants' interactions with others in relation to their depression. Therefore, if the participants could possibly be identified, there is then the possibility that the people they mention (although they do not use names) could be identified by association. While all efforts were made on my part to maintain as much anonymity as possible for the participants and the people in their stories, it is an unfortunate reality that the uniqueness of an individual's story can undo any precautions.

Obtaining Participants

To address the research questions, my research involved three participants. Originally, I was looking for participants between the ages of 18 and 21 who had disclosed a diagnosis of depression to their high school classmates, as well as to school personnel, within the past three years. I chose these characteristics for three reasons: to investigate recent experiences, to help reduce the effect of time on memories, and to obtain participants who are legally adults and of the age of consent. I had no preference for male or female participants. The participants also needed to be willing to attend several interviews and to relate their experiences as stories. The first three participants to meet all of these criteria would be selected for the study.

To obtain participants, I first asked Nipissing University's Student Development and Services: Accessibility Services department and Canadore College's Student Success Services to place posters in strategic areas, inviting students to contact me via telephone or e-mail if they had disclosed their depression to high school students and teachers in the previous three years. Nipissing University's Accessibility Services also sent the poster and introductory letter via e-mail to their student contact list. I later approached Laurentian University and Cambrian College counselling services as well as 27 other locations in the North Bay and Sudbury, Ontario areas, asking them to place posters where young adults who might fit the study criteria would be able to

view them. I received positive responses from the university and college, 15 social services agencies, and two hospitals for a total of 17 additional locations for my recruitment posters.

I had wanted a very specific type of participant and, ideally, an opportunity to select the participants who best fit the parameters of the research, but the reality of the field created a different scenario. I was able to obtain only three participants: one fit most of the criteria, another fell outside almost all of the criteria but her stories of depression were from high school, and one was a mental health worker who would speak about her experiences with one of her clients who again fell outside my exact preferences. When initially speaking with each participant, I explained the research and the general structure of the interviews. I e-mailed the participants, in advance, a copy of the consent form and the questions I would be asking to help increase their comfort level and preparedness with the subject matter.

In examining the difficulty with obtaining participants, I propose that stigma had a large role to play in a young adult's decision whether or not to participate. As discussed in Chapter Two, nearly half of students with depression feared stigma (Leahy & Robb, 2013) and being judged. If the student had indeed divulged his or her diagnosis of depression to classmates and school personnel, perhaps he or she experienced a negative reaction, causing a wariness of further disclosure. Self-stigma could also prevent the students from approaching me, as they would be uncertain as to how I would interact with them. Finally, perhaps the idea in the popular press that many high school students are apparently speaking out about their depression is actually a much smaller number than it seems. The ones who do speak out receive the attention, but for every one who stands up against the stigma, how many continue in silence?

Participant Portraits

Before moving on, I would like to introduce my three participants. Their pseudonyms are

Brittany, Christie, and simply a Mental Health Worker.

Brittany

When Brittany first entered the building where we planned to meet, she appeared a little apprehensive and, when I introduced myself, she was not quite surprised but rather resigned that the interview actually would take place. The reasons for this became apparent later in the interview. She warily followed me up the steps and we entered a room that seemed too large for such an intimate discussion. Tables were pushed together in the centre of the room so that the distance from one side to the other was about 1.5 meters. I sat down and told Brittany she could choose where she wished to sit; she sat directly across from me. She was quiet, having said little but hello at that point, so I began by welcoming her and starting the interview process.

I could almost physically feel Brittany's apprehension and nervousness, and she answered the first few questions about demographics as briefly as was possible. When asked open-ended questions, such as "tell me about . . ." she had difficulty answering and often gave one-sentence answers. I quickly decided to change the format of the interview and asked more direct questions based on her short responses such as "what sort of support did you receive from your counsellor?" This led to more expansive answers, but they were still succinct; I had to use many prompts to encourage her to develop her answers. Although Brittany was not entirely emotionless, she spoke quietly, evenly, and her answers reminded me of someone giving a book report. The information was there, but the interest was not. However, as we neared the end of the interview, Brittany suddenly became very passionate, so much so that it took me by surprise. This change will be demonstrated in her story in Chapter Four. She seemed relieved when we finished the interview, as though it was something to check off her "to do" list and she wanted to move on to the next step in her day. We walked to the front door and we said goodbye in a

business-like manner.

At the time of the interview, Brittany was 22 years old and had been diagnosed with SAD (a specifier of MDD involving cyclical episodes of depression dependent on the season, most often occurring during the winter months with remission in the summer) when she was in grade 10, at the age of 15. She was in her first year of university after having completed a college diploma. Her interview lasted 51 minutes.

Christie

Meeting Christie was akin to suddenly looking up and seeing an old friend. Initially she looked nervous but very quickly overcame this as we walked up the stairs to the meeting room. It was a small room, with chairs for four people but space for only two if you brought anything other than yourselves. Windows covered the two walls behind each side of the table and, during our two interviews, Christie and I found them to be a bit of a distraction. From the first question to the last, she was in complete storytelling mode. Every open-ended question led to a literal flood of information. She was interested and excited to tell her whole story and, although not chronological in any way, I eventually learned what I believe to be her entire experience of mental health issues from grade 3 to the present day.

She was incredibly animated, talkative, and very willing to share her story; she seemed excited and eager to participate in my research. Christie was also funny, amusing, and she enjoyed using unique analogies to emphasize her points. In her eagerness to share her story, she often strayed off topic or reiterated stories she had previously discussed. However, I found the repeated sections to be identical to the original story and they usually provided extra details she missed in the first telling. She, like Brittany, became exceedingly passionate at various points throughout the interview, which will be revealed in Chapter Four. As our discussion went on, I

began to feel that she had more control over the interview than I. She did provide an incredible wealth of information and she was answering the questions, so I let the interviews unfold within her comfort zone. I did use some prompts to redirect her answers but, admittedly, a few prompts were more out of curiosity than research based because I became so wrapped up in her enthusiastic storytelling I wanted to know more. I am sure Christie would have continued speaking during both interviews, but other engagements gave a time limit to our discussions. As we parted ways after the second interview, I was sorry to see her go. To me, she seemed like someone with whom I would like to be friends.

When I first met Christie, she was 18 years old and in her first year of university. She was diagnosed with an anxiety disorder when she was in grade 3 and depression when she was 16 and in grade 10. Her interviews were held over two sessions for a total of 4 hours.

Mental Health Worker

My interactions with the Mental Health Worker were quite different. We had spoken on the telephone several times before the actual interview: first to get the posters placed at her location, then she called me to ask if she could send the information to a student she believed would be an excellent candidate for my research (yes), a follow-up to that phone call asking if the student had contacted me (the student had not), and then a discussion about whether or not her vantage point would be of any use to me. She offered to illustrate the experiences of the student she had tried to engage, as much as her profession allowed; the student she represented had been diagnosed with depression and anxiety. I agreed that her involvement would complement my research and we arranged to do the interview via telephone that afternoon. The Mental Health Worker seemed eager to help with the research and mentioned that it would be good to get more information about youth and mental health out to the general public as well as

those who are in a position to help. Although she was unable to answer some questions due to confidentiality (city, gender of the student, and history of the student's depression), she was able to provide her perspective of the supports, barriers, and disclosure the student experienced. She also asked that I refer to her only as a Mental Health Worker (with the pronoun she) and the student she represented as "the student."

Even if I had spoken with her in person, I believe her restrictions on what she could tell me would have made the interview as awkward as it was on the telephone. There were many pauses as she considered the level of confidentiality my questions posed. She was friendly, engaged, and clearly trying to be as helpful as possible, but her answers remained brief and to the point. She was able to address many questions about her role in working with the student and sometimes included brief crossovers to other clients in similar situations. However, her answers about specific details were either forgotten or within the realm of client–worker privilege. She did confirm that while she had the letters written to the school, she did not have the student's file with her. Although permitted, she was relying on memory to describe the exact results of the requests made.

Her interview was completed in 37 minutes and we hung up on good, professional terms.

Two Settings

Setting, in this research, has two meanings. First, the physical settings for the interviews were chosen by the individual participants based on their needs. They were all settings that were convenient, relatively private, and without distractions. However, the second meaning of setting is based on the recollections of the participants. As narrative inquiry looks at a continuum of experience across time, the participants were interviewed in the present, but they were reflecting on the past and possibly projecting themselves into the future. They were asked, in the present, to

examine their experiences as students in high school and to relate stories about disclosing their diagnosis of depression to classmates and teachers. The setting in the past is high school, classrooms, and the social environment. Looking into the future, the setting is dependent on the participant and how he or she expects his or her life to unfold.

Interview Procedure

Using narrative inquiry, interviews are central to my research work. I had hoped to conduct three open-ended, semistructured interviews, no longer than 90 minutes each, per participant over a 3-week period. The interviews would build on each other, with the first one covering the history of the participant's experiences with depression and school, the second interview looking at the actual event when the student divulged his or her diagnosis of depression, and the final interview reflecting on the experience (Appendix A). However, the individual participants chose to complete the interviews in ways that best suited their needs. Brittany and the Mental Health Worker each chose to do a single, succinct interview, whereas Christie preferred longer conversations over two sessions.

At the beginning of the interviews with each participant, I again explained the research and its purposes. I presented the consent form, ensured they understood each point, answered any questions, and had the participant sign the form. I also provided them with a printed copy of the consent form, as well as the questions, so they would be able to follow along during the interview. Finally, as a person who has lived with depression for nearly 20 years, I informed the participants of my own diagnosis before beginning the interviews. This seemed to help build rapport with the participants, and they may have been more forthcoming with information knowing that I may have some insight into, and understanding of, their experiences.

I digitally voice-recorded the interviews, including the interview done over the phone.

This allowed me to take some field notes describing body movements or body language that may have changed the meaning of what was said and as a supplement to the recording. Despite having open-ended questions written down, they were used only as a guide through the interview process and a way to ensure we covered everything needed for the research. I provided time to give a full response, allowing pauses and other methods of collecting one's thoughts. I let the stories flow freely and naturally, without the restrictions of a concrete outline to inhibit the way in which they remembered and told various aspects of their stories. In some cases, I did have to provide prompts to expand on information or to clarify statements. Furthermore, there were a few instances where I had to reiterate the research questions and assuage fears from the participants that they were not telling the "right" stories or not providing the information I needed.

Finally, I asked the participants if they had any documents such as letters, journals, art, photographs, or memory box items they wished to share as part of their experience. They were also given the opportunity to write their own stories in addition to the interviews. Interestingly, one participant (unaware at the time) actually did write some of her story in her initial e-mail to me, where she gave a very brief outline of her experiences. No additional information was provided by any of the participants, however.

Transcription

I transcribed the interviews myself and included nonlexical expression and pauses in the transcriptions to help provide important cues regarding intent and wording. Matching my interview and observational notes to these cues provided a deeper understanding of meaning. The transcripts were given to the participants for review to ensure their stories and meanings were appropriately captured. They were also given the opportunity to make changes or have sections

removed from the research, which I did upon request.

Restorying

It is “the researcher – rather than the survey, the questionnaire, or the census tape – [who] is the 'instrument'” (Richardson, 2000, p. 925). As my ultimate goal is to relate stories of experience to the reader, I restory the participants' stories from their interviews to create coherent, logically sequenced histories that include each of the dimensions of narrative framework: interaction, continuity, and situation. When interviewed, the stories the participants told were not related in a perfect timeline but rather as they came to the participants’ minds. The stories sometimes wandered in a different direction when a new memory surfaced or moved back and forth through time as the participants wanted to share more context for their stories. These chronology issues were solved by restorying, as I was able to frame the stories within the recognized standard of a beginning, middle, and end, including problems, characters, and plot. By including setting and context, realism is enhanced, allowing the reader an opportunity to more deeply identify with the story and heighten overall understanding.

As with the transcripts, the participants were given their restories to review for errors, omissions, or clarification. Upon being notified of errors or omissions, I worked with the participant to rectify and ensure the research reflected an accurate and satisfactory account of their experiences and intentions. I also gave the participants the opportunity to provide additional details they felt would clarify and add to the construct of the story. This process allowed me to most accurately represent the stories of the participants. “For once a story is told, it cannot be called back. Once told, it is loose in the world. So you have to be careful with the stories you tell” (King, 2003, p. 10).

Voice

Voice, both mine and the participants', is important moving forward. I have chosen to present each participant's story in its entirety as I feel this method will allow the reader to become fully immersed in one person's experience from beginning to end, to increase understanding of the issues, and to appreciate the character of the participant in divulging his or her diagnosis of depression. To properly represent the participant while creating a flowing story, I used phrases and complete descriptions directly from the participant. By doing so, this preserves the signature of the participants, their particular ways of speaking and telling their stories in their own words. To maintain the fluidity of the restory, the pauses, nonlexical expressions, and stutters were removed. However, where these interruptions may have an impact on the understanding and analysis of the restory, I included indications of the actual manner of speaking. Overall, I feel that my most important task was determining the correct chronology. My voice, my own experience with depression and how that affects the research of this phenomenon, is more evident in the analysis of these restories in Chapter Five.

Thematic Analysis

It is the investigation of stories that informs narrative inquiry, and in my analysis in Chapter Five, I look past the words to find insight and knowledge that can be shared with others. To analyze the stories I had collected and restoried, I used thematic analysis which was conducted on the level of the restory itself and not individual segments. The exploration into themes compares the three restories and looks for cross-themes, which link some of the experiences together. To categorize these recurring themes, I first examined the restories and identified the sections that corresponded with my research questions, such as the details surrounding disclosing the diagnosis of depression and the supports and barriers encountered. I

also linked topics of interest to those identified in the literature review, such as perceptions of depression and stigma. I then dissected the sections from each restory to find points of similarity as well as differences. While similarity is useful because it may lead to further research into generality, the differences also demonstrate the complexities faced by both students and schools. This organization of themes uncovered three layers: (a) family, background, and onset of depression; (b) links to the research questions and categories in the literature review; and (c) the current views and attitudes of the participants. While not identified in my research questions, the first and third theme layers provided an opportunity to look further into cause and effect by examining the participants' past and their plans to move forward in future.

Validity

Validity in narrative is more about engendering trust in the researcher and participants than proving facts. This is an important difference, as Ellis and Bochner (2000) remind us that "narrative is always a story about the past and not the past itself" (p. 745) and that the "goal would not be so much to portray the *facts* of what happened to [one] accurately, but instead to convey the *meanings* [one] attached to the experience" (p. 751). As mentioned in Chapter One, the participant is the expert concerning his or her life, and it is my responsibility to present the participants as truthful and thorough in their storytelling. This task is completed in two ways: sharing the complete stories of the participants, instead of segments, to help establish the trustworthiness of the overall experience; and using the language and the description provided by the participants to create a setting or situation in which the reader can be immersed.

While conducting the interviews, I maintained internal consistency by obtaining clarification from participants on areas of the stories that were unclear or if any comments in the interviews contradicted earlier statements. Validity control is also evident as the participants were

provided the opportunity to view the transcripts as well as the restories and provide feedback and changes. In examining the participants' experiences in Chapter Six, I outline the thoughts behind my interpretation, providing context, and I discuss my own background and how it may influence my interpretations. Finally, I acknowledge that my interpretation may not be the only one possible but rather a viable outcome of the presented restories.

Reflexivity

Reflexivity is an acknowledgement of my own biases, role within the study, and understanding of the phenomenon. Narrative research will never be objective and neutral, as it is originally based on choice, "curiosity, interest, passion, and change" (Pinnegar & Daynes, 2007, p. 29). This interest, passion, and the focus on change are very much true in the case of my research. Biases and increased subjectivity can come from mentors, colleagues, opportunities, and environments as well as personal determinants such as history, geography, and demography. By practicing reflection and remaining self-aware of each of these factors, I identify and address my biases and subjectivity throughout my research and analysis.

Limitations

The main limitations of this study, as with all narratives, is that it is not representative of a larger sample and cannot be exactly replicated because the stories are specific to a time, place, and individual. This research is meant to "provoke, challenge, and illuminate rather than confirm and settle" (Bullough & Pinnegar, 2001, p. 20). It is in the meaning-making of the stories that the learning and knowing occur. Another limitation is the semistructured nature of the interviews. As each interview unfolded in its own way, there was little consistency among the participants. However, the guiding questions and probes did elicit responses that addressed each of the research questions, and there was enough information to match questions and responses. A final

limitation is my own background with depression. My own personal meaning as the researcher may influence my understanding of participants' narratives in this study. By ensuring my voice is clearly identified as separate from the participants', I rely on two points: (a) the strength of the participant stories to allow the reader to make his or her own judgments as to the validity of my analysis and (b) the extent of data checking performed throughout the process, including allowing the participants to make changes to their own stories.

Summary

Research done using narrative inquiry allows participants to talk about and explain their specific experiences within a phenomenon: in this case, their storied remembrances of divulging a diagnosis of depression to their classmates and school personnel as well as the supports they received and the barriers they faced. Using open-ended interviews, the transcripts of their stories are restoried to provide a timeline moving from beginning to end, which helps increase the understanding and involvement of the reader. By maintaining the voice of the participants, the restories are unique and representative of the person, not the researcher. The analysis of the three restories, with a focus on the research questions, was done by identifying various intersections between the restories of the participants. Finally, as my own history with depression cannot be forgotten, I acknowledge my biases and discuss the influences on the analysis.

CHAPTER FOUR: PARTICIPANT EXPERIENCES THROUGH STORY

In this chapter, I present the restories from the three participants: Brittany, Christie, and the Mental Health Worker. To provide verisimilitude for each participant, I use their exact words, as taken from their transcripts; their statements were provided in response to my questions. In this way, the participants themselves are the exclusive storytellers of their own experiences and their individual characteristics can more clearly be observed. By presenting the participants' voices verbatim, my voice is minimal. I use the word "restory" because, while the words are from the transcripts, I was still the person who made the decisions about the chronological order and reorganizing the transcripts for easier reading, the removal of nonlexical expressions, and whether nonessential information could be eliminated, while still ensuring the participants' full stories and intentions were represented. Words encased with < > are my own descriptions of what occurred beyond the words: actions, tone changes, and explanations of unusual words used.

Brittany

Twenty-two-year-old Brittany was diagnosed when she was 15. Initially apprehensive and nervous at the beginning of the interview, she spoke quietly, evenly, and briefly. However, with prompts, she was able to elaborate on her responses. Her demeanour changed though as we neared the end of the interview, and she became more invested in her answers. Her restory is outlined below.

Brittany's Experiences with Friends but not Teachers

My parents worked a lot so I spent a lot of time by myself. Both my parents came from abusive families so I don't think they knew what to do emotionally, like giving me emotional support, so they left me alone a lot so it wasn't good. Especially when I was younger in my room by myself; I didn't do anything. So it was definitely the first time where I felt depressive

feelings. I think the first really bad one was when I had a really bad breakup when I was in grade 10 and I locked myself in my room, didn't talk to anyone. I completely shut myself out, out of society and all my friends. I started going to see a counsellor when I was in grade 9. We had some family struggles with my dad, emotional abuse on my dad's side, my mom didn't know what to do so she put us in counselling. Just my mom, my sister, and I. My dad didn't go because he's my dad. He's just stubborn. So, definitely talking to the counsellor, just telling her my feelings about everything. I did go to a counsellor all through high school and that did help. We talked a lot about my family dynamic and how I can deal with it and so that helped a lot. I don't know how to describe it. Just how to take in emotions that I was getting from my dad especially with him yelling all the time, stuff like that, 'cause I would keep it negatively. But now, it helped me through counselling, to not care as much, so like "whatever dad," it's no big deal. I could talk to mom about it. It was something she understood. My mom suffered with depression when she was, I think, in college she said and my dad suffers from depression, so just them going through it, it was easier. But if my parents had no idea what depression was, my life would probably be much different.

