# Coping with Depression: Support, Stigma, and Deciding Whom to Tell

An Honors Thesis Presented by

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# Introduction: It's okay to cry

*"Is it okay to cry?"*

The words sounded strange coming out of my mouth, but the question was burning in my mind after my first experience with ethnographic research. My face flushed red with embarrassment as I asked my fellow thesis writers and seminar professor this seemingly simple question. I had been to a support group for people with depression and bipolar disorder and their friends and family, and after hearing these heartbreaking experiences, it was impossible not to react emotionally. Everyone in the room had been touched in some way by depression or bipolar disorder, and although they were all strangers before that day, there was a sense of trust in the room. I could not help but cry, even though I had always thought of anthropologists as impartial observers when in the field, putting nothing into the situation that could influence or change what is going on. Crying, I felt, would change the way they perceived my presence, but I learned that it is okay to cry. As anthropologists, our informants respect and trust us because we engage with their lives, and by crying, I was actually showing them that I care. Throughout my research, I was able to use this experience to help establish trusting relationships with my participants. Many of them ended up revealing incredibly personal experiences, like losing friends, crying in the bathroom, feeling like no one cared, or more serious distress like being raped, abused, or attempting suicide.

When I first decided to write this thesis, I had planned to write about the effects of postpartum depression on people's relationships. For several reasons, including the Institutional Review Board's (IRB) ridiculous demands, I switched my topic to the effect of relationships and social support on depression, which led to thinking about social stigma as well. I was somewhat disappointed at first—I no longer had the aspect of maternal and child health that I was interested in—but I was quickly immersed in my new topic, and I would not hesitate to change it again if given

the choice. Depression is one of the most intensely personal experiences one can have, and my participants allowed me to get a glimpse of what it was like for them.

As an anthropologist, I was interested in looking further into the subject, this time from a social and cultural anthropological perspective. The biomedical system is used so widely in America today that there are many people, including some of my participants, who would not even consider thinking about it from an anthropological perspective. Being from the culture that I was studying, I soon realized how hard it was to look at it objectively. I began to recognize just how deeply-rooted it was for me to think about depression from a biomedical or psychological viewpoint. This was the only way I had ever really thought about depression, and I had to retrain my brain to think differently.

Before starting this project, I knew several people who had experienced depression, and have personally seen the effects it has had on their lives. Because I had these preconceived notions about depression, I had to be careful to put them aside. I found that I both expected and was surprised by some of the things they had to say. Some of the people that I interviewed had been relatively fortunate, for the most part, growing up in loving, supportive homes, while others were not as lucky as they had been. The tone with which they spoke, the cracks in their voices, and the tears that flowed all emphasized to me what an unpleasant experience depression is, and for them to talk about and relive it as they explained it to me must have been difficult. One person had been abused as a child, one had been rejected by her family for her sexual minority identity, and another had been raped. These are not exactly something I would wish for someone to experience.

I decided to look at depression in American culture and the way people perceive it, deal with it, and are supported through it. Depression is often said to make people more socially withdrawn, but it may be a time in which people need support more than ever. The stigmatization of depression recognized in American culture also has a huge effect on someone's decision whether

or not to even tell those close to them, which can determine whether or not they will get any social support at all. Although there are many different ways someone can get support for depression, I focus mainly on the social support they get from friends and family members, regardless of whether or not they are aware of their depression.

In semi-structured interviews, I asked ten people who have been depressed and seven friends and family of people who have been depressed about their experience with depression, including their opinion on the way depression is represented in the media, the stigma around depression, and their accounts of changes in their or their friend or family member's social lives from the time before they experienced depression to the time of the interview. We also discussed their support and coping methods and considered how mainstream American culture may have influenced these practices. By asking about pre-depression knowledge, opinions on depression, and resources available, I found that the influence of mainstream culture varies significantly, depending on the individual. The cohort that I ended up interviewing is not intended to be a representative sample of all people that have experienced depression in the United States. The majority of my participants were white college students from Michigan. They had different degrees of self-reported severity, and the length of time they had been experiencing depression varied from a few months to multiple decades. Some had gone to biomedical doctors and received antidepressant medication while others had kept it to themselves and chose to deal with it on their own. Although they seemed to have a varying degree of knowledge of the exact definition, they all used a definition of depression similar to that in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Defining Depression

The term depression, as used in the United States, generally refers to major depressive disorder (MDD) or dysthymia disorder[1]. Major depressive disorder has been defined in the DSM-IV-TR[2] as five or more of the following symptoms, present for two or more weeks:

(1) depressed mood most of the day, almost every day,

(2) decreased interest in all or almost all activities, most of the day, almost every day,

(3) significant weight loss not attributed to dieting,

(4) insomnia or hypersomnia,

(5) psychomotor agitation or retardation almost every day,

(6) fatigue almost every day,

(7) excessive guilt or feelings of worthlessness almost every day,

(8) inability to concentrate almost every day, and

(9) thoughts of death or suicide,

At least one of the symptoms must be either depressed mood or loss of interest (American Psychiatric Association 2000). An overwhelming but chronic state of depressed mood for more than half the days for at least 2 years is characteristic of dysthymic disorder (American Psychiatric Association 2000). These criteria are required for a clinical diagnosis of major depressive disorder or dysthymic disorder by a psychiatrist or psychologist, although I have chosen to include both those who are self-diagnosed and those who have been diagnosed by a doctor in my research, as some people might view depression differently than a doctor would. As an anthropologist, I was

[1] Depression can also refer to a feature of bipolar disorder, but for the purposes of this thesis, I will focus on these two types of depression.

[2] The Diagnostic and Statistical Manual of Mental Disorders is the main source for mental illness diagnostic criteria for doctors in the USA. The current version is the DSM-IV-TR, updated in 2000 as a revision of the DSM-IV version published in 1994. A more detailed analysis of this will be given in a later chapter.

interested in how the people suffering from the illness of depression intersected with the American Psychiatric Association's "official" description of it as a disease.[3]

I asked all of my participants who had been depressed to explain what their experience was like with depression. It sounds like a simple question, but almost every answer was wrought with long pauses, a frustrated tone of voice, or hesitant phrases, such as "um," "uh," "like," and "kind of," as they struggled to find the words to describe the way they felt. Michael attempted to describe it, "I don't know, I just had this overwhelming feeling of just kind of…just like emptiness, nothing was like, I couldn't really see like…like they say, the light at the end of the tunnel, couldn't see things getting better, and I was just getting sick of that feeling." Some resorted to describing certain aspects of their depression in relation to particular situations, as Jessica described, "I would start crying over something so insignificant, that once I started to think about it, I would start crying again *because* I was crying over nothing, and it sort of became this never ending cycle of tears." Many also pointed to a frustration with being unable to shake the feeling and being unable to point to a specific cause:

> I didn't have the energy to even do regular activities, and the fact that there was no trigger for it was the big thing to me. It was that, I felt this, I knew that sometimes I would be down as a result of certain events, but there was nothing that would have caused this. Like, I was living my life exactly as I had lived it earlier, but everything felt different. – Matthew

Others indicated a lack of interest in hanging out with friends:

> It's kind of hard to describe, but it's kind of like, no matter who you're surrounded by, let's say you're at a party with your best friends in the whole world, you're engaged in conversation with them, you're laughing, but inside, I mean, you put on a great cover, but

[3] The disease/illness dichotomy, the difference between the sufferer's experience of illness and the validity based on the biological explanation for the disease, will be addressed in further detail in Chapter 3.