My dad has seasonal affective disorder and I had a lot of the same symptoms as my dad, especially with the weather changing. Like, we'd go on a like a vacation in the middle of January and me and my dad will be completely different people than we were the week before just because of being in the sunlight. And longer days is definitely a part of seasonal affective disorder. But I wasn't really diagnosed until grade 10 with seasonal affective disorder and I was 15 I think. I do struggle a little with anxiety as well, but not as much. It wasn't a big shock, I guess, because I've dealt with my dad dealing with it. So just like using stuff like the mood lamps, just like my dad had one, so I get one and my parents started making me take vitamin D.

It explained how I thought about things, how I react to things; it made more sense. I used to be very passive, so at one point I was very passive and at one point I would lash out. Like, one time I was mad at my sister and I pulled her hair. I never did that before so now I'm more passive again. I don't let it bother me and I don't lash out. So, I kinda went through a phase. So, it was like I used to internalize everything and then I externalize everything and now I'm kinda in the middle. Once I moved out from home, when I was in college, it was better 'cause there was no nagging from my parents, or whatever. I could discover myself and how I would react to things. So, I think that was good. Even my roommate; I've lived with her since September and she's never seen me cry. She's like, "Brittany never cries." I'm like, "Uhhh, it's not something I like to show."

I don't know how to describe my depression. Very alone and like you're in a box, I guess. You just feel like no one can understand you, no one can help you. Just this intense sadness. It's a hard thing to describe. I think sadness and loneliness are definitely the biggest parts of it. And just like you feel trapped like you're in an emotional cage and you can't get out of it. It's hard to put it into words. I was never really embarrassed about myself in high school but I guess a lot of people are about depression. I just kind of embrace it as a part of who I was so it wasn't as difficult for me as probably other people and the fact that my mom knew everything about depression helped a lot. I think I had it decently good compared to other people, probably, who haven't talked about it in high school.

I told my friends when I was 16 just so they knew what was happening with me because I kinda had isolated myself. I wasn't really myself, and I was kinda experimenting with alcohol and drugs and stuff, and I decided to tell them this is why I'm doing this. Like, I'm not crazy, I guess. And then like everyone was like, "Oh, okay, that makes a little bit more sense." It was like

eight people in high school, the people I hung out with a lot. Most of them understood. Some people I told never talked about it again, they were like, “Okay, whatever.” People who don’t understand, didn’t understand mental illness, I think I kinda knew how the person would react before I said something. Like, I wouldn’t tell somebody, “Oh hey, I’m Brittany. I suffer from depression.” Yeah, I wouldn’t do that. I kinda know how a person would react, especially in high school.

Some people I could talk to about it. I think my friends who also were experiencing stuff, like even my friends who were going through a divorce with their parents or something and they felt that sadness and they could kinda relate to me a little bit more. But people who had never experienced anything like that, they were just like, “Okay, whatever.” So I didn’t really show them the deeper side, I guess. The deeper side was usually one on one with somebody. I’ve had like friends that I’ve gone to the park with and we’d just, like, have big talks about it. And it makes you feel better especially when they relate to you and can understand. So, I did that a lot, lots of one on one with people. It was all over the place, just like how you feel about your impact on your parents and your impact on your friends, your impact on you from school and life and dreams and emotions and how it impacts you and how it affects your depression, like ups and downs, what makes you feel good, and what makes you not. I remember one conversation with my friend, just like trying to explain how you feel and he kinda got me about it, like he understood. Just like intense feelings. This is the hardest thing to describe. Sometimes you didn’t even have to talk. Sometimes you can just kinda, especially if someone is in the same situation as you and they just kinda know, you don’t even have to talk. And that’s why it’s hard to describe it to someone who doesn’t have mental illness.

My friends that suffered with mental illness as well, our relationships were closer. Like I

think I had a close relationship with some people at one point. But they were short and I know one girl I became really close with because we related on that level so well, but our problems were so alike we couldn't deal with each other's problems; we had to stop being friends. It was just like hers were too intense for me and mine were too intense for her and there was just too much sadness. We just couldn't deal with it. So that was a really sad experience because it was just so negative on each other and we couldn't be friends anymore. At first it was very dramatic but I think now it's mutual. Like we'll talk to each other every once in a while and I think we met up in the summer and it was okay and like she told me that she's got, I forget, some disorder where you scratch your body at nighttime and she's covered with scratches. And I was like "oh I can't deal with this." I think actually one of my college teachers asked if she was okay and I said I really don't know because as much as you want to help other people, you have to help yourself first. I had to help myself first before I could help her and she wasn't trying to help herself so I had to stop hanging out with her. I've been trying to be friends with more positive people just because you feed off that energy whether it's positive or negative.

I think that I was easily intimidated by people. So, if people were very confident, very good looking or something, I couldn't talk to them so I couldn't be friends with those kind of people. So, that's the only thing that would stop me from being friends with somebody just because I felt that I wasn't good enough to talk to people who just look like they have their whole life together. I felt like I wasn't good enough to associate with them. Those students were really my biggest barrier. A lot of my friends in high school were very eccentric, like I was in drama—I started doing drama to help with my confidence—and I was in music. I did lots of music with very odd people but they were nice and those were the kind of people I hung out with in high school. I used to be very, very shy so even making friends and stuff was always hard.

I never let my depression affect me in my school work or anything because I didn't want it to define me. Like, even now, when I tell people I have depression, they don't believe me 'cause I work so hard and I always try to be happy anyways. It seems so pointless to be sad and upset. Sometimes you have to feel that way but I just try to get through it because life is so much more enjoyable when you're not upset. So, even when I'm feeling down I just try to look happy 'cause even that helps a little bit. 'Cause when you're down with other people, people are going to be down to you too. They're not going to be like, "Oh hey, what's up?" if you're hiding yourself. So, if I just put on a happy face and people are going to come to me and then I feed off their positivity. So, that's what I've done the last few years anyways.

I don't think I would have told more people than I did because in general people still have a stigma against it and it was just, I felt like if this person knew I had depression they probably wouldn't want to be friends because it's a burden to them or an issue they don't want to deal with. So, I strategically told people. I didn't just tell anybody and my teachers not knowing didn't really affect anything. High school is not as hard as university is and you don't see high school teachers as much 'cause your classes were only like 40 minutes or however long, an hour, and if you're having a bad day you just kinda tune out and then leave. In high school it's easier to just leave, like if you want to skip class, and go home and not deal with anybody. Here, I'm with people all the time. I like live with all these people. I'm with them all the time and I have all my classes with everybody. So I see them all the time.

Even now if I'm left alone I start to get depressed. So, I usually go out and find something to do. I'm always making plans with people and usually back-up plans in case those plans get cancelled. I'm trying to think of the beginning of high school; I kinda like blocked that out of my brain. I think making good relationships . . . like I always had friends but I've never

had a best friend. Even now I don't have a best friend and it's just like making that intimate relationship I guess, especially with another girl like a girlfriend. I can't do that. I just feel like I don't think the same way they do. Like just about life, like talking about it. I don't even know how to describe it. Just views on life I guess. They want to do one thing and they think this is really fun and I don't. There's just, I guess, being scared to get that close to somebody, especially girls because girls are very judgmental. There's a fear of being rejected I guess, because of my depression, I think. Like, I don't want someone to tell people that I have depression. I don't want them to know so much about it where I think they get scared of me I guess. So, like, yeah, I have depression but I'm still happy so I'm still awesome but then if they really know how far it gets into then they might get scared. I want people to think that I'm strong and like I'm suffering through something but I can still push through it. I don't want them to see the hard part. I think people who especially don't understand mental illness, they get scared of it and they don't know how to comprehend it. Like if I hang out with someone who has a mental illness, it's easier. But if someone who has never experienced any sort of mental illness and doesn't really understand it then I feel like that stigma is still there.

I know our school separated us into applied and academic so it was like a little bit of a stigma for people who needed extra help. So, that's why I never really came out to the teachers 'cause I didn't want them to think I was dumb or something like that. So I tried my best and I did the academic/university classes. I didn't trust my teachers in that way and it's not like a relationship I could have had with my teachers to talk about stuff like that. Even the teachers I was close with, I didn't talk about it with them. I didn't really let them see another side of me other than as positive as I could be. I didn't feel like it was important. As long as I just tried to get a good mark, it didn't matter. Especially if they're going to be like a reference or something

like for a job, it's not something you want to tell them. It might make them think of you differently. I was surprisingly decently successful in high school. I think 'cause I did spend a lot of time by myself so I guess I got things accomplished sometimes.

Our school is very accepting of gay people which was nice, so I felt like people were okay with that, so mental health wasn't a big deal, either. I had a lot of gay friends in high school that I could talk to about that but we never really had posters or anything like they do at university like awareness. We never really had that. But everyone, the majority of my school, is accepting of the LGBT, so most people were accepting of mental illness, most of them anyways. Which I was lucky because I know not many schools are like that.

But this year especially, my first year of university, has been a very stressful year. With the stress and my depression, I couldn't deal with it so I talked to the school. I just have like more time on exams, which helps a lot because I get so stressed out and so it's nice to have extra time to just like relax for 10 minutes. So, if I had that accommodation in high school I think I would have gotten much better grades. Even though I feel that I'm smart, I feel like I could have been more successful if I was accommodated. Just with a little bit more writing time. So, I just started this semester. I wrote my first exam on Tuesday in a different location and it was 100% better. I did really well on this exam and I don't think I would have done so well if I had written in the other room because sometimes, well, last semester people were leaving and because other people were leaving I was just … felt so upset so I didn't finish my test. Not that I couldn't do it, just that I felt that "how could other people be finishing?" just 'cause I need that extra time to process things.

More counselling services are needed. We only get the counsellor coming here once a month and I think mental health is a big issue here. I think mental health is much more talked

about at this campus anyway. That's why I feel more comfortable talking about it with people. We're talking about how to deal with it. I think it's being talked about more in high schools. It's more on TV, too. I watch Degrassi, it's like in Toronto, and it's about people in high school and they talk about it a lot. I feel that there are more signs and they have more help lines like the Good2Talk help line and they have advertisements like the Bell Talk thing. So, I feel like in high school it's being talked about 'cause I think that's when it affects students most. I think it should be put in the curriculum, too. I think they're doing more signs and stuff and like my sister knows a lot about mental health and she's 16. I don't know if it's in the curriculum but I would like it to be like in health class or something.

<Brittany starts to become more animated and involved in her answers> I know that in this university, it's talked about a lot and all the teachers understand that. In college, in my field anyways, we talked a lot about health and mental health. And we've had presentations and projects about it and I feel it's important and all that. I was doing a presentation on depression last semester and I said "I do suffer from depression" as an example and I was just saying some of my experiences. Now, I'm like a huge advocate for talking about mental health. Like, helping other people is definitely a big thing for me. So, even just like talking to other people and then finding out that they are suffering too and they would have never told anyone if I didn't say anything. So it makes me feel really good that I could help other people ask for help. 'Cause I have directed people to counsellors many times and I feel like mental health isn't like a small percentage, it's a bigger percentage now. Just talking about it and helping other people makes me feel really good about myself and, then, knowing that I'm not alone.

Now, I don't really care unless it's an employer. I feel like with employers it's an issue. Like I went for an interview last week and they said that I needed a doctor's note saying I was

mentally fit to work for them, work with children. I told my friend that and my friend's like, "Well, I guess you can't work there then" and I'm like, "I can work with children. Just because I suffer from depression doesn't mean I can't work with children". I was kinda taken aback and I was like whoa. I'm not a psychopath. She just kinda blurts things out 'cause she knows that I'm suffering with depression and she knows that in December I had a really big breakdown and I had to go on medication. I don't think she understood. I feel like people my age are a little bit more accepting but older people, especially employers and teachers, I guess, especially when I was in high school, they don't understand that as much because it wasn't talked about as much.

I have a whole journal from when I was in grades 9 and 10. I don't really look at it. I think I looked at it once before and it was very depressing. And I used to write music, very depressing music. Music was a huge thing for me, it got me through a lot. Music is a great way to express yourself without using words, I think. I think most of it I threw away because I didn't want to think about. I do have a journal when I was dating my ex-boyfriend 'cause I'm pretty sure he had a mental illness too and well, we just fed off each other's negativity. It was horrible. I'd probably be embarrassed of it though. I used to like take pictures of myself and I used to edit them and stuff and put words on it but I think a lot of them I deleted because I was embarrassed of them. I'm just like I can't believe I felt like that; just the memory of how I felt, I didn't want to deal with that anymore. And through photography too. I was really into black and white photography; it was kinda like my outlets. And dance. I did a lot of like arts stuff in high school. So, music, dance, drama, photography, media art, and now I'm just starting visual art here in university. I did everything except for visual arts and I'm like oh, I'm going to start that now.

I like who I am today so I try not to regret how I've done anything. I wish I knew how to ask for help more. When I started seeing a counsellor I really didn't know how it was supposed

to work. Now I know how to ask for help, no problem; they have help lines. I wish I knew how to even call KidsHelpPhone or something. Just I wish I knew how to ask for help more 'cause I was spending a lot of time alone. 'Cause my friends didn't really know, no one really knew 'cause this was back in 2006. No one really knew anything, not much about mental health anyways, not anything. It wasn't talked about as much as it is now.

<Brittany really becomes passionate> I am a really strong advocate about talking about mental health and I want other people to help themselves. I don't want to see anybody suffer through depression. 'Cause I suffered through it and it's horrible. I want to make sure that people get help and that's why I wanted to do this 'cause definitely getting more information out to help other people is really important to me. I don't want anyone to suffer alone. I think talking about mental health is good because it brings more opportunity for help and for other people who may be suffering so they can get help too.

Christie

Eighteen-year-old Christie was diagnosed with depression at the age of 16. Interestingly, she, like Brittany, wrote music and songs because she was unable to express her feelings with words. Excited to share her story, she gave detailed descriptions for each question and spoke with passion and enthusiasm. Although sometimes a little off topic, she always seemed to have a reason for sharing that larger part of her story. Analogies, of which she used several, are provided in her restory and are identified with their own headings and italics.

Christie's Analogies and Stories About Friends, Teachers, and Self

My story kind of started in three different chapters at the same time when I was in the third grade. The first one being abusive relationships, then my brother being diagnosed with [names illness] that shifted the focus completely toward him versus like kind of a balance so if I

had problems or needs they weren't necessarily addressed, and then the other part when my anxiety disorder started. I remember it too because it was based off a presentation we got at a fire hall about stranger danger. I was just like, oh, it could happen to anybody, it could happen anywhere, anything, so that's how that kinda started.

I remember begging for a dog for all I could. I remember coming home from Montreal with my brother and my mom and I come home and I see my dog for the first time. We have this big bush in our front lawn, and my dad was standing there and I noticed something blue on his hand and I didn't know what it was and you couldn't see him because the bush was so big. I jump out of the van 'cause I wanted to see what's in my dad's hand. I come around and there's the dog. He was originally supposed to be there for one week. We kind of like fostered the dog but after three days, my brother and I would be bawling because we didn't want him to go back so we asked for another week. Then halfway through the second week, we looked on the website and it says he's adopted so I guess we adopted him. He played a huge role. In some old journals that I have, I have like stories of what [dog's name] and I did today. I remember I wrote a letter kind of like talking in detail about the abuse and what it was like and then what [dog's name] did for me. He's my four-legged pal, because if I was sad about anything he was right there and he would just like sit, like that's all they do is sit as a dog, but like I could just talk it out and I knew I wasn't going to be judged, I knew I wasn't going to be yelled at, hurt, or anything.

My dog passed away when I was 16 and I kinda lost the only support I had. Anxiety is kinda always tied to depression; if you're anxious, you're more likely to be depressed. So, I was diagnosed with depression officially then 'cause that was when my parents were like okay, my child is not okay. I got cognitive behavioural therapy from the therapist that I see and I still see her to this day. The reasons why I see her have kind of changed. They used to be for working out

strategies with anxiety and depression 'cause I needed help. I lived every day in fear with my anxiety. We had to deal with depression and now we're kind of working on kind of the newer chapter to my awesome, fun experience of life <unhappy exaggerated expression>. It's just eye-opening going through a mental illness and abusive relationships over and over again.

I was never suicidal or cutting or I never got into the addiction side of depression. It was more or less the aches and the pains of getting up every day. Living every day just because I have to, not because I want to. And I even remember too, when I turned 17, on that birthday they tried to make it the best I've ever had, and I just couldn't care. Like I didn't really want to get out of bed. Like my only birthday wish that year was to be left alone and nobody wants to really be alone on their birthday. So, that was kinda like the worst of the worst.

Depression was like living in slow motion if I could best describe it. It's like everything was moving at regular pace and I was two times slower. I wouldn't really be listening. I could see their mouths moving but I just was focussed on what I was depressed about. I had that plus, I don't really know if it's the same for everyone who has depression, I had muscle aches and pains when I was just sitting and not moving. So, I'd be curled up in a ball like in my bed and I'd just feel like pain in my leg or I'd feel pain in my chest or a lot of it was in my shoulders 'cause I guess I was so tense. It just hits you all at the same time so your body's just trying to figure it out and it's all wonked out and it's like being hit by a bus, you feel it mentally, emotionally, physically. I found it just so overwhelming in the beginning because it all came at once and anxiety is kind of not necessarily the ideal mate for depression. So having an anxiety disorder and growing up with it and not dealing with it properly until later on in life was an added struggle. So trying to balance everything about depression and everything that I dealt with was just kind of the most horrifying combination that anybody could probably ever ask for in that

boat of depression and anxiety. It was just kind of a negative blurred mindset. That's probably the best way I could describe it in the beginning. Just very unclear. So, some days yes, depression is more present than others. Like depression will live with you your entire life but it depends on the level of severity it has. You can have like a really awful time so when I was in that frame of depression where it was at my worst compared to now, like yeah, I still have depression but it's not to the level here anymore.

Stained Glass

> *Before I was diagnosed and living in a mind space, you see negative connotations associated with yourself as a person and after you're diagnosed, you kind of break through this like glass kind of thing. This glass is made up of all the components that you think are negative to you. So, like a stained glass window. The yellow part of a picture represents your brain and the way you think; the pink represents your physical; the blue represents your emotions. Like all these pieces you think of as a whole and when you're diagnosed something breaks that window and you kind of see the light that comes through that hole.*

I just remember sitting there on the couch when she said like you have depression and I was just like "ah." At first I was devastated, like even more than I already was because I'm very critical of myself. I want to fix it, I want to do better, I want to be the best I can be. So, when she told me that, I was like, this is something I can't fix. At that time, I thought "this just gave you an answer and a little bit more clarity" after being diagnosed officially.

Ham Sandwich

> *When I get my anxiety, depression I know is coming up next. It's hard to describe it. It's kind of like a sandwich in a way. So, in the beginning of an episode, it's like the*

bread, so like the bottom slice and that's kind of where like the thoughts start to come together, those are like the basic thoughts, or the regular thoughts that one would feel before a test or an assignment, where it's like "did I study enough" or "I'm kind of nervous." The filling is anxiety/depression and most people can style their sandwich any way they want but for me it's always like you put mayo on first so there's the anxiety. The next one, the depression, would be the ham and it's heavier than mayo, so it's going to hit you harder than anxiety. Then the next part would just be the other slice of bread. So, like, the last slice would be the final thoughts, it's kind of like not necessarily calming or relaxing at all, but you're breaking that chain of thought, like you're breaking it off from that long piece that's kind of intertwined with anxiety and depression.

I first told a classmate because of an incident that happened at school with her. We are best friends to this day still, but there was a rough patch when it came to relationships. She found a boyfriend and I was dropped basically as a priority. One day I was telling another friend how I felt and how I don't really know what to say to her and to not hurt her feelings. I was just trying to talk to her about it. Then, later in French class, the two of them would work on paragraphs of texts to send to me and they could see my reactions. So, basically, what they sent was atrocious, like I would never say anything like that to somebody but it got to the point where they said it was my fault for having such mental issues and behavioural issues and it's my fault that these things like they're part of me and it's my fault that I'm "fucked up" quote–unquote as they say and it's my fault that I have all of these like disorders and problems and it's just not something that they feel they should have to deal with. I was just so unhappy and I remember I had to leave the class 'cause I was so upset and I just hid in the stall in the bathroom for the rest of the class. And then I came out like after everybody had left, it was actually after school at that point, and

that's when my teacher said, "Are you okay? What's going on?" I've known this teacher for a couple of years and she said, "If you're ready to tell me anything, I'm always here." I just remember sitting there for 2 minutes just trying to find the words to just say, "I have depression." A lot of people just think it's easy to say if you just say the broad statement like "I have depression" but they don't really realize like how difficult it is to say it in that simple form just because of the components with it. So, you wanna talk about the effects that it has on your brain and on your body and the way that you are with people but you don't want to say it all at once and kinda overwhelm them. So that's when I first ever told a teacher and she kinda just like said, "I had no idea. I had some concerns when it came to your head space recently but I wasn't sure what had gone on at home or something."

That's the first time I've ever told anybody about depression and like my experience with it and I think that it had a significant role. So, telling her just kinda started my journey, I guess, to kind of accepting it, which kind of led to telling my best friend. She had some idea. I remember she said, "Well, I know that you have changed since grade 8 when you used to be the girl who was always shy but she was happy and she may have been quiet but when she had something to say it was either really, really funny and she could always cheer someone up or she was serious enough that it should have been taken note of." But she said that basically she had no idea about what I go through on a day-to-day basis. She told me then that she had depression in grade 10 (but I knew), like she's been through it herself. So that was when I started talking to her and that kinda led to talking to my peers about not necessarily depression but a little bit more about why I act the way I do.

Originally it was just the one and then I have told a few more as it kind of made sense to tell them. So, like one of my friends I know, when I told him it was because I was dealing with

something he was going through. Like he came out to me and he said that he was gay and so he was dealing with a really tough patch and all. He was just describing like how he was feeling and I'm like, "Ah, that's really similar to when I had depression" kind of thing. So, it's kinda like if I told people it would made sense. It's not something that I would just say out loud all the time. 'Cause like I know a lot of people can either run with it and like not necessarily accept it but like they're just, they're like, "Ah, okay, cool." Or, they'll take it into a negative sense. So, it really just depended on the context of who I told.

But you just can't keep it inside all of the time. Sometimes you have to let people help you out and you can't be on your own. I kind of realized that afterwards, like once I told my friend about it, it kinda felt good like just to say, "This is this." I was relieved, I don't know, I just felt like this huge like weight was lifted off of my shoulders and it just feels good to let it go. You don't necessarily expose yourself, but like you're just opening up yourself to people 'cause you don't want to be alone anymore. I don't know about other people's cases of depression, but I know that I don't wanna be with people, I didn't like people, I kind of hated anything to do with people. I'm not sure, it was just a good time to tell people and, I don't know, just try to save any friendships I could. And, I don't know, just realizing that you're not alone, people aren't as bad as they seem. It made sense to just tell.

Diet Coke and Mentos

> *Well, I decided to start like telling people I guess just 'cause it's hard enough to keep it inside all the time. It's a lot to take in the whole time like when everything's bottled up. Like, oh yeah I see it, it's like a huge bottle like diet Coke and like every time you have a new worry or a new stress you just put another Mentos in and eventually it just goes everywhere.*

Supports from my classmates were kinda like a 50/50. Some of them when I told them they would be like, “I’m always there for you,” like the typical things you’d get from a response like that. Like, “If you need me call me,” whatever. But a lot of times those people don’t actually like respond to your call or your text or they can’t handle it properly. A lot of people just say it in the spur of the moment to try to make it seem okay. Whereas other people were very different. They said like, “It’ll be okay,” but they never said like call me or text me or anything like that and then when I needed someone, they’d be right there. I would warn them, I’d be like, “Hey, if I’m ever like this, this is what you need to do.” Because I know how to handle myself ’cause like before, I’m used to being on my own, so I know how my body can react to things and how I can kind of like dissolve from a problem. So, I would be saying like, “If I’m in such states with you, leave me alone” ’cause I think that it’s the worst when you’re in like one of those moods and people are like, “Are you okay? Are you okay? What’s wrong? Nah-na-na-na, nah-na-na-na” and I’m just like shut up, shut up, leave me alone, go away. So, they know how to deal with that so they’re more supportive that way, where like they accommodate me. A lot of the time when I’m in funks or states or depressive episodes, I need to deal with them alone like just because they have everything to do with me. I need time to reflect on it and try to find the best action to go with it. Yeah, they’re there for me, but you don’t have to deal with this, I do and I have to reflect upon this myself and figure out what I need to do with it. So, a lot of the times, yeah they’ll just leave me be and I’m perfectly content because once I figure it out, then the mood changes completely.

So, I’d rather have people understand a little bit of how it happens versus like them not knowing and them coming up with their own interpretation of what they should do, because everybody’s different and everybody deals with, like, these symptoms and this disorder

differently. But, if you set like a guideline for a person, it's a lot easier for them to follow. Like, if you know what works for you, tell people, "Okay, this is me when I'm like this and this is how you can help like if you really do want to help," like this is what you do. If you don't, then you have the option to be like okay I don't really want to do this, like you're not obligated to do it.

I only told some teachers because I trusted them. But if I didn't feel comfortable with you, no way. Nooooooo way. I don't want that to burden in any way and I don't want that to be talked about. I don't want it to be something that they can just joke around about and I don't want to be seen differently by them. So, I told some just because I felt like I could and then some teachers even guessed it. Like, I never directly had to tell them. I just remember another teacher in grade 12 pulled me aside and said like, "Hey, like what's going on? Like are you okay?" just because of like the incident with my friend and I was still upset. So, that's when I told her and she's like, "Ahhhhhh, ahhhhh, okay." So, I just told some just 'cause like I felt comfortable and I felt like I could trust them with it and I know that it wouldn't be something that comes up later. Or, they just guessed and it was kind of like, yeah, bingo, you got it.

My French teacher probably was the best because she made accommodations for me. She'd make a seating chart once a week 'cause we'd always be moving around, but she'd always let me check it first. Like, she would always make sure the person I was sitting beside was someone I was comfortable with. If I wasn't comfortable, she'd just move people around and make sure everybody was okay. And then, if I was in one of these states, we had like this cue, which was this <rubs her nose>, she'd look at me, and she'd go like this <rubs nose>, and so that's when I would know, and if I responded back that means I was okay. If I didn't respond back, that means that I was just not into anything, and I was in one of those kinda moods. So, she basically just kinda accommodated that way. For writing tests and stuff like that, she'd ask what

I'd prefer, like "would you like to write it with a person, with me? How do you want to do this?" So, it kind of helped, it kind of like solidified that after French 'cause that's when she'd take me aside and I'd sit beside her and I'd write my test. She would never give me pointers on how to like finish the test or give the answers away but just having her there was helpful. It wasn't until later on when we realized that maybe I just need to be in a different space or I need to do my testing differently so sometimes she'd put me in the hall. Like, I needed to be alone and away from people. Then we knew that this is what I needed in order for me to be successful. I don't know, it was just awesome to have her around.

She was like the main one; the only other one I had was my Biology teacher. I had a panic attack the day of a biology unit test, and I said, "Mom I can't do this, I need you to write me a note right now saying my daughter can not do this test in this room and asking that she gets special accommodations to be put in the hallway or some special place so that she can write her test and be successful." I couldn't even bring myself to hold a pencil at that point because I was so anxious. The teacher did make accommodations; she would let me write at one of those little separate counter areas where I wasn't with people. So it was kind of like what happened with French. The accommodations just kind of started for me. Other teachers just like said, "Okay, that's fine" and then moved on. It just really depended on who it was. I was never one of those students who would ever advocate for themselves so if I ever needed help, like I would never go get it.

The teachers never were a barrier towards me. They were normally really, really supportive or some even apologized to me because of what they said beforehand because I got a lot of parent–student interviews in high school just because of my academic performances and behaviours. So, they would apologize for what they had said, they'd be like, "Oh, I'm sorry, I

had no idea that that is why you did this or this is why you're like that." None of them were really like shunning or rude about it or anything like that.

When I got my accommodations in high school, a lot of people would look at me and be like <whispers>, "What is she doing?" Doing the typical like things; I still get it here in university. But the majority of the time people would just not say anything to my face. A lot of people assume like if a teacher's beside you, they're giving you the answers but in reality it's just comforting to have like the French teacher there just because it calms down any form of anxiety which leads to depressive episodes. And I just feel better like not being able to see what other people are writing because if I spot someone else's test and it's not similar to mine, no matter what question it was, I think I'm stupid and I start bringing myself down and that's where the depression would start. It's just more beneficial that way and I don't think a lot of students see that. A lot of people say that I'm lucky to have what I have, like being able to be in a separate place or sit beside the teacher, and I just say like "meh" or "whatever" 'cause they don't understand why, they just know that I get it. Like, yeah, it's nice that I have these accommodations set in place. Like, I do benefit from it that way but I would love to go through a day where I'm not like freaking out. I'd love to be able to go a day without having like, an hour-long anxiety attack over nothing. So, no, it's not lucky, it's just kinda going through the motions with it and that's what they don't understand. They always see the girl I put on every day. In high school I never told anybody because I didn't really think they could handle it in a manner that I wanted to be known for. Like I didn't want people to be looking at me and be like, "Oh, that girl has depression." I think that a lot adolescents or teenagers don't share their stories because of that. They're like "people don't really care, they're just going to be like I know this about her" and they could use it like some sort of threat against them. I used to think that and I still kind of

do towards certain people where I don't want them knowing so they could use it against me one day. So that's why I think that a lot of people like my age range in general don't share their stories 'cause they are just afraid of what's going to happen next.

No matter who you are as a person, I think you need one person at least in your life to be there for you genuinely. But in the summer, I went into hibernation from friends. So, that's been a huge barrier. I also didn't want my depression to be seen as some sort of card, like a hall pass or a "get out of jail free" card. So, if I had an incident with a friend, I didn't want my depression to be like it makes it okay, like if we argue about something and then you remember that I have depression and then you pretend as if nothing happened. It takes a huge toll on them. That's like one of the reasons why I don't like to tell people that often. I just don't want to see it as an excuse or, like, a burden to put on people. So, it's just an extra weight that I don't want to put on people. So, that's kinda like another barrier in itself, like, the fear of what is going to happen with it. Like if you were a happy person, you could make the person sitting next to you happy because you're happy and that chain goes. So, I think that depression where I would be unhappy, I would have these thoughts in my mind going on and it would reflect how I would behave and then it has that effect as well where it just spreads to everybody whether they're directly affected or not. So, if I'm in a funk and they're in a really positive mood, it's okay, but if they're in like a very aggressive mood or an unhappy mood and I'm in one of those moods, it's best that we stay apart, like two beta fish—you don't put us together. So that was suddenly a huge barrier for friendships. People have actually said I'm using this as a "get out of jail free" card. The first time it ever happened I was furious because it's not a "get out of jail free" card, it's something that people live through every day and I bet the majority of them would choose not to live the way they do with it. It's not something that people ask for at Christmas, it's not something they want

on their birthday, it's real life, and it's not a board game, like you can't just use it and go to the next square. You live with it every day and most people go through things that nobody else should ever have to go through so no, it's not a "get out of jail free" card at all. And I don't think they understood that when they used it. They don't realize what they're saying.

School, too, is a big barrier because of the influence that it has. Like I don't think a lot of people really understand that when I see really bad grades, it makes me feel stupid, it makes me feel like I'm not at the level of other people and that brings me into a depressive aggressive state so my aggression comes in and out. That is a barrier of itself because yeah sometimes I know when it's going to come and other times it just hits you like a ton of bricks and you're just like "oh shit." Like that's the best way to describe it hands down like "oh, oh no." So, yeah those are probably the barriers to friendships and school.

I definitely recommend that they tell people 'cause it does feel good and it does open up so many more doors. I probably would have told more teachers versus friends. Teachers have a different role than students. Like teachers are not only there to like teach you and educate you but they are there to support you; to guide you in their class and in life. I would say tell all your teachers. I recommend that 'cause some may be more accommodating than others, but they will kind of understand a little bit more about you. Like, no I'm not asking for sympathy, empathy, anything like that. I never have and I never will ask for it but giving them the heads-up helps when I didn't do my homework because I had an episode last night where I couldn't even bring myself to even touch a pencil. It helps versus me having to coming up with an excuse every time. But I don't think I would have told more people, like as friends or well, like, students, other than the people that I did. You want to tell certain select people who you are the closest to. Yeah, like they are your friends and friends are supposed to bring you up, not bring you down, but I don't

think high school is the right place to do that. I'm happy that I didn't tell more 'cause I just didn't trust them. So, I'd probably tell more teachers but not any more students than what I did. But, yeah, I definitely recommend telling people, oh yeah, hands down. I don't know why I didn't do it earlier.

My parents are a support for sure. At first they were kind of embarrassed. So, at first they were a barrier, now they're just a support. They kinda got the red light saying like, "Hey, stop, like you can't continue pushing whatever she's feeling aside and you need to bring it to the table and you're going to have to deal with 17, well, 16 years of unhappiness or an anxiety or feelings that you've never addressed before." So, they're still to this day, that's 2 years ago, trying to piece more things together so that they can kind of accept that I have it but they just don't understand really what their role is yet. They keep saying like "it'll be okay," "you'll be fine," "just remember whatever the context of the episode or (I need to stop saying that) of the moment is." But now they're starting to ask me questions like "why are you in this state," "how did," and like who, what, when, where, why are huge parts of it. A support for me is just talking about how I'm feeling so it's kind of taking that state that I was in and kind of changing it to a more positive one. Once, my mom gave me strategies, she gave me tips on what the next steps forward were, and we went from there.

It's crazy how much disclosure just changes your life. I had low*er* self-esteem, just because I thought all of these negative things about myself. I always thought of the negatives, like, "Are people going to judge? What are people going to say?" But, when you tell people it's kind of like you're taking off any excess weight that you don't need. You're kind of like letting people in and you're going from like a very dark stage to a light one. But it's gradual, you have to wait for it to get to its full light and, I don't know, you just realize that you're not really alone.

So, part of me is kind of like happy that it's kinda getting out there now 'cause it does affect your life. Like, I'm naturally very outgoing and naturally willing to do anything for anybody or any person like any thing but when I was in these states, I wasn't. I was the polar opposite to who I actually was. I don't think a lot of people my age realize how it's not always going to be a bad thing to come out with it 'cause it just kind of get this discussion going, like the reality of depression, not the stigma behind it. They don't really realize how positive telling others can be and, also, like the more stories that you hear of people your age going through it, the more you can kind of read about them, or see them, or even like think about them, and realize that you're not the only person. It's not a million to one, people. It's like everybody has someone they can associate with. So if I can help just one person with my story, then I can help a hundred people. I can help a lot of people and feel comfortable with the topic itself because it is something that's kind of put under the rug. So, instead of just hiding this I think it's just something that needs to be put on the table like even just a 5-minute conversation about it is better than not saying anything at all. I think that telling people has changed my life just because there seems to be like another level to the friendship. It's made me who I am today so you have to kind of see that kind of positive side to it and it takes a while to get there but you do get there.

I think that there is a stigma. We never had counselling at my school. We only had guidance counsellors so if you need to see a counsellor, they would give you a card that had people's names on it and you can go call those people up and say I want help. In my high school, we had one health class in grade 9 and that was part of your gym unit, like it wasn't even a separate class, and it was on pregnancy, physical health, healthy eating, diabetes; that was it. Mental health was never talked about. It was something behind closed doors and where I'm from if you have anything different about you, you're kind of put to the curb. If you did not physically

look like you had a disability you were not considered disabled. There were so many students like me who have any form of mental impairment and we don't look like we have anything but we do have something and we were never accommodated for it. So, no, it was never talked about in high school. We did have stuff like that on the walls like posters, advertisements about groups wanting to meet but it was for pride and gay, lesbian, LGBQ. So, if you were like lesbian, gay, bisexual, transgendered, queer, whatever, you felt represented, not only as a gender but as a person. Mental illness was something kept in the dark. So, having discussions or even just acknowledging someone having a mental illness, or depression, anxiety, whatever is going on for that person, was put in the corner for them to deal with alone or as a family alone. The only time when we ever had anything was Bell Let's Talk but that's because it was on Twitter. But it was never said on the announcements "it's Bell Let's Talk day"; there's never any announcements in general about mental health or different races. But a lot of people do it for the wrong reasons. People do it for the retweets and the popularity that comes with it versus donating to the actual cause for the reason.

But I've done Bell Let's Talk every year because it means the world to me. So when we did it this year at [names university], it was awesome. It was just a completely different day, it was so supportive, and I even did something that I would have never done back in high school. For Bell Let's Talk on Facebook I made a status opening up about me. I said in the beginning, "a mental illness is not as intense and conquering as it seems when it takes over your life" and I just like thanked people for giving me the strength to become the person who I am today. "If I didn't have that support or help or if I didn't go get help, I would not be in university, I would not be doing what I'm doing today, and I could not be happier where I am today." Basically I just said like, "I'm just one of the millions who have/had a mental illness and today is our day, so raise

awareness for mental health". I think I got like 120-something likes on it, which is a lot for me. That means that 100 and something read it and they realize it, like they actually know. I think now I can even accept it because I could never talk about it before in a way that I felt good about saying it. I used to have like an awful taste in my mouth when I said depression and anxiety together in relation to me. It's just not something I would ever feel comfortable enough to deal with and have people knowing 'cause I don't want to be judged solely based on an experience. If I'm going to be judged, I want to be judged accurately. So, I don't want to be held back by anything like that.

I'm still depressed now. In university you have to adapt to so many new things and it would be harder for someone who had these components to deal with stuff. At least twice a week I get in a state where it's just miserable and I don't want to leave my room. I don't really want to do anything, like I don't want to talk to anybody, don't want to do anything, I just want to lie down and just not be in contact with anything. Yeah I totally feel depression, some days more than others. I have anxiety about two to three episodes a day. Most are not severe at all, they only normally last for about 5 to 20 minutes depending on what it is. Having anxiety and depression is just really overwhelming but, like, I deal with it. I get accommodations now, too, at university. I write in a private room. I get 50% extra time added on to my time, I get a computer, I get grammar and spell checking So, those two teachers in high school, they kind of like started this whole trend I guess or pattern and kind of like set the guidelines for my accommodations, so I don't know, I guess it's kind of good that I told them then. I also go see a counsellor who's wonderful. Like I just get to talk and I love talking. So, I knew that if I ever got the opportunity to kind of speak out, I'd do it, hands down. Just like, I didn't care how uncomfortable I would have ever been at that opportunity. I would do it because I think that a big problem is people not

necessarily understanding the extent that it has. Like a lot of people have their own opinions and stigmas about it.