> inside, you kind of feel like you're on the outside looking in, you know, like you're looking through a window. – Emily

And some explained their belief that no one wanted to be around them and the social isolation that resulted from it:

> I guess it's hard to explain. It was really shitty because you just felt like crap. No one wants to be my friend, no one wants to be around me, and it was like this downward spiral of nobody caring and you not caring that they didn't care, but I kind of sorta did, but it just didn't make sense to care, if that makes any sense at all. - Sarah

A majority of people also spoke about feeling something different in their bodies that they could not exactly explain:

> I kind of felt myself gripping at my chest, and gasping for air as I was in class. That kind of threw me into this really agitated moment of myself, kind of freaking out, and myself not being able to be in the room any longer—I had to leave and cry in the bathroom. So, that was kind of a key moment, where I realized that something was going wrong with my body, with my system—there was something weird here. –Danielle

It was interesting to see how clinical descriptions given by psychiatrists could not compare to the actual lived experience of my participants. I have read about them, but symptoms written on a piece of paper cannot describe the experience as well as the people who have actually gone through it. It is one thing to read about depression in a book, but it is an entirely different thing to hear about it directly from them and see on their faces how it has affected them. Hearing about it from my participants emphasized to me how depression cannot truly be expressed as a list of symptoms.

This became clear to me even at the very first interview I conducted and only became more powerful with each interview. Michael described his experience with a list of the symptoms that he

experienced, but the most powerful part was when he described what it was like to feel the symptoms, what it was like realizing that he was depressed, and what it was like trying and failing to stop these feelings from overcoming him. The parts that are usually missing in the media's representation of depression were very present in his description of his experience, and gave me a much better idea of what depression is like than the media ever could.

In America, the idea that depression has always existed and has always been diagnosed by doctors and psychologists widely persists, but this is not necessarily true. There is a difference in opinion about whether or not it has always existed in the population whether or not it was actually diagnosed. Many Americans would be surprised to learn that the term "major depressive disorder" was not created until the 1970s, and did not appear in the DSM until 1980 (Philip et al. 1991). With each new edition of the DSM, the criteria for diagnosis of depression has changed, and as the American Psychiatric Association prepares to release the DSM-V in 2013, the debate is about *what* to change, not whether or not to change it.

Biomedicine has evolved tremendously as culture has changed over time. Diagnoses and treatments have developed as scientists have had new "breakthroughs." Diseases that were once thought to be social, like alcoholism, depression, or ADHD, have changed over the course of history to be defined as biochemical in the biomedical system. Depression used to be thought of as a purely social disorder. With recent scientific research, biomedicine has found that it exists as a biochemical imbalance, although it is impossible to ignore the social aspects of depression. For example, in 1929 with the start of the Great Depression, suicide rates spiked after Wall Street's crash, increasing by almost 50% between 1928 and 1929 (Vital Statistics 2009). They remained higher throughout the next decade, before returning back to a similar rate as before the initial spike, showing the effect that social aspects can have on depression and suicide rates (Vital Statistics 2009).

Although biomedicine has changed its views on this disease somewhat throughout this time, the social stigma[4] of the past still exists in society today. Sadness has different meanings and expressions in different cultures throughout time. As depression was resituated from having social causes to biochemical causes, treatments changed, and it began to be treated with medication. Experiences of depression have changed through time as well. As biomedicine has spread around the world, more cultures have adopted biomedicine as an explanatory system. Not only does society have an influence on biomedicine, but biomedicine has an influence on society.

In the same way, illness labels within biomedicine change over time as well. There are diseases that are no longer diagnosed, such as hysteria, as well as new diseases diagnosed as science "discovers" them, such as Attention Deficit Disorder. In 1952 when the Diagnostic and Statistical Manual of Mental Disorders was first published, it only had about 60 different disorders included in it, and did not include depression. As time went on and society changed, so did the diagnoses in the DSM. In the most recently published version in 2000, over 400 distinct diagnoses were given in the DSM (American Psychiatric Association 2000). Many new diagnoses were made in the years between the first publication of the DSM in 1952 and the most recent one in 2000, with the culture of the time playing a considerable part in these changes.