It's not something I'm ashamed of anymore. I stopped being embarrassed about it but it's not something I wear it on a T-shirt every single day. I'm not going to have it written on my forehead. But, if someone were to ask me about it, yeah, sure, I am an open book. Instead of keeping these things inside and not telling people and just going through it alone, I use it as a lesson or an educating tool for people. That's why I'm more comfortable with people asking questions. I think that a big part of educating people is one on one talking or talking to people face to face. Like, you can only do so much with a video; you can't physically be there to see their reactions. You can see their facial reactions but maybe their hands are underneath the table, maybe they're clenching their fists, maybe they're pulling their fingers. Like I pull my fingers all the time but nobody would know that that like a part of my anxiety and depression. When I'm stressed out or something, I'll pull my ears <pulls ear> and that means that I'm either really, really anxious or depressed or I'll pull my fingers. <I realize she's been pulling her fingers a lot and ask about it.> No, it's just a lot like when I'm asked these questions, I just think okay, what exactly is it that I'm trying to answer and just trying to put it in the right context. So, like I had an anxiety episode earlier today so it's also from this, like pulling my finger is still from it, it's just lingering now, it's like that last slice of bread kind of thing where it's still there but it's not affecting me right now. I'm like 100% focused on this.

Novel Chapters

> *Every person has a different story but like the person that they put on every day and the person that they truly are may be different. That real person that's there is made up of a whole series of chapters and it's just their book, it's their personal thing. Just*

think of the world as one huge library full of different books and people. So, if I was ever asked to divide my life into a novel that someone would want to learn about what it's like to have depression, I'd probably divide it up into sections: elementary school because elementary school kind of was the beginnings of what led to depression, high school would have four different chapters: one for each particular grade because each grade was completely different, and then now with university, it will probably have different years for different chapters. So, for this chapter, it's an 18-year-old's first-year university student chapter.

<Me: Another analogy. I love them. They're awesome.>

Puh-choo <shooting noise>. It's fun to think of life in pictures sometimes.

I think that a lot of people in this age group don't talk about it for a variety of reasons but I think that they need to say something. It is hard to find like any form of data or anything for adolescents 'cause I had to do a paper for Psych, but they had nothing about adolescents at all. Like there were no studies that were ever done and a lot of the articles I was reading were saying like there's nothing on this age group; it's very rare to find something like that. Like, I don't know where my story's going to go, but if it gets to a point where other people read it and can take something away from it whether it's for themselves or for other people, I helped one person. I think that people who are my age and who go through this need to realize that it is beneficial for yourself. They need to realize how much it helps other people where they say, "Hey, that person's like me and they did it so why can't I do it?" I think that it just gets the ball rolling and I think that people need to understand that depression is something that people go through every single day, different people, different ages, different stories; they're all different but they all like tie together in some way, form, or another. So, some people could relate to my story whether it's

through abusive relationships or they can relate to being like, “Hey, my best friend and I had an argument and that’s when I told her I was like this too.” I think just getting that conversation started and kind of acknowledging that it is an everyday thing is important.

The Chain That Binds Us

> *I think that my story just kind of represents a piece of it that it is going to kind of tie to another story. If you could think of it as like a chain, you’re gonna have two little circles* <she makes two circles with her fingers> *and they can be the exact same but when you put them together* <she links her fingers>*, they become something special. So, you have two stories separately and they might be significant on their own, but when you put them together, you have something special, something that people are going to take notice of. Individual differences get put off to the side a lot because of our norms and our values of this society where we want to be just like everybody else. But, if you notice that your individual difference matches and you create this like little chain you’ll see how more people will link. So, I went through a variety of things and other people can relate to my depressive thing but then another person can relate to like another part of my life and I can relate to somebody else’s story where I can say, “Ahh, I can relate with you.”*

I’m not going to lie. I have one of those memories where it’s very selective where I will talk to you about something and I’ll remember one or two pieces of what I actually say. Based on this entire interview, like I can’t really put my finger on something that I would directly take away just because if you take out a piece of something, like you’re not getting the whole package. I just wanted to help with this research. I just like wanted to say thanks for the opportunity, like hearing my story. It could be just staying in your big essay, or it could grow, it could do anything. I think that having this interview was just a different way of getting the ball

rolling. I know that it is a topic and it is something that is going to be a part of my life and probably for you as well, like whatever you take from the experience, whether it's just like having the interviews one on one with each of the people that you talk to or actually like sitting there writing it or transcribing it. Everybody benefits and grows from each experience that they go through.

Your Personal Painting

> *I think that everybody's story, no matter how black, white, or colourful it was, if you talk about it in relation to how you see yourself, you can see yourself as like a blank canvas. Then every experience, story, something that you go through, is just another, I don't want to say stroke of colour, but by the end of your, not necessarily lifetime, but after the end of every experience, you're going to have some form of beautiful artwork at the end of the day. Yes, like, it's going to start off dark, like depression you can paint it black, you can paint it navy, you could do it red even just because of anger and frustration, but at the end of the day those, plus every step that you took, so the greens and the yellows and the oranges, will create something so nice and it's not always going to be viewed as something very negative. It is going, like, no matter whether you think it or not, it is going to turn into something positive 'cause you'll, by the end of your lifetime, you'll be able to look at all of these canvases and think what a masterpiece of an artist you are.*

Christie's Analogies

Christie's analogies added an interesting break from the standard interview or story. Without pausing in her storytelling, she would transition into an analogy as though she had prepared it ahead of time. However, it was evident that the comparison had suddenly occurred to

her as she was attempting to explain something and, for her, it was the easiest way to represent what and how she was thinking. Furthermore, she seemed most satisfied with her explanation of an event or feeling when she was able to apply an analogy to it. In each case, the analogy was pictorial, detailed, and often elicited images of colour: stained glass, a ham sandwich, diet Coke, books, chain links, and paintings. Clearly someone who thinks visually, Christie even states: "*oh yeah I see it*" in the diet Coke analogy and says: "It's fun to think of life in pictures sometimes" when I commented on her use of analogies. While unconventional, her stories within stories provided yet another way to relate with her and her experiences.

The Mental Health Worker

This interview is based on a Mental Health Worker's experiences as an intermediary for a high school student. Eager to help with the research, but confined by confidentiality, she was still able to provide an external perspective about school accommodations. Although well-spoken, due to her professional restrictions, her answers tended to be brief. It was clear, however, that she was passionate about mental health awareness.

The Mental Health Worker and Her Role as Intermediary

My role in working with youth who have depression, my experiences, are limited because I mainly work with adults. However, there have been some students who have come through my services who are on the milder scale of depression and I usually try to refer them to people who work more specifically with children and/or adolescents. These would be places such as the school mental health program or [name of another organization] because their mandate is to work with school-age children up until the age of 18. At the same time, that being said, there are some of the issues that the students are facing which could be resolved and in the interim because there are long waitlists, especially with [the other organization], and can be resolved

without the help of external sources. But, I don't always know if the students are accessing those other services. I can facilitate their referral but if they are actually attending or accessing those services, I'm not always privy to that. It has been my experience that adolescent-aged individuals who suffer from depression or other mental health issues that there's not a lot of follow-up because the students are not always compliant with therapeutic methods.

My work as a Mental Health Worker is not just me; I'm part of an interdisciplinary team and I feel blessed to be part of the team where, if I find that the symptoms are getting worse or if there's medications involved, I can advance the appointment with the health care provider because we work collaboratively with both nurse practitioners and doctors. What I've been told, and that I can certainly testify to that, is that students like my services because I'm affiliated in the health centre building. Well, some might tell their parents, although I encourage open communication, that they're just going to see a doctor as opposed to a counsellor.

The barrier I see with the students is one of disclosure; they don't want to be identified. There are many reasons and some will choose not to say it because they don't necessarily want to be singled out or have any special favours on their behalf. Or have special privileges or any curriculum that could be modified that other students might notice. I think they just don't like being different from their peers. But that's their perception, right? Also, I know that there are school counsellors, and a teacher has told me that his students don't necessarily want to be seen waiting outside the counsellor's office for an appointment. If they're seen outside the office some of the other students might be like: "Oh, you're going to see the counsellor." Many of the high schools do offer school mental health programs so the counsellor will also liaise with the teachers and find alternative avenues to help the students. These programs offer access to the counsellors that work in the schools but some of the counsellors may be working with other

schools as well and do kind of a rotation so they'll be there Thursdays and Fridays for instance; I'm not always sure who's there full time or not.

The students see their friends as a support, but when I speak to the individuals, some of the support can be a little misguided. I find there's a lot of value with peer support but as long as, and I'm always hoping that the support is right, it's not leading to more alcohol or using drugs, for instance, to self-medicate. It's been an issue with a few students that I can think of and there are others that don't use drugs or alcohol. Those students kind of take it in silence.

When I do see students who have depression, I've offered to help address any barriers they are experiencing in school. Some have chosen to accept my help to liaise between the school and themselves. It's been my experience that, with the support of the whole health care team to help the student out, I can get a doctor to cosign a letter so I think it also gives a little credibility. Now, I'll use those services to the student's advantage, of course, when they're required. I'll often say I'll be your champion in your corner, or your cheerleader—I present it in various ways—but having an advocate could be very helpful in opening up the dialogue that we need to have with the schools to take away that stigma. Yeah, you may have depression, but we can work with this, we can try and support you better. What would you find helpful?

As an intermediary between the student and the school, I first need to obtain their permission and explain what our intentions are, how it will happen, and explain the risks. I can't guarantee how the school will respond to my reaching out, so I can only hope that their professionalism and their interest in helping out the student will prevail. The student I'm thinking of in particular did not want to be present for those meetings so I had all my consents lined up and full permission about exactly what I would say and what I wouldn't say. I had reviewed that information with the student beforehand. There was also a trusted teacher that the

student identified and it was okay for me to speak to this teacher on the student's behalf. I requested a discussion so I met with the school principal and, because the trusted teacher wasn't available at the time, the principal had to relay that information to him or her. I made sure that the student was heard and understood in his or her needs and wants and the limits to that as well. The school was very open, very helpful, and very understanding. I also stressed the confidential aspect of this and the student in question was reassured by the fact that I would stress the importance of being discreet and having information that is shared treated accordingly. For myself, if I'm sharing that information with the school, I'm asking the school to be cognizant, discreet, and respect the privacy of the student. I can stress that to the teacher and the principal but that's also in their hands as well. We have to work on that together.

As a liaison, my goal is to open up the communication with a trusted person, like a trusted teacher where the student can go for support or know that there's an adult that, if they're having a bad day, the student can go to him or her. And that teacher can lead the student to the support that is needed; especially if you're assessing suicide risk for prevention. In this case, the teacher the student trusted did some check-ins with the student but was also available should the student have a difficult time during the school day. The student had a safety person, an adult in the school, other than his or her peers, that could assist if needed. With other students, teachers aren't always considered for support. Again I encourage communication with a trusted teacher but some choose to share and some choose not to because there's support through friendships.

The student identified that it would be helpful if we could do something about his or her exams. The principal and I came to the conclusion that having the student not doing those exams at the end of the year would be very helpful. The student's school performance up until the exam point had been more or less exemplary. Like the marks that the student was bringing were like in

the high 80s. And some in the 90s. I have to say that the student had really, really high marks and worked really, really hard throughout the year: went to school every day, didn't miss any classes, and was a very serious student. But the student had an irrational fear of failing the exams. The final exams were such a huge, huge, huge, immense stressor that they even brought on suicidal thoughts and a paralyzing fear of failing an exam; the student had very high expectations of him- or herself. The fear and the anxiety was beyond, out of bounds. So, with the student's permission, I wrote a letter and his or her primary physician cosigned the letter with me requesting permission to not do the exams for that semester. The permission was granted because of the work that the student was handing in throughout the year, throughout that semester. They found it sufficient enough to grade the student without a final exam. At least I think they might. You know, looking back, and I don't have all my notes in front of me, they might have done it orally, like a modified exam. But, they granted it. In my letter I asked, and I think there were some tests that were done orally towards the end. And done one on one instead of with the student sitting in a classroom with all his or her peers. Writing an exam or test became too much for the student to bear.

The accommodations brought down all the symptoms. The panic, the suicidal thoughts, the feelings of intense sadness, and depression were minimized. The relief was felt because these permissions that were granted. But then we encountered the same thing in the following semester that year, so I'm actually seeing a second letter that was asking for accommodations again for the second semester. It was a bandaid solution but we felt that we needed to act upon it to relieve that potential crisis. And, because of the fragility of the mental health state, we felt that the student benefited from that at the time. I can't think of any barriers and if I had, then I would work around that.

I think our plan was successful from day one and I think the school was remarkably open to helping the student out and that made everything so much easier; made my job easier. I've encountered success so far, but I mean I've liaised once with the schools and I've had a really positive experience. I can only speak of that one experience with the school, but I've worked with younger students in facilitating crisis conferences and such but they weren't at the adolescent age. A lot of students don't want us to represent, I mean not a lot; there's one student in particular that didn't want that kind of liaison done with the school personnel or the teachers. At the time, it was because they did not want to be identified. That student just wanted to deal with it on his or her own and with my help, and the doctor's help.

It's been my experience that with depression oftentimes you'll meet anxiety. It's also my experience that those who experience depression and some anxiety symptoms are high achievers. They often excel in school and they're very hard on themselves performance wise and needing to have that mark. It needs to be an A or over in order for them to feel successful. For two students in particular, both are high achievers and both are perfectionistic and the fear of not achieving the high marks or the high esteem by their teachers was pretty high. That's been my greatest difficulty, or challenge, in working with this type of student. Especially the perfectionism: you don't get an A, you're subpar. There's a need to meet that expectation, or perceived expectation, of others, their peers, or even teachers.

You know what, I think maybe a suggestion or a recommendation is identifying a safe teacher that the student trusts. Someone that they can go to if they're experiencing difficulties or difficult emotions; that they can go to that teacher who can guide them or lead them to the appropriate service, or help, or referral. And it may be just talking about it to a trusted teacher could be helpful. I know they're not necessarily trained in mental health, but they could maybe

help them liaise with the school counsellor if there is one on site. Also, maybe the counsellor could meet with the student in a classroom other than the office when the student is concerned about the labelling. As long as they get help and support at the time, that's what counts.

Even though we were successful with the high school, I know that things might repeat themselves when the student's faced with another exam once they're pursuing postsecondary education. So, I facilitated the student's transition from the high school to the university as well. That would never not even happen. If a student were coming to see me, I always facilitate the transition if they're moving on to another city, or a new school, or anything to that effect. That's very, very important. You need the continuity of services as long as the person wants it, right? I contact the other social worker, or the other provider, and even set up an appointment. I tell the student: "Well now you're going to be in this city, you're going to be going to this university, and I've made contacts with the university, primary care providers, and social workers. And I've booked appointments." I would never think of not doing that. If you don't do that, you're missing the boat. So, you put a bandaid on the situation in high school but still want them to be transitioned to appropriate good hands.

Summary

The participants provided a wealth of information with which to work, and it was interesting to learn about the different ways they chose to address their depression within an educational setting. Quickly examining the restories, one can find several experiences which are shared amongst the participants. For instance, the similarities between Brittany's and Christie's childhoods, their relationships with peers who also faced difficulties, and their eventual advocacy work. Furthermore, all three participants used counselling services, discussed their trust of teachers, and spoke of stigma within their schools. Finally, both Christie and the Mental Health

Worker's student were provided with accommodations in high school as well as postsecondary, and Brittany acknowledged the usefulness of academic interventions. These and many other themes that emerge across and between the restories are contextualized and analyzed in Chapter Five.

CHAPTER FIVE: THEMES AND ANALYSIS

Using the experiences of the participants presented in Chapter Four, I first look at the cross-themes using only the participant restories. I then turn to the thematic analysis whereby the details provided by the participants are used in comparison to the research presented in Chapter Two to confirm, contradict, or contribute to current studies. Due to the participant cross-themes as well as the nature of the themes overall, which are sometimes not easily relegated to one section, there is some overlap and repetition. This has been kept to a minimum but was necessary in the use of this type of analysis where participant voices speak together and are then linked with researcher voices.

Emergent Cross-Themes

In examining the three restories, I identified dozens of cross-themes that I then grouped into overarching themes to present a recognizable pattern. These are organized using the headings from Chapter Two that allows some correlations between the literature review and my research. There is also one additional heading which represents the students' and the Mental Health Worker's interest in sharing some information about moving from high school and on to postsecondary. As has been evident throughout this research, participant voice is held in high regard. I feel it is important to let those voices speak first for themselves before being compared and contrasted to research. In this way, their combined experiences can be clearly heard and acknowledged.

Students: Perceptions of their Depression

In their younger years, both Brittany and Christie spent a lot of time alone without much emotional support. When Brittany was diagnosed with SAD as well as anxiety, she found that learning about her diagnosis helped her understand her thoughts and actions. Although Christie

was devastated with her diagnosis of depression (her anxiety having been diagnosed in elementary school), she also found that it provided answers to her state of mind. Christie indicated that depression and anxiety are often linked, and this comorbidity was also mentioned by the Mental Health Worker. Brittany described depression as horrible suffering, and Christie stated that, together, depression and anxiety were horrifying.

Both Brittany and Christie began seeing counsellors once they were diagnosed, and Christie continues to see her counsellor regularly. In counselling, Brittany and Christie learned about managing emotions and practicing strategies to deal with their depression. This helped them handle their episodes of lashing out at others, although Brittany was the only one to report that she was able to reduce her outbursts. Christie talked about learning to understand her own reactions. Interestingly, both Brittany and Christie wrote their own music to express themselves in a way that words could not. Once Brittany and Christie were diagnosed with depression, they felt that their depression put a burden on others and that their depressed mood would spread to those around them, making everyone unhappy. To combat this, and in an attempt to fit in with their peers, Brittany made an effort to look and be happy and Christie tried to put on an act to hide her true difficulties. However, Brittany purposefully blocked many of her memories, and it is unclear if Christie used her selective memory to deal with these issues as well.

Also of importance are the instances where the participants had opposing views. For instance, Brittany said that she was not embarrassed by her depression in high school whereas Christie was both ashamed and embarrassed, although she no longer thinks of depression and herself that way. The Mental Health Worker simply noted that students did not want to be viewed as different. Last, Brittany and the Mental Health Worker referred to depression as a suffering, whereas Christie often said “episode” but preferred the word “moment” when describing a

depressive feeling.

Students: Empowerment to Disclose and the Social Effects

After being diagnosed, Brittany and Christie experienced periods where they secluded themselves from their friends, but the need for disclosure soon made itself evident. For Brittany, disclosure was a means of explaining her current behaviour—experimenting with drugs and alcohol—and for Christie, it was a way of reconnecting with her best friend. When telling others about their depression, both Brittany and Christie preferred to speak one-to-one. They both felt the need to explain everything to the person with whom they were speaking, but Christie recognized that this could be overwhelming to the other person if delivered all at once. Most friends responded with, "Okay, whatever" and never brought it up again. However, Brittany and Christie found that in talking with friends who either had depression or were dealing with other difficult issues, they were able to relate on a level that did not occur with other people. The Mental Health Worker, though, expressed some concern about speaking to peers because this could lead to either positive or imprudent support. Other than people who also had depression, Brittany and Christie found that people who were of the lesbian, gay, bisexual, transgendered, and queer/questioning (LGBTQ) community, especially those who were gay, could relate to their experiences the most.

Both Brittany and Christie strategically told people about their experiences with depression. Their interviews also showed an agreement: Although they may be speaking about depression with friends, they were not advertising their mental health status and did not disclose information to the general student population. Brittany states that she would not have told more people than she did, but Christie's response is confusing when she says she would not tell more students and then expresses a need to have told more people, especially teachers, because of the

understanding, support, and help others can provide.

Teachers: Encouraging Disclosure and the Educational Challenges Faced

Brittany was adamant in her distrust of teachers, even those with whom she was close; she felt awareness of her depression was not important for teachers to know. She thought that her teachers might think of her differently. For Christie, speaking with a teacher was actually her first foray into disclosure, and most other teachers either approached her with concerns or guessed that she was dealing with depression. However, she was quite resolute in ensuring that teachers with whom she did not have a positive relationship did not find out. She felt it would be a burden to her teachers and, like Brittany, she feared being seen as different. The Mental Health Worker felt it was very important to identify a trusted teacher, someone in the school that the student could go to in times of need. Even if the teacher was not trained in mental health, he or she could be an outlet for simply talking or as a liaison with the school counsellor.

Students: Supports Experienced in School

Brittany was eager to ensure that her depression would not affect her schoolwork and did not seek accommodations. Contrastingly, Christie received accommodations from several teachers in high school that addressed her discomfort with being around people while writing tests. She was given a separate space to write, and one teacher sat with her to offer peace of mind. Christie was also privy to a seating chart so she would be in a socially comfortable space and had a signal established with one teacher to identify her mood. The Mental Health Worker's student was given special accommodations for his or her tests and exams, with them being done either one-to-one, orally, or not at all based on work done during the semester. Having recently experienced accommodations in postsecondary, Brittany now believes that she would have done better in high school if she had asked for and received accommodations at that time.

Students and Teachers: Barriers Experienced by Both

The largest barriers experienced in all three cases were centred on testing and grades. Brittany's challenge was in observing people who had already finished the test and becoming so frustrated that she was not yet done, that she did not complete her own work. Similarly, Christie had a difficult time if she could see what other people were writing. Also, she could not handle poor grades, as her depression and anxiety often manifested as aggression. The Mental Health Worker's student, despite excellent marks, was irrationally afraid of failing due to extremely high expectations. Another barrier was a lack of counselling services: In Christie's high school, there were no counsellors, and in the Mental Health Worker's student's high school, the counsellor was only there on specific days. Brittany and Christie both stated that they tried to not let their depression define them, but they lived with the fear of rejection and judgement, which was not improved by the lack of curriculum concerning mental health.

Students: Stigma and Self-Stigma Experienced

All three participants identified stigma about mental health and depression to be an issue. Both Brittany and Christie mentioned that the LGBTQ community appeared to be accepted in their high schools where posters, groups, and announcements were common. However, similar methods of support were not available to people with mental health issues. Brittany identified that there was a stigma toward people who needed extra help but contradicted herself when talking about whether or not there was any mental health stigma in her high school. Christie said that mental health issues were secrets that were never spoken about in high school at all. Specifically, Christie and students who worked with the Mental Health Worker did not want to be identified as people with depression. The Mental Health worker felt there was stigma in the high school her student attended and her role was to help eliminate some of that stigma.

Students: Moving Forward

Heading to postsecondary education meant changes to the schooling routines established by the three participants. However, they all eventually made contact with their universities' centres for accommodations. Brittany was assessed and given more time for her exams, Christie already knew that she needed a separate space to write her tests and exams, and the Mental Health Worker helped her student transition by setting up appointments with a social worker and notifying the university of the student's needs. Both Brittany and Christie are now advocates for talking more openly about mental health. They know that depression affects a lot of people and they want to get information about depression out to people in general. They also want to help others who have depression by talking with them about how to get assistance or to simply help them feel that they are not alone. Christie also uses Bell Let's Talk day as a way to get conversations started.

Thematic Analysis

Upon reviewing the three participants' restories and comparing them to the research questions, I found 54 points of intersection including both comparative and contradictory experiences. Examples include: drugs, trust of teachers, lack of posters, counselling, and fear of rejection. I then grouped these points into 13 themes such as seclusion, reactions, supports, and recommendations. Finally, I aligned these themes within the headings from the literature review and found six matching sections. I created a seventh section to incorporate the information each participant provided about their experiences after high school. All of the original points of intersection will be discussed under their respective headings from Chapter Two.

I would like to note that, in some cases, determining where a theme should be placed within the sections was quite difficult. Many points and themes were fluid; they fit under

numerous headings. To address this difficulty, I first kept the points of intersection between participants together. I then looked at the context within which the point was made for each participant. Based on that, I finally decided upon a placement within the headings. An example would be a fear of rejection or judgement. Initially, this seems to fit within the stigma heading. However, when looking at the restories, Brittany and Christie are discussing barriers to their education, not stigmatization. One could argue that, in this case, barrier and stigma are one and the same, but the points of intersection had to be arranged in some manner that fit within the headings from the literature review, and I chose to use the point of view of the participant telling the story.

Students: Perceptions of Their Depression

Wisdom and Green (2004) identified several adolescents who wanted to return to a time without responsibility, a time when they were not depressed. For some, this was childhood. However, for Brittany and Christie, childhood was not an ideal time in their lives. Neither spoke fondly of the time they spent alone and without emotional support from their parents. Even Christie's diagnosis of anxiety in grade 3 did nothing to increase the support she received at home: "My brother being diagnosed with [names illness] . . . shifted the focus completely toward him versus kind of a balance so if I had problems or needs they weren't necessarily addressed."

Interestingly, none of the researchers mentioned that their participants were engaged in counselling in any way. Even before her diagnosis, Brittany was in family counselling, which helped her handle some of the emotions she was feeling. Upon her diagnosis, Christie saw a therapist for cognitive behavioural therapy, and she continues seeing a therapist even today. Clearly, the student represented by the Mental Health Worker also partook of counselling, although the exact purpose was not revealed.

Before being diagnosed with depression, Brittany explained that she was confused about her thoughts and did not understand why she externalized all of her feelings, often through episodes of anger and aggression; Christie also experienced aggressive states. This is supported by the work of several researchers (Farmer, 2002; Wisdom & Green, 2004; Woodgate, 2006) where their participants spoke of anger, outbursts, and emotionality. Upon learning of her diagnosis of SAD, Brittany's reactions began to make more sense to her, and counselling helped her learn to control some of her outward emotions. Christie talked about being overwhelmed, which is alluded to in many of the researchers' participant accounts, and she, too, learned coping strategies for these feelings.

In describing depression, both Brittany and Christie mentioned words that echoed other researcher participants' explanations but, like those researchers learned, they both had unique ways of expressing their experiences (Friedson, 2013; Hinatsu, 2002; Wisdom & Green, 2004). Brittany says:

> I don't know how to describe my depression. Very alone and like you're in a box, I guess. You just feel like no one can understand you, no one can help you. Just this intense sadness. It's a hard thing to describe. I think sadness and loneliness are definitely the biggest parts of it. And just like you feel trapped like you're in an emotional cage and you can't get out of it. It's hard to put into words.

Christie felt more sure of her description of depression:

> Depression was like living in slow motion if I could best describe it. It's like everything was moving at regular pace and I was two times slower. . . . It just hits you all at the same time so your body's just trying to figure it out and it's all wonked out and it's like being hit by a bus, you feel it mentally, emotionally, physically. . . . [It] was just kind of the

> most horrifying combination that anybody could ever ask for in that boat of depression and anxiety. It was just kind of a negative blurred mindset. That's probably the best way I could describe it in the beginning. Just very unclear.

The Mental Health Worker referred to depression as suffering, a description that Brittany supports: "I don't want to see anybody suffer through depression. 'Cause I suffered through it and it's horrible." One topic that is not mentioned by the researchers is the physical pain Christie experienced.

Also interesting is an observation by Wisdom and Green (2004) about adolescents with depression feeling pressured into feeling happy, which is also supported by MHCC (2012) and Abraham (2008). Brittany explains that "when I tell people I have depression, they don't believe me 'cause I work so hard and I always try to be happy." Christie simply states: "They always see the girl I put on every day." I also shared a story about the exact same phenomenon in my Master's thesis:

The Illusion of Happy

> *"You can't be happy all the time," my grade 10 honours-level Biology teacher protested.*
>
> *"Why not?" I countered, looking through my previous week's worth of assignment pages. We had been given a diary of sorts to fill out each day, indicating our mood (on a scale of 1 to 10, at different points in the day), the weather, and any observations or feelings we had. It even had a doodle box for pictures or notes or anything else we wanted to scratch in there.*
>
> *"Because no one is happy all the time," he explained vaguely.*
>
> *Defiant, glancing at the 9s and 10s circled on every page, I responded, "I am."*

> *"Try to think about your true mood and feelings, the deep down ones," the teacher tried again. "You need to put more effort into this, Lorna, and take it seriously."*
>
> *Even at 15 I knew. If I did not force myself to be happy all the time, I would be sad, very sad—and I did not want that to happen. I could maintain the illusion of "happy" for only so long before I had a moment of weakness and my family suffered for it.* (Corzine, 2011, pp. 9–10)

In another coincidence, both Brittany and Christie mentioned blocking periods of time from their memories, both difficult occurrences and the mundane. While not mentioned by other researchers, I, too, experienced this coping mechanism and discussed it in my Master of Education coursework (November 9, 2007). Crites (1986) writes that there are people who live in the past and those who live in the future and the different perspectives each holds. "I cannot fail to have a past, but I can let it be forgotten, or I can actively suppress it . . . in this case I lose my identity" (p. 171). I felt, and still feel, that although I do forget the past, I do not live for the future, but rather hover in the present. Although Crites says "the present is not a static point" (p. 163) because as soon as that moment happens it becomes the past, I see the present as a moment-to-moment bubble of time that is protected from the past and shielded from the future. I feel it is a very real point in time and I use this anomaly as a self-preservation technique to fight the overwhelming emotions I experience and concentrate on the day-to-day aspects of my life to get through one more day without serious problems. Christie points out that she "would love to go through a day where I'm not like freaking out. I'd love to be able to go a day without having like, an hour-long anxiety attack over nothing," a statement with which many who have depression can agree (Adamson, 2010; Farmer, 2002; Hinatsu, 2002; Wisdom and Green, 2004).

Brittany and Christie believed that their depression would be a burden to their friends or

teachers. They also shared the notion of their depressed mood spreading to others. Brittany explains that "you feed off that energy whether it's positive or negative. 'Cause when you're down with other people, people are going to be down to you too" and she tried to associate herself with people who had a more positive attitude so she could "feed off their positivity." Christie uses a similar explanation:

> Like if you were a happy person, you could make the person sitting next to you happy because you're happy and that chain goes. So, I think that depression where I would be unhappy, I would have these thoughts in my mind going on and it would reflect how I would behave and then it has that effect as well where it just spreads to everybody whether they're directly affected or not.

All three participants also spoke about embarrassment. While Brittany said she was not embarrassed by her diagnosis of depression in high school, she acknowledged that a lot of people are. She attributed her own comfort to the support she received at home from her mother and her father's own diagnosis of SAD. Ross et al. (2003) found that students often turned to family as a safe environment to express themselves. Christie identified that she is no longer ashamed or embarrassed about her depression, but she made this comment in a section of interview when was speaking about her experiences in the present, while in postsecondary. She was unclear as to when her embarrassment subsided, but I suspect it was after high school. Instead of using the word "embarrassed," the Mental Health Worker used the phrase "did not want to be identified." She elaborated in a way that made me think the student was embarrassed by identifying student responses such as "singled out," "don't necessarily want to be seen waiting outside the counsellor's office," and "wanted to deal with it on his or her own."

Finally, there are three more points that were expressed by the participants but not

addressed by the researchers. First, the participants used several words to describe their experiences with depression such as episode, attack, and reaction. Christie, though, chided herself whenever she used one of these words and tried to portray depression, not as something that precludes the person, but rather as something that can be managed, by using the word "moment." Second, both Brittany and Christie have an artistic aptitude and utilized the writing and playing of music to help express their emotions when words failed them. While I do not believe they shared these songs with anyone else, I cannot be certain. Third, the link between depression and anxiety was mentioned by all three participants and seemed to play a pivotal role in each case, often by increasing their depressive symptoms and need for external assistance.

Confirmatory Student Perception Research

My research reiterated many aspects of students' perception of their depression that had already been covered by other researchers: the unique descriptions of depression, externalization of emotions, feeling overwhelmed, the need to appear happy, and wanting to return to a "normal" life. One contradictory revelation was identified by two participants who did not find their childhood a place of security and caring as Wisdom and Green's (2004) research suggests.

Contributions to Student Perception Research

The participants in this research have augmented the knowledge base of first-person accounts of depression in several ways. They discussed using counselling to develop coping strategies which helped them manage their depression, the physical pain that can sometimes accompany depression, and the choice to block periods of time from their minds. They also contribute a fear of being a burden to others, the embarrassment of the diagnosis, and the notion that people can be affected by the emotions of others around them. Finally, they add the importance of wording used to describe a depressive "moment," using music and art to help

express their inexpressible feelings, and that depression and anxiety are often experienced together.

Students: Empowerment to Disclose and the Social Effects

When she first experienced depression, Brittany lacked any sense of empowerment or connection to the world outside her mind. She said she "locked myself in my room, didn't talk to anyone. I completely shut myself out, out of society and all my friends." When she finally decided to tell some of her friends it was

> just so they knew what was happening with me because I kinda had isolated myself. I wasn't really myself, and I was kinda experimenting with alcohol and drugs and stuff, and I decided to tell them this is why I'm doing this. Like, I'm not crazy, I guess.

Christie also had moments when she wanted to be left alone, such as on her 17th birthday, but, in general, seemed to continue on after her diagnosis, attempting to use her external mask, until forced, in a way, to defend herself and her illness. Her two closest friends had sent texts to her that were

> atrocious, like I would never say anything like that to somebody but it got to the point where they said it was my fault for having such mental issues and behavioural issues . . . and it's just not something that they feel they should have to deal with.

In both cases, there were obvious external factors that led to the disclosure of their diagnosis of depression; it was not entirely voluntary. Hetherington and Stoppard (2002) also noted this external influence on disclosure; however, it was when friends would ask why their mood had changed, as opposed to a response to a negative event.

When initially speaking with friends, it seems that Brittany and Christie had different approaches. Due to the drugs, alcohol, and personality changes, Brittany appeared to tell eight

friends within a short period of time because she stated: “And then everyone was like, ‘Oh, okay, that makes a little bit more sense’.” She related that most people were understanding, but those who did not really understand mental health issues swept it aside and did not discuss it further. After this initial explanation, Brittany spoke one-to-one with people with whom she felt comfortable discussing her experiences. Often these were people who were having difficulties themselves, whether it was family, mental health, or LGBTQ issues. Speaking with others who have mental health issues is also identified as a method of disclosure in research by both Hetherington and Stoppard (2002) and Wisdom and Barker (2006).

Christie’s first experience with telling someone about her depression was with a teacher in response to the difficulties she was having with her friends. She explained that:

> I just remember sitting there for two minutes just trying to find the words to just say, ‘I have depression,’ A lot of people just think it’s easy to say if you just say the broad statement like ‘I have depression’ but they don’t really realize like how difficult it is to say it in that simple form just because of the components with it.

This need to build the courage to speak with another person is also mentioned in Hetherington and Stoppard’s (2002) research. Similar to Brittany, she continued the one-to-one method of speaking with people when “it kind of made sense to tell them.” Again, some people pushed it away, but she felt it was important to tell others for several reasons: to keep her friendships, to let people help, and to not feel so alone. She also found a friend who was having a difficult time with LGBTQ issues and discovered they had a lot in common. This need to eliminate the aloneness one can feel with depression is addressed by Roumeliotis (2011) but with specific reference to learning of others who also have depression.

The Mental Health Worker was unable to give me information about her student’s

disclosure activities outside of the health centre, but she did know that some adolescents with whom she worked would sometimes be given inappropriate advice about how to deal with depressive feelings. This included using drugs, alcohol, and remaining silent about their difficulties. Her concerns are supported by the American Academy of Child and Adolescent Psychiatry (2011) and Davidson and Manion (n.d.).

Gammell (2003) mentions that students are more likely to disclose to people when they "'have the right kind of relationship'" (p. 153). This was true for both Brittany and Christie: While they were talking about their depression, it was not to everyone, and they were selective with whom they told. For Brittany, it was stigma that kept her from telling more people whereas Christie limited it to the friends with whom she was closest. In retrospect, Brittany confirms that she was content with the number and whom exactly she told. Christie, though, gave a more complete answer. She says:

> I definitely recommend that they tell people 'cause it does feel good and it does open up so many more doors. I probably would have told more teachers versus friends. Teachers have a different role than students . . . I would say tell all your teachers . . . I'm happy that I didn't tell more [friends] 'cause I just didn't trust them. So, I'd probably tell more teachers but not any more students than what I did. But, yeah, I definitely recommend telling people, oh yeah, hands down. I don't know why I didn't do it sooner.

Her use of the word "people" makes it difficult to discern exactly who that encompasses, but I have taken it to mean adults, given her adamant statements about students.

Although several researchers mention the negative effects of telling others (A, 2015; Bosacki et al., 2007; Farmer, 2002), only Christie makes one statement regarding this: "'Cause like I know a lot of people can either run with it and like not necessarily accept it but like they're

just, they're like, 'Ah, okay, cool.' Or, they'll take it into a negative sense." The participants did not appear to have had any major negative reactions.

Confirmatory Student Disclosure Research

A lot of what was shared by the participants regarding disclosure of their diagnosis of depression confirms what is present in existing research. This includes: finding the courage to speak about one's depression, talking with others who also have mental health issues, sharing information with close friends or those where good relationships have been formed, and wariness of obtaining appropriate advice.

Contributions to Student Disclosure Research

Adding to the current research is the idea of a complete lack of empowerment in the first days/weeks/months of diagnosis when one wants to be alone. Furthermore, the influence of external factors in coercing a disclosure and the need to decrease one's aloneness in general, not just with others who have mental health issues, is important. Finally, it was interesting to note the possible links of support between those with depression and people in the LGBTQ community.

Teachers: Encouraging Disclosure and the Educational Challenges Faced

After Christie had received the derogatory texts from her friends, her teacher approached her when the rest of the students had gone. The teacher was calm and open, ready to listen to whatever Christie had to share and thereby created an environment that encouraged Christie to finally talk about her depression. Christie says:

> That's the first time I've ever told anybody about depression and like my experience with it and I think that it had a significant role. So, telling her just kinda started my journey, I guess, to kind of accepting it which kind of led to telling my best friend.

The positive reaction and support that she received from that teacher at that time obviously

helped her make a pivotal choice in her life with depression. A similar event is reported in Tyler's (2014) research whereby a teacher approached a student who appeared to have difficulties and worked with that student to get the necessary help. The OME (2013c) also includes information for teachers about talking with students about mental health either by approaching the students themselves or having the student approach them.

Subsequently, Christie told a few more teachers whom she trusted, while other teachers asked or guessed about her difficulties with depression. The one thing she emphasized was the need to feel comfortable and to trust the teacher with whom she was speaking. She said: "If I didn't feel comfortable with you, no way. Noooooo way. I don't want that to burden in any way and I don't want that to be talked about." Christie was fearful of being thought of differently by those teachers in particular. Leahy and Robb (2013) confirm that being talked about, even if it is meant to help, can severely damage, and even eliminate, trust.