Research points to the fact that everyone experiences depression in their own way, but I had no idea just how much my own research would confirm this. For example, the DSM allows for diagnosis of differing levels of depression, including minor depression, which can be diagnosed if only two of the symptoms of major depression are present (American Psychiatric Association 2000). I came out of every interview with a different view of depression, and ended up changing my ideas and opinions about depression almost daily. Therefore, the ideas I had for this thesis changed as well. The people I spoke with made me think and rethink depression more than I ever

[4] I will discuss the social stigma around depression in more depth in Chapter 2

imagined, which made me wonder if people experiencing depression changed their thoughts about it as much as I did.

I decided to ask people whether or not they experienced depression the way they imagined it would be. The overwhelming response was that it was much worse than they expected it to be. As will be discussed, the way depression is depicted in the media, particularly in medication advertisements, the idea prevails that all one has to do to get over it is start taking medication and it will be cured. As Amy said, "All the commercials, like after you take the medication, they're skipping down the street, and everything's hunky-dory. It's like, no, it doesn't work like that at *all*, and if anything, hopefully one day, someone does emphasize it more, because that's huge."

Because they expected to be able to get over it whenever they wanted to if they worked hard enough, many interviewees described a frustration with themselves at first. Once they got over this frustration, they started to be frustrated with the way depression is shown in the media for misleading them. As Michael put it, "I knew it would be a pretty bad feeling, but I didn't know it'd be an ongoing kind of thing, like no breaks from it really, kind of just like you're down all the time and you can't get up." Michael has seen other members of his family suffer from depression, and he admitted that he was guilty, at first, of not understanding why his relatives could not get better, why some of them were, as he put it, "on Zoloft for life," but once he felt what it was like, he understood that they could not just stop being depressed. He understood that it was much worse than he and most people would expect.

## Depression and Speech

The ways many Americans talk about depression and the way it is represented in the media are partially responsible for Michael's, and other people's, misunderstandings of depression.

Depression is under-diagnosed and undertreated, partially because of the stigma around it and partially because of the misconceptions of what it actually is like. Many of the people I interviewed said that they either knew very little about depression before they experienced it or had a completely different idea about it than what they actually experienced. As Michael described:

> "The image [of depression] is definitely accurate in the regard that they show people not being able to do anything but it's different in like, I feel like people don't know—and the word 'depressed' is thrown around so much—I feel like people don't know what it truly means to be depressed. Like when people are sad, they'll be like, 'Oh, I'm depressed,' and then they'll be fine a few minutes later, but when you're clinically depressed, you aren't fine, like *ever*, so, I don't think people understand that."

He touches on the point that most people talk about "depression" in a sense that trivializes the way depression is felt as an illness, spreading the use of the word as a feeling rather than a disease, and the idea that someone should be able to get over depression in a few hours or days if they want to. There becomes a double meaning of the word, but because there is such widespread misunderstanding, most people do not necessarily know the difference. The "depression" that most Americans refer to, in this case, is not the illness of depression as they would define it. Rather, it is a general feeling of sadness that does not truly become depression and is easily overcome. Although people probably do not realize they do it until it is pointed out, this trivialization has a huge impact on the way Americans see and consequently seek help for depression. This informal use of the word contributes to this misconception, and many of my participants pointed to this as their reason for not realizing they were depressed until they had already been depressed for some time. They often spoke about not realizing that depression would go on for as long as it did because the little that they did know about it came from casual use of the term or its (mis)representation in the media.

People who have been depressed can also be to blame for the perpetuation of this stereotype. If people who have been depressed let others describe depression incorrectly and let the media misrepresent it, people who have not felt depression have no way of knowing that it is incorrect to characterize it this way. As Riesman (1950) explains, language is how we relate to each other and can act as a tool to figure out a person or society's mood or tone. When we use language that trivializes depression, and there is no one there to correct it, it becomes the norm, and we learn that depression is trivial, when, in fact, it is not.