The Mental Health Worker mentioned several times the need for a trusted teacher in the life of a student with depression in high school. The teacher that her student chose "did some check-ins with the student but was also available should the student have a difficult time during the school day. The student had a safety person, an adult in the school . . . that could assist if needed." She felt that communication with this teacher was important for the student to increase access to support, assistance, guidance, and help during times of crisis. This teacher could also be a liaison with the principal or school counsellor. This recommendation is similar to a suggestion by School Mental Health ASSIST (2013).

Brittany, however, did not trust teachers at all:

> I never really came out to the teachers 'cause I didn't want them to think I was dumb or something like that. . . . I didn't trust my teachers in that way. . . . Even the teachers I was

close with, I didn't talk about it with them. . . . I didn't feel like it was important. Her teachers neither saw the signs of depression nor were given the chance to help.

Confirmatory Teacher Disclosure Research

Almost all of the information from the participants about teachers encouraging disclosure is already in the literature, including carefully approaching students who appear to be having difficulties and maintaining trust. The idea of trust seems to be an important factor for all three participants and influenced the route each chose to take.

Contributions to Teacher Disclosure Research

The only item to add to the research is the need to work with the student to determine a trusted teacher if disclosure is made through another avenue such as a counsellor, parent, or liaison. While mentioned by School Mental Health ASSIST (2013), their statement does not have any research backing.

Students: Supports Experienced in School

Christie's trust in teachers was well rewarded and she obtained accommodations in the classes in which she needed them. However, from my understanding and the following of her story, it seemed that disclosure did not really occur until her last semester of high school, about a year after her diagnosis. In Tyler's (2014) research, teachers talk about offering accommodations to students without fuss and documentation and that choice, including where they wanted to sit, was important. As though taken directly from that research, one teacher worked with Christie to develop accommodations that would suit her needs, inclusive of her depression, anxiety, and mood changes. Since the class seating schedule changed each week, Christie was allowed to review it to ensure she was comfortable with her surrounding peers. The teacher would check with Christie during class using a cue to ensure she was doing okay, which is supported by

Woodgate's (2006) research. Furthermore, the teacher was open to any suggestions Christie had regarding test writing, which is also mentioned by the CMHA (n.d.a). At first, Christie chose to sit beside the teacher during tests for a sense of stability, but they later realized that Christie simply needed her own writing space:

> It wasn't until later on when we realized that maybe I just need to be in a different space or I need to do my testing different so sometimes she'd put me in the hall. Like, I needed to be alone and away from people. Then we knew that this is what I needed in order for me to be successful.

Using this knowledge, Christie was able to ask for accommodation in her Biology class and she was permitted to write at a table away from the other students. She also found that having teachers aware of her difficulties made explanations for late or missing work easier and more truthful.

In advocating for the student, the Mental Health Worker said that "the school was remarkably open to helping the student" and she found it easy to arrange alternate formats for the student's tests and exams. Once these accommodations were made, the intensity of the student's symptoms was greatly reduced. Again referring to the trusted teacher, Farmer (2002) does note that teacher supports can be important in the circle of care and have a significant impact on the student.

Lacking trust in her teachers, Brittany worked through her classes without accommodations and said: "I didn't feel like [help] was important. As long as I just tried to get a good mark, it didn't matter. . . . I was surprisingly decently successful in high school." However, reflecting on her current situation and accommodations in postsecondary, she, seconds later, admits that "if I had [exam] accommodation in high school I think I would have gotten much

better grades."

Confirmatory Support Research

Overall, the participants listed few supports, but the ones mentioned played significant roles in their success in high school: choice, nonverbal cues of distress, and overall teacher support. Each of these can be found in prior research.

Contributions to Support Research

Although mentioned by the CMHA (n.d.a), my research can actually confirm the positive aspects of making test accommodations for students.

Students and Teachers: Barriers Experienced by Both

All three participants encountered issues regarding grades and tests. Brittany found that if she noticed people had completed their test and she had not, she questioned her own ability to be successful. She said: "I was just . . . felt so upset so I didn't finish my test. Not that I couldn't do it, just that I felt that 'how could other people be finishing?'" which led to the self-destructive behaviour of leaving her test unfinished. For Christie, it was being able to see what others had written on their tests. Within the context of her interview, I do not believe she was reading what other people had written but, rather, could see the length of the answer compared to hers. Christie also struggled when she received a poor grade:

> It makes me feel stupid, it makes me feel like I'm not at the level of other people and that brings me into a depressive aggressive state so my aggression comes in and out. That is a barrier of itself because yeah sometimes I know when it's going to come and other times it just hits you like a ton of bricks and you're just like "oh shit."

The Mental Health Worker understands this reaction. Her student had "an irrational fear of failing the exams" which led to suicidal thoughts and extremely severe anxiety. She says several

of her adolescent clients who have both depression and anxiety are perfectionists and they measure themselves and their worth by the grade they receive. It was in this way that she became a liaison for a student who found test writing to be a huge barrier to his or her success in school. This idea of a liaison can be included in Farmer's (2002) circle of care that helps ensure the student receives the support necessary to feel comfortable in school. Interestingly, the research uncovered in the literature review did not address the issues of grades or tests.

One area that does appear in the research is counselling services, or the lack thereof. There was no counselling available in Christie's school at all; if you went to the guidance counsellor, they recommended personal counselling in the community. The Mental Health Worker noted that, in her area, "many of the high schools do offer school mental health programs" but a counsellor was available only on a rotational basis. These issues are mentioned often in the research (A, 2015; Leahy & Robb, 2013; Lewington, 2013; Nabors et al., 2000; Rodger, et al., 2014) and are frequently considered one of the top barriers in high school.

Neither Brittany nor Christie had any form of mental health education in their curriculum throughout high school. This is not uncommon, as nearly two thirds of students receive either no education or a brief mention of mental health issues in their high school courses (Leahy & Robb, 2013). While the lack of education for their peers is a barrier of its own (A, 2015), this also led to both Brittany and Christie experiencing a fear of judgement and rejection from teachers and peers. Brittany said she was

> scared to get that close to somebody, especially girls because girls are vey judgemental. There's a fear of being rejected I guess . . . I don't want them to know so much about it where I think they get scared of me. . . . I don't want them to see the hard part.

She also talked about being intimidated by confident people and that she "wasn't good enough to

associate with them" and says that her peers were her largest barrier in high school. As mentioned earlier, Brittany also did not want to be seen as "dumb" by her teachers. Sadly, Christie was so sensitive to judgement regarding her feelings and thoughts that she turned to her dog as her support while he was alive. She was especially concerned that teachers would talk and joke about her and see her in a different light. Leahy and Robb (2013) only briefly discuss the issue of teachers and judgement, but Janes (1996) and Riley (2009) speak about it in more depth. The CMHA (n.d.a) also states that some students fear the student–teacher relationship will change.

Despite these fears, both Brittany and Christie expressed that they did not let their depression define them. Christie says: "I don't want to be judged solely on an experience [with her depression or anxiety]. If I'm going to be judged, I want to be judged accurately. So, I don't want to be held back by anything like that." Joan (A, 2015) sums it up nicely when she says: "I am not a problem. I am an individual. I am complex. And I deserve to be listened to" (time stamp 3:17).

Confirmatory Barrier Research

This research confirms what researchers already know: that the lack of counselling available to students remains a large barrier to those who have depression. Also, the lack of mental health information provided to students via curriculum is addressed as a concern. However, research also supports a circle of care model that includes community services. Two of the participants identified judgement and rejection, which supports research discussed under the stigma and student empowerment headings in Chapter Two.

Contributions to Barrier Research

The largest barrier identified by the participants was the traditional setup for tests and

exams. The research does not mention speaking with students about their particular testing needs, although the suggestion of providing additional time is made (OME, 2013c) and not substantiated here; extra time was not introduced to either Brittany or Christie until university. However, the issues that appear in this research extend beyond a need for extra time, such as location and test format. Finally, another barrier that can be added to the research is that grades themselves can have a drastic effect on a person who has depression and anxiety.

Students: Stigma and Self-Stigma Experienced

The stigma that continues to surround mental health was identified by all three participants as an issue in school and dealing with their depression. Christie identified that there was definitely stigma, not just in her school, but in her community as well: "Mental health was never talked about. It was something behind closed doors and where I'm from if you have anything different about you, you're kind of put to the curb." The Mental Health Worker believed that an advocate for a student could be helpful in many ways, including "opening up the dialogue that we need to have with the schools to take away that stigma." As discussed in Chapter Two, stigmas in general are ongoing and present in schools according to Janes (1996) and Riley (2009). The prevalence rate of mental health stigmas in schools and teachers is undetermined, but we do know research indicates that only a third of teachers felt comfortable dealing with mental health issues (Andrews et al., 2014) and less than 6% believed that mental health information was important to share with students (Kovacs, 2010).

Christie and many of the Mental Health Worker's clients also indicated that they did not want to be singled out as persons with depression. They did not "want to be seen waiting outside the counsellor's office for an appointment" which is supported by several studies (Kovacs, 2010; Lewington, 2013; MHCC, 2012; Nabors et al., 2000; Ross, et al., 2003). Brittany, however, was

a little contradictory. She first says that “I don’t think I would have told more people than I did because in general people still have a stigma against it” but then: “Our school is very accepting of gay people which was nice so I felt like people were okay with that, so mental health wasn’t a big deal, either.”

Of some interest is this intersection of information about LGBTQ and mental health. Earlier in this chapter, both Brittany and Christie spoke of their friendships with people who were gay, but they also brought to my attention several other details. Both mentioned that their schools had absolutely no posters regarding mental health, and Christie explained that there were not only LGBTQ posters but advertised meetings of groups at her school. Although Brittany does not explicitly mention LGBTQ posters, the context of her interview at the time makes me think that her school had posters as well. Also, Brittany and Christie talk about the acceptance of the LGBTQ community in their schools, with Christie stating: “So, if you were like lesbian, gay, bisexual, transgendered, queer, whatever, you felt represented, not only as a gender but as a person.” This aspect was not covered in the literature review, but I was intrigued by the apparent openness some high schools had toward LGBTQ members but not those who had mental health issues. Adamson (2010) states that about 20% of youth will experience depression. In a class of 30 adolescents, about six students can be expected to have been, are currently, or will be depressed at some point in their high school careers. In looking for similar statistics for LGBTQ, I found that Statistics Canada puts the population of people who are homosexual or bisexual at 2% (Lafontaine-Émond, 2013) and a Forum Research poll identifies “that 5% of Canadians identify as lesbian, gay, bisexual or transgender” (Blaze Carlson, 2012). So, in that same class, one to two students may be of the LGBTQ community. That leads me to wonder: What is preventing adolescents with depression from garnering the same level of recognition as a

population one quarter its size? What has the LGBTQ community done to increase their visibility in high schools, and how can the mental health community replicate that?

Confirmatory Stigma Research

Both this research and research done by others confirms that stigma about mental health in general remains predominant, as well as more specific actions such as waiting to see a counsellor or being identified as someone with depression.

Contributions to Stigma Research

The appearance of acceptance of those of LGBTQ orientation but not those who have mental health issues is a thought-provoking addition to current research.

Students: Moving Forward

As all three participants are now pursuing postsecondary education, it was natural for them to speak about the change between high school and their current situation. Brittany, not having sought out assistance in high school, waited a few years before seeking accommodation:

> But this year especially, my first year of university, has been a very stressful year. With the stress and my depression, I couldn't deal with it so I talked to the school. I just have like more time on exams which helps a lot because I get so stressed out and it's so nice to have extra time to just like relax for 10 minutes.

Christie, however, arranged her accommodations immediately:

> Having anxiety and depression is just really overwhelming but, like, I deal with it. I get accommodations now, too, at university. I write in a private room. . . . So, those two teachers in high school, they kind of like started this whole trend I guess or pattern and kind of like set the guidelines for my accommodations.

The Mental Health Worker also prepared her student for the change:

> Even though we were successful with the high school, I know that things might repeat themselves when the student's faced with another exam once they're pursuing postsecondary education. So, I facilitated the student's transition from the high school to the university as well. That would never not even happen. . . . You need the continuity of services.

Both Brittany and Christie also spoke about the strength they found to become advocates for mental health once in university.

Brittany noticed a change in the atmosphere about mental health once she reached university. She discovered that "it's talked about a lot and all the teachers understand that." She even did a presentation in the previous semester about depression and, after telling the class that she had depression, used her own experiences as examples. Brittany said that she wanted to help others who have depression and learned that, by her mentioning her own struggles, others have come forward looking for help. She directs them to counsellors and has recognized that mental health issues are more common than she realized. Concluding her interview, Brittany states:

> I want to make sure that people get help and that's why I wanted to do this 'cause definitely getting more information out to help other people is really important to me. I don't want anyone to suffer alone. I think talking about mental health is good because it brings more opportunity for help and for other people who may be suffering so they can get help too.

Christie had similar revelations once she reached university. She was no longer ashamed or embarrassed and used her experiences as "an educating tool for people." She believes that it takes one-to-one conversations to really help another person understand her message about depression and mental health: "even just a 5-minute conversation about it is better than not

saying anything at all." Christie encouraged talking to others about depression because it helps people realize they are not alone. During her interview, Christie was most proud of her actions on the most recent Bell Let's Talk Day. She changed her Facebook status to:

> A mental illness is not as intense and conquering as it seems when it takes over your life. . . . If I didn't have that support or help or if I didn't go get help, I would not be in university . . . I'm just one of the millions who have/had a mental illness and today is our day.

To conclude, the three participants had recommendations moving forward for both the schools and additional research. Regarding mental health in the curriculum, Brittany states that it should be covered and Christie makes reference to it through its absence. Christie also alludes to the need for available counselling in schools. The Mental Health Worker felt that an important suggestion, due to the stigma of waiting outside the counsellor's office, was that perhaps the counsellor could arrange to meet with a student in another location or classroom. These suggestions, and others, will be discussed in more detail shortly.

Contributions to Post-High-School Research

I think the most important contribution to the research is the change from hiding one's struggle with depression to speaking openly about it. From the way Brittany and Christie explained the change in their outlooks, it had to do with the atmosphere of the educational institutions they were attending. This brings to light the power of attitudes, tolerance, and acceptance and the effect it has on the oppression of people with mental health issues.

Summary

Focusing on the role that high schools have in the perception, disclosure, supports, barriers, and stigmas of someone with depression, my research was able to both support some of

the research previously conducted but also introduce new information to that knowledge base. As a review, this research has uncovered the following relevant experiential additions: the need for counselling, blocking of memories, fear of being a burden, overall embarrassment, the effect of emotion upon others, external factors in disclosure, a need to decrease the sense of aloneness, identifying a trusted teacher, test accommodations, difficulties with traditional test setups, the effect of grades, and the influence of atmosphere regarding mental health. Using these points and other information from the restories, Chapter Six addresses the research question with an interpretation of the data.

CHAPTER SIX: INTERPRETATION, CHALLENGES, AND OPPORTUNITIES

At the beginning of this dissertation, I identified my research question as the school experiences and storied remembrances of individuals who divulge diagnoses of depression to classmates and school personnel with an emphasis on the supports and barriers experienced by the students. I noted that researchers, governments, schools, and the students themselves are more closely looking at mental health issues and their effect on adolescents. With almost 20% of youth experiencing depression (Adamson, 2010), there is a glaring lack of firsthand accounts about the effects of depression on the adolescent population (O'Mara & Lind, 2013), and there is no evidence-based material to assist schools in offering support (Crundwell & Killu, 2007). In the literature review, I examined two populations (students and teachers) and the research regarding their experiences in a variety of school-related depression situations. These circumstances included perception and knowledge of depression, disclosure of depression and the social implications, supports available and received in school, barriers encountered in school, and stigma and self-stigma.

Chapter Three outlined narrative inquiry as my choice of research method because I felt that obtaining the firsthand accounts mentioned by O'Mara and Lind (2013) and providing some initial sources for evidence-based approaches as suggested by Crundwell and Killu (2007) could most accurately provide the information needed to investigate my research question. More importantly though, it brings to life the everyday experiences of someone who has depression and how he or she manages the illness. Then, in Chapter Four, using their own words and expressions, the participants told their stories of initial diagnoses, the problems they faced, the help they received, their own feelings about depression, and their future plans. Next, I examined some of the cross-themes that were evident strictly in the participant restories. I then thoroughly

investigated the themes, cross-themes, and other areas of interest I derived from the review of the three restories and compared my observations to the literature discussed in Chapter Two, noting any links or contradictions.

In this chapter, I turn to my research question, outlining the interpretations I have made of the restories, dividing the experiences into three time frames: beginning, middle, and end. Looking back at the research process, I identify some of the challenges faced with my recruitment of participants, including stigma. I also look to my own voice and biases, especially as someone who also has depression, and identify possible preconceptions. Finally, I discuss additional limitations of my study and propose ideas for further applications and research.

Examining the Research Question

Through the use of story, I explored the school experiences, supports, and barriers of three participants who shared, with peers and teachers, their diagnoses of depression. The main question for this research is actually quite encompassing: What are the school experiences and storied remembrances of adolescents who divulge a diagnosis of depression to classmates and school personnel? I intended the question to be very broad because I did not want to diminish the importance of some experiences over others by focusing the question; I do so in the second and third questions, but not for my main research interest. The other questions are: What educational supports did they receive, and what educational barriers did they face?

However, upon meeting the participants and hearing their stories, I realized that there is a lot more to consider than just the original questions. The answers to those questions are just a fragment of the story, plucked out of the middle of a chapter, to borrow Christie's analogy, and cannot be fully understood without the rest of the characters, plot, setting, theme, and style. This fragment, without context, has no meaning, and it is important in narrative inquiry to understand

who the participant is before analyzing his or her responses to any question. Now, with the whole of the stories, I am able to uncover specific aspects to interpret the school experiences of the participants.

Interpretation of Restoried Information

In general, all three participants experienced positive school experiences when they disclosed their diagnoses to friends and teachers. Most specifically, Brittany's peers provided a good atmosphere for her disclosure, Christie had encouraging experiences with both peers and teachers, and the Mental Health Worker's student was well accommodated by the principal and teachers of his or her school. I see their restories unfolding in this way: a beginning, before and at the time of diagnosis, prior to the school environment; the main story, that of the experiences of the students' disclosure and the ramifications; and the end, where the students are now, physically and emotionally. There are some overlaps within the sections, as it is difficult to isolate various topics without using examples and outcomes.

The Beginning

Trigger

Both Brittany and Christie experienced a severe emotional loss that they identify as the point at which their depression began. For Brittany, it was a difficult breakup and for Christie, she lost her dog whom she had found to be her only support. Experiencing the loss of a strong emotional bond and the resulting depressive episodes may have left a feeling of emptiness. To fill that void, they may have turned to their friends and relied on them more than in the past. They could then deal with the loss by talking with these friends and perhaps even substituting the emotional ties that were lost with the further development of friendships, leading to the point of disclosure. This could be very true in Christie's case, as she described her dog as her "four-

legged pal . . . I could just talk it out and I know I wasn't going to be judged, I knew I wasn't going to be yelled at, hurt, or anything." As she had no support from home, if her two friends had developed into a replacement for her dog, having them turn on her, judge her, and hurt her only confirmed her belief in the need for her dog. However, as the dog had passed away, she might have wanted to recover that acceptance again, leading to her disclosure. At first, Brittany seemed to fill her void with drugs and alcohol, isolating herself from her friends. But, like Christie, she soon wanted her friends to understand and accept her once more. I believe that the need to fill the void left by emotional loss could lead to the necessity of disclosing one's diagnosis to whoever can fill that void.

Diagnosis

Brittany states that her diagnosis "wasn't a big shock, I guess, because I've dealt with my dad dealing with it." Christie, however, was

> devastated, like even more than I already was because I'm very critical of myself. I want to fix it, I want to do better, I want to be the best I can be. So, when she told me that, I was like, this is something I can't fix.

Both experienced the initial effects of depression, although Christie seemed either to get worse symptoms or she was more elaborate in her storytelling: the need to be alone, lack of motivation, physical pain, and a feeling of being overwhelmed. Due to the difference in handling their diagnoses of depression, it appears that one's reaction may have little influence on later disclosure.

Independence

Both Brittany and Christie, having grown up without much supervision, may have learned to be self-reliant. They indicate that they "know how to handle myself" and that it was

important to “help myself first before I could help [others].” This could have led to their very selective disclosures. For instance, Brittany felt confident in knowing how someone would react to her disclosure, and she was strategic in selecting who to tell, and Christie told those when it “made sense to tell them.” Christie also developed guidelines for her friends to follow should she have a “moment”; she told them that when she acted a certain way, if they responded in a specific manner, it would be helpful to her. This self-knowledge is also demonstrated in what both Brittany and Christie are now doing: helping others, talking about depression, and trying to eliminate mental health stigma. Being self-aware can demonstrate strength of character and may support the divulgence of one’s diagnosis and the ability to become an advocate for mental health.

Familial Involvement

Brittany received a lot of support from her family upon diagnosis; her mother had had depression in the past and her father had his own diagnosis of SAD. She admits that “if my parents had no idea what depression was, my life would probably be much different” but her mom knew a lot about depression and she was a big support for Brittany. She thought she probably “had it decently good compared to other people.” Christie, however, did not get support from her family. They were embarrassed, a barrier in her life, and still continue “trying to piece more things together so that they can kind of accept that I have it but they just don’t understand really what their role is yet.” Due to the lack of involvement of Christie’s parents, there may have been a need to seek teachers as a source of adult support, whereas Britany may have had all the adult support she needed with her parents. Based on this research, neither positive nor negative family involvement can be supported either way in the disclosure of one’s diagnosis.

Counselling

All three participants partook in counselling before and during, their disclosure; Brittany was already in counselling at the time of her diagnosis. In at least two of the cases (Brittany and Christie), they discussed their diagnosis with their counsellors, as well as their emotions and emotional control. By having spoken openly about their diagnosis with their respective counsellors, they may have been more prepared to discuss their experiences with depression, having done so, as Christie mentions, "over and over again" in therapy. They had already put words to their diagnosis, their feelings, and their experiences, so they were not trying to explain something for the first time when talking with others. It is unknown whether the Mental Health Worker's student spoke with peers, but it is suggested that he or she may have: "The students see their friends as a support, but when I speak to the individuals, some of the support can be a little misguided." Even though the student was not willing to personally meet with the teacher and principal, the student was still open to the idea of communicating his or her diagnosis with others to obtain support.

Christie says:

> A lot of people just think it's easy to say if you just say the broad statement like "I have depression" but they don't really realize like how difficult it is to say it in that simple form just because of the components with it. So, you wanna talk about the effects that it has on your brain and on your body and the way that you are with people but you don't want to say it all at once and kinda overwhelm them.

This indicated a willingness to talk, extensively, with others. Brittany was almost nonchalant about her disclosure:

> I told my friends when I was 16 just so they knew what was happening with me because I

> kinda had isolated myself. I wasn't really myself, and I was kinda experimenting with alcohol and drugs and stuff, and I decided to tell them this is why I'm doing this. Like, I'm not crazy, I guess.

Brittany may have been more prepared, or perhaps she had other support that may have increased her confidence. I postulate that having the support of, and talking with, a counsellor could make one more open to including others, thereby supporting the disclosure of one's diagnosis.

Summary

This research indicates that depression beginning with an emotional loss may create a void that the student feels the need to fill. In these instances, disclosure of their depression to others could fill that void. It appears that an adolescent's level of independence and the support of a counsellor may also be a factor in disclosure. Advocacy work could then eventually grow out of these disclosures. The research does not seem to indicate that a student's reaction to his or her diagnosis or the level of family involvement has any bearing on the whether or not a student discloses his or her diagnosis to others.

The Middle

Disclosure to Friends and Reactions

Several items regarding this topic have been discussed previously. Brittany and Christie may have disclosed their depression to friends to fill an emotional void left by their losses, and they were both selective in whom they told about their depression. Furthermore, Brittany's and Christie's discussions with their counsellors may have provided practice in explaining their situation. This could have translated into greater comfort in speaking with friends, as discussing their depression was not an entirely new conversation.

Both Brittany and Christie were aware of the stigma of mental health, and Brittany spoke

of “a fear of being rejected.” However, as Christie says, “I don’t know, just try to save any friendships I could,” the need for their friends to accept them seemed to override any fears of being rejected. As a result, both Brittany and Christie experienced friends who remained genuinely interested and concerned about their mental health issues, but they also encountered those who were more dismissive. The less supportive friends, though, did not seem to cause any issues and did not spread the information to others within the school. This research indicates that there may be a need to tell others about one’s experiences with depression. Preparation, through counselling and careful selection, could be significant in obtaining a positive and supportive outcome with friends.

Disclosure to Teachers and Reactions

Christie was initially encouraged to disclose her diagnosis by a teacher who expressed concern for her well-being. Other disclosures to teachers were either purposeful by Christie or discovered by the teachers themselves. The teachers were very supportive of her and her diagnosis and Christie says, “some even apologized to me because of what they said beforehand because I got a lot of parent–student interviews in high school just because of my academic performances and behaviours.” The Mental Health Worker’s experience with both the principal and the trusted teacher was also very positive and helpful. These experiences seem to indicate that teachers are open to hearing about depression-based issues that affect their students and react in a positive and understanding manner.

Educational Supports

In both cases where educational supports were sought, Christie and the Mental Health Worker’s student, accommodations were made that helped ensure the academic success of the participants. In Christie’s case, it seems that one teacher voluntarily began accommodations upon

learning about her depression and the other teacher complied, without complaint it appears, upon request. The Mental Health Worker, along with the trusted teacher and the principal, worked together to ensure the student received the accommodations he or she needed to be able to complete the exams in a way that was much less anxiety inducing. The supports requested and received were: different seating arrangements, cues to indicate needs between student and teacher, alternate locations for test writing, and modified exams. According to the participants, these approaches worked very well and helped them succeed in their high school classes. This information provides evidence-based research material to confirm that seating arrangements, cues, separate locations for tests, and adapted exams are possible methods to help ensure students with depression have the tools they need to succeed. It also demonstrates a willingness of teachers to accommodate students within their classrooms.

Educational Barriers

While the participants did note some general educational barriers that could be obstacles, only Christie mentioned one that affected her: the grading system. However, I find that this statement is too large and vague a comment to broach in this research.

Stigma

Neither Brittany nor Christie indicated that they were subject to any form of stigma, although they were aware of the general stigma about mental health issues around them. However, examining the restories from a different point of view, could all three participants be stigmatizing their teachers? Brittany says:

> I know our school separated us into applied and academic so it was like a little bit of a stigma for people who needed extra help. So, that's why I never really came out to the teachers 'cause I didn't want them to think I was dumb or something like that. . . . I didn't

> trust my teachers in that way and it's not like a relationship I could have had with my teachers to talk about stuff like that.

First, is it the students or the teachers who created the stigma for those in the applied classes? Had the teachers demonstrated, in some way, that they believed people who required additional support were lacking in ability? Granted, trust is a different matter; it is on a personal level. However, if the decision to trust someone is based on fallacy and not actual experience, is it a fair statement? Christie had similar comments about trust: "I don't want [my depression] to burden in any way and . . . I don't want to be seen differently by them." She did speak with the teachers she trusted but seemed to feel differently about others. Did those teachers lose her trust in some manner? The Mental Health Worker also mentions "opening up the dialogue that we need to have with the schools to take away that stigma." She did not say she had encountered any resistance or stigma with schools previously. Without knowing what the Mental Health Worker's student was thinking, it is impossible to comment on why he or she felt the need for an intermediary. However, the student did identify a trusted teacher and included that teacher in his or her team of support. It is my belief that instead of encountering stigma, the participants may have stigmatized teachers in general and automatically disregarded some as a possible support.

Summary

"The Middle" initially overlaps with "The Beginning," as the need to talk to others about one's depression and counselling's role in preparing the student for this has been mentioned. The research then demonstrates that friends may be either supportive or noncommittal toward the student. Teachers' reactions to students who have depression include a willingness to listen, learn, and understand the issues faced by the student. The teachers are also open to supporting the students in the way of seating, nonverbal cues, and adapted tests and exams; no barriers were

uncovered. Finally, stigma does play a role, but it may be the students stigmatizing the teachers as people who are untrustworthy and who will disrespect the students' experiences with depression.

The End?

Environment

Brittany and Christie noticed a definitive change in the educational atmosphere in moving from high school to postsecondary education. They both felt that mental health issues are spoken about more often and in a more positive light in postsecondary education. This openness likely led to seeking out accommodations as well as their advocacy work with others; they may have felt safer and less afraid of judgement. When compared with the negative atmosphere in their high schools, this research indicates that the atmosphere of the environment can have a significant impact on one's overall experience with depression.

Accommodations

All three participants eventually received accommodations in postsecondary; Christie and the Mental Health Worker's student sought accommodations almost immediately, while Brittany waited a while before accessing this service. It is interesting that all three participants were open and trusting of their postsecondary institutions without much, if any, evidence of the possible trustworthiness, whereas trust was a significant factor in high school. Both Brittany and Christie report success with their accommodations, and Brittany comments that her exams were "100% better." I believe that a positive atmosphere in an educational institution can create a feeling of acceptance, which can then be translated into trust and honesty with regard to academic needs.

Advocacy

At the time of the interviews, Brittany's and Christie's advocacy work was of the utmost

importance to them. This may have grown out of the frank conversations that they shared with some of their friends in high school and then flourished in an environment that had more positive views of mental health issues. I believe that their interest in sharing more information about depression drew Brittany, Christie, and the Mental Health Worker to my research. When they saw the poster or read the e-mail, they may have realized that I could be another way to share their stories, to tell others, and to pass on their experiences. Christie ends her interview with: "I just wanted to help with this research. I just like wanted to say thanks for the opportunity, like hearing my story. It could be just staying in your big essay, or it could grow, it could do anything." Based on the very different paths that one can take to reach the possibility of an advocacy state, this research cannot speculate on the route to becoming an advocate.

Summary

It may be that the desire to tell one's story attracted the participants to this research. This desire seems to have emerged from positive experiences within their postsecondary institutions and the accessibility of accommodations, as I believe that they would not have shared their stories while in high school. There appear to be no quick and fast answers about creating an advocate. But, perhaps garnering someone's trust or offering a sense of security can be easy, under the right conditions.

The Stages of Grief

Interestingly, the way the research unfolds and the designations of beginning, middle, and end follows the last phases of "The Stages of the Grief Cycle" as presented by Danes (2008), who adapted Kübler-Ross's 1969 work, *On Death and Dying*. Of course, one can move back and forth through the grief cycle (Danes, 2008, p. 4), but the layout presented seems to represent the participants' movements within their stories. The first two stages, "Shock and Denial" and

"Anger" are not represented in the restories and were not covered; but, by adjusting some subheadings from Danes's (2008, Figure 4, p. 3) work, "Depression and Detachment" (diagnosis, struggle to find meaning), "Dialogue and Bargaining" (desire to tell one's story, reaching out to others, exploring options, putting a new plan in place), and "Acceptance/Returning to a Meaningful Life" (empowerment, self-esteem, meaning) seems to fit well within the interpretation of the restories. Perhaps this link with the stages of grief can be studied at a later date.

Summary

There is no map to guide one through the disclosure of depression to peers and teachers. This research presents just three of the stories of those with depression who have come before and, from that, perhaps some insight can be gleaned into what may or may not work for someone in future. However, each person is unique, as are their experiences: Their beginning may be different, their middle may be their now, and their end may be their true beginning. While this research provided some confirmations of other studies and outlined some new findings, that is not necessarily the true learning to take from this work. In contemplating my entire dissertation journey, I believe the one thing to remember is that one cannot understand another's depression without first understanding the person and the context of his or her life at that moment. Only then can one offer assistance on any meaningful level. There are no static plans that will suit every student who has depression, but rather unique solutions for unique individuals. Students are people first, not their diagnoses, and should be treated as such.

As my research often identifies topics specific to students and teachers, I offer some suggestions aimed specifically at students and schools, which can be found in Appendices B and C respectively.

Research Challenges

Participant Recruitment

My research was not without several challenges, the largest of which was participant recruitment. Originally, I had wanted to use purposive sampling as I felt the characteristics of the participants would need to be quite specific to provide the information I required to complete the study (Johnson & Christensen, 2012; Seidman, 2006). Ideally, the participant would be between the ages of 18 and 21 and have disclosed a diagnosis of depression to both high school classmates and teachers in the past 3 years. Furthermore, to obtain the narrative, story-based research data, conducting face-to-face interviews was important, so the participants needed to be within driving range (up to 300 kilometres). My initial plan was to meet with the various candidates, determine if they fit the research criteria, ensure they were aware of the commitment needed for the research, and explain the details of informed consent (Seidman, 2006). I would also inform the participants of my own diagnosis of depression to ensure they were fully informed of my background before considering sharing their own. This would give both parties the opportunity to determine appropriateness to continue. I had hoped that, as Rudnick et al. (2010) indicated, there would be several students with depression who were interested in sharing their stories for varying reasons such as removing stigma, helping others, and public disclosure.

Within the first few weeks, I had a number of respondents. Interestingly, most were first-year postsecondary students who had divulged their diagnosis of depression upon entering postsecondary education and did not fit the criteria at all. Despite their eagerness to assist, I was resolute in the need for high school experiences of disclosure, and only two students fit that criterion. Several more weeks went by without respondents, and I interviewed the two students I had already identified. I then began approaching other organizations and agencies that interacted

with youth. I relied on telephone calls to these various locations, explaining my research and asking that they place posters advertising my need for research candidates. I also tried to encourage snowball sampling whereby participants or others approached could help identify additional potential participants (Bogdan & Biklen, 1992; Creswell, 2008; Johnson & Christensen, 2012). After many months, I still did not have a third participant. However, a mental health worker, who had attempted to encourage one of her clients to come forward but was not successful, offered to speak with me instead, and I accepted her compromise. Overall, while not ideal by the initial standards of my research, it came to pass that the three participants in this research gave me much broader, and different, examples than I could have expected surrounding the issues of disclosure in high schools and how students are expressing their needs.

Reevaluating my strategy, I would not have changed my criteria for participants but I would have changed my recruitment technique. The posters appeared to be ineffective as only one participant was obtained in this manner, and they were obviously not clear enough based on the phone calls from people who had disclosed their depression in postsecondary institutions. In retrospect, I would have obtained permission to speak for a few moments in some of the larger classes at the university and college, introducing myself and explaining my research. With the organizations and agencies, I would have asked to speak at meetings or gatherings that may have been held for the youth. In this way, the message would have been directly delivered to the target audience and the youth would be able to see me as person, someone who also has depression, and a researcher, not just an anonymous name on a poster.

Stigma

As I mentioned in Chapter Three, stigma in general may have had a significant role in whether or not a potential candidate initiated contact with me. Both Brittany and Christie

indicated that now, in postsecondary education, they were very open about their experiences with depression. They were already active in fighting the stigma surrounding mental health at the time of their interviews and felt comfortable speaking about their illnesses. But what of those who still felt stigmatized, either externally or within themselves? Even Christie, in her interview, acknowledges "that a lot of people like my age range in general don't share their stories 'cause they are just afraid of what's going to happen next" and they "don't talk about [depression] for a variety of reasons." Friedson (2013) identifies that "for many people who are depressed, it becomes harder to tell their story. Attempts may have been stilted, muted, and disconnected from one another. Others may be quite articulate in describing their inner states, but the 'why' remains elusive" (p. 6). Possible reasons for this silence were discussed in Chapter Two under the stigma headings.

In 2011, there were nearly 1.8 million young adults between the ages of 18 and 21 in Canada (Statistics Canada). If 20% of these people are or were affected by depression (Adamson, 2010), there is a potential research base of 360,000 youth. Then, if 50% of the potential participants are unwilling to disclose their depression to anyone (Leahy & Robb, 2013), that leaves 180,000 youth with depression spread across Canada who may be willing to *seek help*. But how many of those are ready to *speak out*? Although I mention in Chapters One and Two that it appears more adolescents are talking about depression, it is perhaps in the hundreds (A, 2015; Children's Mental Health Ontario, 2015; MHCC, 2012; Roumeliotis, 2011), not the thousands. If I, as suggested in the section above, had made personal presentations to adolescents, I might have reduced some self-stigma or fear about speaking with another about their experiences with depression and garnered a broader base for my research.

Researcher Biases

I cannot imagine a research project that does not have some sort of bias; mine is not an exception. As a person with depression, interviewing others with depression was interesting. I could relate to much of what they said and was truly captivated by experiences that I had not had. Following, I examine the biases that may have affected my research and the outcomes, such as the transcription and restorying process, my own voice, and my preconceptions.

Transcription and Restorying

In an interesting analogy, Mishler (1991) compares transcription to photography, stating that "the connection between image and reality is not simply 'there,' even when we might naively expect it to be in the case of a photograph. It must be made (i.e. constructed)" (p. 259). This construction begins before the first interview with the call for participants (and perhaps even before then with the original thought) and continues throughout the interviews, transcriptions, restorying, analysis, and meaning-making. As the researcher, the way in which I choose participants, how I listen and question, and how I interpret the audio recordings of the interviews is similar to how a photographer may set up a photo—choosing the subject, selecting the lenses, and using various techniques in the darkroom. It is all constructed and very much "an interpretive practice" (Mishler, 1991, p. 259; Riessman, 2008, p. 50).

I wanted to present the participants' stories as a whole, with beginning, middle, and end, and not as excerpts. This worked well for Brittany and the Mental Health Worker, and I was able to restory their entire interview. However, as I began work on Christie's transcript—with 4 hours of audio and nearly 70 pages of text—I realized her story had to be condensed. I did not want to stray from using her original words and ways of speaking, so I had to decide which parts of her story could stay and which had to go. Some of it was easy; there were off-topic conversations

and then a lot of information she decided she no longer wanted to share. But, I was still left with about 35 pages of text that was too much to place in Chapter Four. I was the one who had to say "this part of her story does not enhance my research," and each time I deleted a section, I felt as though I was chipping away at a marble statue of Christie, taking who she was and making her something less. I was also using my own interpretation of what was important to the research and what was not. Friedson (2013) agrees, saying: "Who am I to decide which elements warrant our attention and which become insignificant by their omission?" (p. 24). In both this chapter and Chapter Five, I felt the repercussions of my decisions as I looked for a specific statement I knew Christie had made, only to discover that it had been disregarded and was no longer part of the research.