Most people spoke about the change between how they thought of depression before they knew they were experiencing it and when they first realized they were experiencing it. There is a huge amount of secrecy due to stigma around it and this contributes to the misconceptions. Sarah, describing a possible reason for why there isn't widespread knowledge about what depression is actually like, said, "No one needs to know about it if they don't have to. I don't think other people really understand what I've gone through, but to some extent, I don't really want them to. If they can be saved from the horrible experience that is depression, then that's a good thing, right?" Jessica echoed this feeling, but most other participants felt that this lack of knowledge perpetuated the upsettingly inaccurate stereotypes. These stereotypes of depressed people, as people who ruminate over the state of their life without doing anything about it, are what perpetuate the use of the word in both contexts.

Due to the double meaning of the word, the symptom of sadness is overemphasized in American culture and the media while suicide is not highlighted very often, especially in relation to depression. Tatum et al. (2010:424) analyzed suicide coverage in American newspapers and found that, "suicide stories often detailed suicide method (56% of stories) and location (58%), and rarely provided information about warning signs and risk factors (1%), the roles of depression (4%) and alcohol (2%), and prevention resources (6%)." Friends and family members play a big role in

preventing suicide, but if they are unaware of the warning signs and risk factors, they will not be as capable of helping prevent it. Unfortunately, newspapers and other media are one of the main sources Americans have of information about depression and suicide, and when they leave out crucial information about suicide, there can be deadly consequences (Tatum et al. 2010).

Depression can be the cause of some of the lowest points in people's lives, so support from friends and family can be especially crucial during these times. Attempting suicide was the way Megan found out she was depressed. Being only 14-years-old, she was not completely aware of what depression was until that day. She said she could remember showing some of the signs of suicide that she learned about later, but that she and her family were not necessarily aware of the implications they had. People in America rarely talk about suicide, even those who have told their friends and family about experiencing depression. As Amy said, "I've never thought about suicide, but I've also never talked about it with anyone, really, not even my therapist other than to say that I've never thought about it." Jessica observed a similar response present in the media:

> "Depression commercials never talk about suicide, except as a possible side effect of taking their medication. There is this, sort of, rule that all people in depression commercials are sad, but not suicidal, and I think that that makes an already at-risk group of people feel even worse about themselves."

Suicidal thoughts can make someone feel more hesitant to tell their friends and family about it, even though they may have a harder time hiding their depression because of it. So, those who are the most in need of support are often the ones who lack it. Because the stigma is worse in relation to depression when suicide is brought into the picture, suicide and suicidal behaviors are seen on a completely different level than depression without suicidal thoughts. This makes people less likely to talk about it, contributing to the misconceptions about depression.

After doing this research and writing this thesis, I have come to the conclusion that most people think they know what depression is, but actually do not. They might know the clinical symptoms listed in the DSM, but they do not know the actual experience that people have with it. They lack that human element of the illness experience. My interviewees told me about all the symptoms that I had read about in the DSM and on the internet, but included their personal experiences in their descriptions. It was so much more than just a list of symptoms.

Outline of the Argument

Writing this thesis has changed the way I see depression. By looking at it in a completely different way, I hope that readers come away with a better awareness of what depression is and what the experience is actually like, as well as the social factors that go into the stigma commonly associated with depression, the effect this has on support of people with depression, and the consequent decision about which of their friends and family members to tell. These aspects of depression are all interrelated and influence one another. I also hope that readers start to see depression from a new perspective, from a different view than what most American sources will give, and start to think about it with the knowledge that depression is a complicated issue and one cannot be confined to thinking about it in such a narrow way, like that in which most Americans do. Nearly all Americans, at some point in their life, will be affected in some way by depression, whether it is when they themselves experience it or when they are responsible for supporting a friend or family member through it. This is why it is so important that everyone be able to see depression for what it really is and have a changeable view of it.