My Voice

As someone with depression, my voice is woven throughout this research. In Chapter One, my building passion for my research begins to take shape and I share my own stories to begin the process. Chapter Two experiences the whispers of my thoughts as they enter the literature review, my opinion on various topics difficult to exclude. Chapter Three demonstrates my strong interest in narrative research, and then, in the participant portraits, I use my own opinions to describe them, to give them life. In Chapter Four, the participants speak for themselves, but Christie's story was significantly reduced by my own valuation of portions of her story. The analysis in Chapter Five, followed by the interpretation and summary within this chapter, are all my thoughts influenced by the research conducted. As the researcher, I am the one who provides the context, not the participant. At this time, I noticed interview holes: areas where I could have delved more deeply into a comment but, likely due to my own preexisting knowledge of depression, I left unexplored because I understood what was being said on a

different level. Now, in analyzing my research, I realize the importance of how those holes could have been used to enhance overall understanding.

My Preconceptions

My knowledge of depression could be viewed as a preconception, but I am aware that depression is experienced in many different ways depending on the person and his or her circumstances. I did not know what to expect from the participants until I was actually speaking with them. At the beginning of my doctorate, a few people were telling me about students who were speaking out about depression in classrooms. From this, I imagined that finding participants would be an easy task; I was wrong. Also, before beginning my actual research, I had heard of a guide for teachers from the OME about mental health. Upon first glance, I envisioned a document that would help erase stigma from our schools and ensure all students with mental health issues received the accommodations they needed. After extensive research into the guide—which occurred after the interviews—I became thoroughly disillusioned with the education systems and my opinions became difficult to restrain in the literature review. However, I do believe I gave a legitimate representation of the guide by using examples and references.

Additional Limitations

> There is a story I know. It's about the earth and how it floats in space on the back of a turtle. I've heard this story many times, and each time someone tells the story, it changes. Sometimes the change is simply in the voice of the storyteller. Sometimes the change is in the details. Sometimes in the order of events. Other times it's the dialogue or the response of the audience. But in all the tellings of all the tellers, the world never leaves the turtle's back. And the turtle never swims away. (King, 2003, p. 61)

In the retelling of any story, it is the new storyteller's version that one hears. And thus it is

with this research. I was told a story and I have retold it, but no matter how close to the transcription of the interview I stay, some of the voice, details, events, and conversations are lost. Then, in the analysis, I looked at what was said and segregated the restory into themes that I chose. Finally, I led you, the reader, through my own interpretation of the retelling of the story (Friedson, 2013).

There are several limitations to this study, some purposeful and others that occurred naturally. The above paragraph demonstrates a purposeful limitation; I knew before I began that the research would follow the route of retelling a story. Also, narrative inquiry generally requires the participants to delve into the past and relate a story of experience. Recollection "is an interpretive and reconstructive process" (Freeman, 2014, p. 16), and as the memories are recalled there is also the question of who is speaking. "Is it the adult interpreting the childhood experience, in which case it is the adult speaking?" (Clandinin & Connelly, 1994, p. 424). Therefore, stories from the past are also influenced by the knowledge gained between the event and the telling (Shields, 2005, p. 180). I was also purposeful in choosing a small sample size because I wanted to become immersed in the experiences of a few individuals rather than get a general sense of the stories of many people. Finally, I also chose a small geographic area strictly due to logistics.

However, there were three limitations that emerged that were beyond my control. As only three people volunteered for the study, I did not have the option of choosing participants who fit the criteria I had originally intended. Surprisingly, though, the participants I did obtain offered a wider scope: one participant spoke with peers, one dealt with both peers and teachers, and one used an intermediary to speak with teachers. It was an interesting combination and certainly added different perspectives to the research. Second, the respondents were all female. While I do

not know the gender of the Mental Health Worker's student, the fact remains that the participant was female. How would a male participant have affected the information I gathered? How would he answer the questions, and what would be his mannerisms? As an interesting bit of information, one of the respondents to my initial recruitment was a male, but as he had only disclosed while in postsecondary, he was ineligible for the research. Last, both of the younger participants were university students and the Mental Health Worker was likely university educated. If the participants had different backgrounds, would the stories change? Would they also be advocates?

Opportunities for Further Study

I was aware, before starting this research, that there would be many branches of knowledge along the way that could be used for further research. The mere fact that I used narrative inquiry means that this study cannot be exactly replicated and what I have presented here is only one interpretation of the restories. Furthermore, as mentioned several times, there is a lack of research in the area of adolescents, depression, supports, and experiences. I say:

> Take what has been learned here and continue looking for answers into the educational experiences of students with depression and other mental health issues. Back up this work or disprove it; it does not matter as long as we are looking to adolescents for their personal experiences within the education system.

The goal, of course, is to gather and use this research, along with other studies, to make changes and ensure all students with depression (and other mental health issues) have knowledge of, and access to, accommodations and stigma-free learning institutions.

There are other research opportunities that presented themselves during the research, both within the educational system and without. It would be interesting to learn about the prevalence

of mental health stigma in schools and then share the successful aspects of those schools with the least stigma. Research into the use and success of the suggested OME (2013c) mental health promotion strategies should be done, of course, as it is a government-funded initiative. Identifying practices to assist students with the transition to postsecondary, much like the Mental Health Worker provided, may make that change more accessible and smooth to students with mental health issues such as depression and anxiety. Finally, based on my experience when trying to obtain participants, it seems that more people disclose diagnoses of depression once they reach postsecondary, and investigating why this might be could be useful to high schools.

Looking outside the education system, there were three questions that really stood out. Discovering more about the LGBTQ community and what they have done to garner increasing acceptance (or, some might argue, tolerance) may be able to help those with mental health issues develop their own community. The psychology of disclosure, while alluded to briefly when examining the research question, would be an interesting study and likely to provide some answers and guidance for those struggling with telling others about their depression. Last, one may easily agree that the stages of grief apply to being *diagnosed* with depression. However, another thought-provoking idea would be the application of the grief cycle on a larger scale, such as diagnosis, disclosure, and advocacy, as suggested earlier. These research questions are reflective of my own interests, and others may choose to expand on my research as I suggest or they may begin their own research using either the ideas above or other possible avenues that I did not see. The point is to continue asking questions and seeking answers.

In 1966, Robert F. Kennedy said:

> Few will have the greatness to bend history, but each of us can work to change a small portion of the events . . . It is from numberless diverse acts of courage such as these, the

belief that human history is thus shaped. Each time a man stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope, and crossing each other from a million different centers of energy and daring, those ripples build a current which can sweep down the mightiest walls of oppression and resistance.

EPILOGUE: CALL FORWARDING

I have never left school. I entered junior kindergarten with knowledge my parents had passed on to me and, since that time, I have always been in some sort of formal education. I finished high school (Englishes, sciences, and maths), completed my undergraduate work at Wilfrid Laurier University (operational business and classics), took a distance education course from the University of Waterloo (religion), completed my French as a Second Language diploma at Collège Boréal, graduated with a Master in Education from Nipissing University, received a certificate for Management of Volunteers from Humber College, and am now completing my doctorate in Education. Some may look at this history and say it is ambition or the pursuit of knowledge, that I am learning more to move forward in the world. But, I look at these disconnected avenues of knowledge and see nothing more than someone who is afraid to leave the comfort of being educated, where there is a teacher at the front of the room who has all the answers, and being thrown out into the world where the answers are not so clear.

However, I have also been on the other side of the "desk," although not necessarily in the traditional sense. My job as a teenager was to teach swimming lessons from Tadpoles through to Bronze Medallion, I taught Sunday School, eventually becoming Sunday School Superintendent, I trained hundreds of university students to tutor children and adults, I worked with some of those children myself, I trained even more people to become community volunteers, and I have done countless presentations and workshops based on my knowledge and experience in various areas. So, in truth, I cannot decide if I do belong in the education "system" where I can continue to grow and learn in various ways and even add my own thoughts and expertise to the structure, or if I am indeed hiding in here from the world.

When I started my Master of Education journey, I had originally planned to complete the

course route, as I was content to simply learn through those classes. I was not particularly interested in researching and imparting new knowledge through a thesis. It was not that I could not research and write—I had done an undergraduate essay for my classics minor and was awarded second place in a national competition—I just felt I did not have anything worthy to say. Throughout the first two years of my program, I learned many things, educationally and otherwise, but I think the most revolutionary awakening for me was that my personal life experiences actually had value in the outside world. From this came my eventual change of mind and an idea which is chronicled in my Master's thesis: a narrative self-study about depression in the workplace.

While happy to simply learn for most of my Master's program, when the opportunity to complete a doctorate became available, I was ready and eager to move beyond texts and do research in, and for, the educational community. Admittedly, my initial research ideas presented in my application were a bit . . . exuberant . . . and given what I know now, probably more suited to a 5- or 6-year grant, as I wanted to both design and test mental health modules in high schools over a 4-year period. Once I started classes, though, I listened. Listened to what my classmates and teachers thought, listened to their opinions, and listened to their stories. As I mention in Chapter One, I became intrigued by the idea of youth speaking out about depression, and I once again found myself contemplating narrative inquiry as a way to capture the experiences of these adolescents.

Stories resonate with me in a way that quantitative or even qualitative data do not or ever will. For instance, I may be aware of some of the details and numbers about World War Two, but it will forever be about my grandfather and his stories of crossing the Atlantic, guarding ships carrying supplies and passengers, of being sunk by U-boats half a dozen times and surviving,

and, most important, of landing in Italy and Tunisia. He never spoke about the War, but on his one and only visit to our home (he lived quite far away) I just happened to have returned from Italy and Tunisia, where I had joined an archaeology team, and was telling him about my trip. He suddenly stopped me and said, "I was there in the War" and began talking about a few of his experiences. I was captivated. He brought to life things I knew from history texts but to which I could never relate. His stories made the War *real* to me. My grandfather died just a few months later.

Similarly, I know, and live, the 1-in-5 statistic for depression. But, to me, even vague comments like Brittany's "mental health isn't like a small percentage, it's a bigger percentage" or Christie's blunt "It's not a million to one, people. It's like everybody has someone they can associate with" feels like it has more impact than saying 20% of people have depression. It is as though, by taking away the science and the analysis, information becomes more real, more raw, more *lived*. And, that is what I wanted to do for the education system: help people *feel* what it is like to have depression in high school and, from being *told*, learn what we can do to help.

I think, overall, my entire postgraduate experience has been about learning that we all have stories of importance that can be used to help others understand things they do not. Furthermore, that our stories are all unique in the way they unfold and the teachings, no matter how closely linked those stories are, are different in each case. And, finally, that even in asking a specific question in a narrative study (such as one's school experiences with divulging depression), you never can tell what you will get in return (a triad of pre-, during, and postknowledge) and how unexpectedly important that will be to the entire research.

Looking ahead, I would like to do more work in three areas: educating educators in mental health, working with adolescents who have depression to determine their needs for

success in high school, and then ensuring those students obtain those accommodations. However, with neither a Bachelor of Education nor a background in psychology or social work, there may be some obstacles in finding ways to do these things. Then again, I never have been one to let difficulties stop me.

Am I hiding from the world? Most likely. But can I contribute to that world from within the educational structure? Definitely.

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Appendix A

Interview Questions and Probes

Demographic

1. How old were you when you were diagnosed with depression?
2. How old were you when you first disclosed your diagnosis of depression to your classmates and school personnel?
3. How old are you today?
4. In which city did you attend the high school where you disclosed your diagnosis?

Interview 1: History

5. Tell me about your first experiences with depression. What was it like? What did you do?
6. Tell me about your diagnosis of depression. What happened?
7. Tell me about any support you received.
8. Tell me about any barriers you experienced.

Interview 2: Details

9. Tell me why you decided to tell your classmates and teachers about your depression.
10. Tell me more about that experience.
11. Tell me about any support you received.
12. Tell me about any barriers you experienced.

Interview 3: Reflection

13. Has the decision to disclose your illness impacted your life? Tell me about that.
14. Thinking back and knowing what you know now, would you have disclosed your illness?

15. Tell me what you would have done in the same manner.

16. Tell me what you would have done differently.

At the End of Each Interview

17. Is there anything we have left out of your story?

18. Do you feel you have given a fair picture of yourself?

19. What are your feelings about this interview and all we have covered?

Appendix B

Suggestions for Students

My first suggestion for adolescents diagnosed with depression is to seek help. Tell a parent, call Kids Help Phone, tell your doctor you want to see a counsellor or a social worker, talk to a teacher or your religious leader; tell someone. Peers are excellent options for supporting you through your depression but, in the beginning, you do need someone with adult experience to ensure you have the information you need to safely work through your diagnosis. Next, if you do not already have one, find a counsellor. He or she will be able to assist you throughout your illness and help you appropriately handle issues that arise, especially with regard to your emotions. It is also important to learn more about your depression. Your counsellor or doctor should have information for you, you can ask a pharmacist, or you can (gulp) check online. I am loath to provide links because I do not want to endorse one website over another, but here are some suggestions to help you find a good site: In your search, use words like depression, youth, and mental health (you could also add your province as well); do not use wikipedia.org (it can have good information but it is not your best source); do not use youtube.com (this site is not well moderated); do not click on depression ads; look for government, hospital, or well-known agency sites; look for sites that end in .ca (they will typically contain Canadian information); and use your good sense (you are more likely to find helpful information in a site called “Mental Health and How It Affects Youth” than one called “Depression and Why It Sucks”). You can also check my references for the websites I mentioned in my research.

Now, you have some choices and you do not have to make any decisions right away. Do you have a friend you can talk with about things like this? Would you feel comfortable talking with this person about your depression? If not, or if you are not ready now, it is okay; perhaps at

another time. Do you want to tell your school or a teacher? If your depression has caused a fall in your grades or a lot of missed school, as difficult as it might be, you may want to try talking to an adult in your school. Even if you have not had any difficulties in school thus far, you may still want to inform the school, much like you would if you had diabetes (see Corzine, 2011, p. 9) or a peanut allergy. I, myself, am listed with Nipissing University's Accessibility Services and have been throughout my doctorate program. I have not had to use their services, but it is nice to know that they are there if I need them. If you do not want to do this yourself or you encounter problems like Joan (A, 2015) experienced, ask a parent or the person you first spoke with to help you communicate with the school.

Think about any issues you might be experiencing from your depression that might affect your schoolwork. Are you tired at certain points during the day? Do you have difficulty concentrating? Do find it difficult to write tests? Does your medication make you ill or groggy, agitated or excitable? Are there many days in a row when you are unable to get out of bed? Think about these questions and others. How is your schoolwork affected? If your work is not affected, great! If it does become, or is affected, you may want to speak with the school or your teachers. They may already have programs or services in place to help you. Or, you and the teacher may be able to come up with solutions or accommodations to help you succeed in school. Again, ask a parent or other adult to support you, if needed. A few ideas were presented in this research by the participants: writing tests in a separate space or in a different format, areas where you can sit comfortably in class, *some* leniency with missed or incomplete homework, and cues to communicate your needs covertly with your teacher. Even more ideas are available in the literature review. Be sure you are comfortable with the accommodation and, if it does not work, look for alternate solutions.

As Christie suggests, try to tell all your teachers. They are there to help you, and by working together, you may have an easier time with all your subjects. The Mental Health Worker suggests finding one trusted teacher, someone you can turn to if you need to speak with someone during the day. Perhaps you have had a mood swing or you are feeling overwhelmed or you just need an adult with whom to speak. The trusted teacher can be there to support you through these "moments" and can also help liaise with your other teachers or your parents, especially if you need to go home early. Both Brittany and Christie do suggest that you find friends with whom to talk. However, you may want to be selective. Once you are ready to talk with others, think about people you can trust or have helped you work through a problem in the past. Perhaps a best friend, or, if one of your friends has gone through a similar experience, you could speak with him or her. As you become more comfortable, you may want to tell others about your depression. You may find that others are experiencing the same thing but, even if you do not learn of others with depression, it does help knowing you are not facing this illness alone.

Appendix C

Suggestions for Schools

The largest barrier identified by the participants is the need for full-time counsellors in all schools. As this is an extremely expensive proposition and not in the hands of individual schools, I instead turn to what those schools can do.

I think the most important suggestion I could make for any school is to devote an entire professional development day to learning about mental health. Set up the day like a conference by bringing in outside speakers such as counsellors, social workers, agency presenters, or even a local researcher or professor who studies mental health and youth. Although there is too much mental health information to cover in one day, try to get the basics and remember to allow time for teachers to talk with each other about mental health. Perhaps someone has been helping a student with depression or has heard of assistance another school provided; perhaps someone has experience with mental health issues, either their own of a family member's. Use scenarios and ask: What accommodations could be made for poor concentration? High anxiety? Inability to attend school? Panic attacks? Have the teachers brainstorm ideas so they are ready when, not if, a student approaches them with needs.

Supporting Minds (OME, 2013c) does provide a good overview of the definitions and symptoms of many mental health issues teachers will face in high schools. However, as there is no evidence-based research, the strategies in the document outlining supports for students should not be presented in a way as to suggest they have been proven to work. They are, in fact, mere conjecture. So, while the approaches in the guide could be helpful, the most important strategy is to ask the *student* what he or she needs, not the parent or the school team. While I am sure the document is not meant to be taken word for word, statements such as "seat the student near the

front of the classroom where the teacher can readily provide assistance or the student can easily leave as part of a coping strategy" (p. 47) should be viewed as "ask the student if there is a place he or she would feel most comfortable sitting." The same corrections should be made for the entire list and a reminder that each student will have different needs.

Next, as Joan (A, 2015) states: "I am not a problem. I am an individual" (time stamp 3:17), it is vitally important to look at the student as a person first. This person deserves every opportunity and chance for success that anyone else has. In a stereotype and attribution study by Riley (2009), teachers were provided cards that gave a student's academic history as well as a few personal background details such as a name or a label with Aboriginal or English as a Second Language. Given the academic history, the teachers were then asked to place new high school students into one of three programs: supplemental, regular, or rapid advance. Four teachers refused to separate the students, stating various reasons such as a need for academic and cultural diversity in classrooms and social growth. One indicated

> part of the teacher's responsibility is to try to meet the diverse needs of the learner regardless of that student's ability. . . . [lessons] should be 'open ended enough to include all kids and challenge all kids at whatever level they were coming in at.' (p. 84)

This teacher's response links well to my argument that students with depression should be accommodated within their classrooms and not placed in special education (Farmer, 2002) or told to drop out (A, 2015). These two experiences seem to be extremes, but there is likely a continuum of "accommodations" that vary from poor to acceptable to exceptional. The goal is to provide exceptional accommodations to all those who need them.

Finally, stigma. The stigma of mental health has to be eliminated. The OME (2013c) document mentions addressing stigma in the classroom but provides no resources to do so. It is

not enough to mention it in class; the whole school needs to become involved. There need to be posters, announcements, safe spaces, rallies, speakers, and days dedicated to the recognition of mental health. In Canada, there is Mental Health Week (first week of May), Mental Illness Awareness Week (early October), and World Mental Health Day (October 10); Bell's Let's Talk Day also occurs in late January or early February. That gives three or four opportunities to get students involved in mental health activities throughout the school year, and those are just nationally recognized events. But, students cannot be expected to initiate these events; the stigma is just too prevalent in many schools. The onus is on the teachers to work together and create initiatives, big or small, that help students feel safe, accepted, and recognized in their school community. Furthermore, teachers must also police themselves, encouraging antistigma talk in the staff room, in meetings, and in other casual conversations. They should also support one another in sharing accommodations that are working and identifying new ways to help students.