The first chapter in this thesis will provide a summary of how depression is represented in the media and how society perceives depression in American culture. I discuss the difference in how my informants saw depression before they experienced depression and how they saw it at the

time of the interview, after or during their depression. Pharmaceutical companies have successfully spread their message to most Americans that depression needs to be treated with antidepressants. The media has a huge influence on what information about depression that people are exposed to in America, which influences their attitudes toward it.

Next, I will discuss the stigma that surrounds depression in American culture. I argue that the stigma mainly comes about because of the inability to physically see the effects of depression on a person's body as well as the similarities between depression and the sadness that people feel in their everyday lives. Everyone has felt sad at some point in their lives, but most people are able to get over it quite soon after the impetus. This leads people who have not experienced depression to believe that depression is similar to the way that they have felt, leading to the stigmatization of people with depression, making them appear mentally weak.

In the third chapter, I will discuss the ways in which people can be supportive of someone who has been depressed and how using people for support, as with medication, can have consequences for the relationship. I discuss the types of things that my participants found more and less supportive and that there were certain relationships with certain people that they tended to find more supportive than others. I will also analyze how this may be affected by stigma and how both of these may affect who they decide to tell about their depression.

In the last chapter, I discuss the factors that go into a person's decision of whether or not, and whom, to tell about their depression and the consequences of telling these people. People can feel very alone when they are depressed because they do not often talk about it publicly. It is important that people know that they are not alone and that depression is much more common than they might think. Telling one's friends and family can either bring one closer with them or can negatively affect a relationship. It can sometimes even be a factor in the termination of the relationship.

# Chapter 1: Depression in Society and the Media

*"I did more research and I realized that I had experienced bouts of depression since middle school. I think it was really strange that I never understood that before. My experiences in life didn't seem like the commercials I saw or the portrayals of it on television. I sort of thought that everyone in the world just felt the way I did." –Angelina*

People learn about health in their culture by picking up on things as they grow up and learn about the world they live in. Americans learn about it from advertisements and television, movies and commercials, family and friends, and even strangers. In this way, Americans are not really *told* the difference between a mental illness and a physical disease, but are taught to separate them into two different categories. Depression is one of those mental illnesses that Americans hear a lot about, but rarely pay specific attention to. They may see it as a reference in a TV show, in a depression medication commercial, or mentioned in passing in a newspaper or internet article, but rarely do Americans seek out information on depression. They are bombarded with cultural information about depression constantly, but do not realize just how much of an influence they have on their perceptions of it.

Depression can be seen in very different ways depending on how someone has learned about it. Someone with personal experience with depression may have a different idea about it than someone with a scientific, medical background, which can also be different from someone who has no experience with it outside of what they see in the media and hear from their friends. There are a wide range of opinions about which ways are best to go about diagnosing and treating depression. As well, there are a variety of sources of information aimed at various audiences. Some are more biased than others, but the reliability usually depends on how culture has taught its population to trust or mistrust the sources. Because biomedicine is so widespread in America today, most Americans may often trust whatever doctors say. They are given a level of respect not given to other sources. For most of these other sources, there is a differing level of trust ascribed to

them, depending on the person and what they know about it. Because there is such a variety of opinions and ideas about depression, it would not be possible to include every different opinion in this chapter. This chapter focuses on the aspects of the mass media that influence the way people see depression.

This was the chapter that I was least looking forward to writing, and at first, I couldn't understand why. Now, I realize that it was because the way that depression is represented in the media is so misleading and biased that most people do not get straight answers about it, even when they seek information from people they believe to be reliable sources, like doctors. I will admit, I was once guilty of these same misconceptions, but after learning about depression from less biased sources and hearing directly from my informants, I have come see just how different depression is than I originally was led to believe. Many people think they know what it is to be depressed, when in fact, they have been getting biased messages, often without realizing it.

The way that depression is represented in the media, in my opinion, is horribly inaccurate and misleading. Medication commercials especially, make it seem like all it takes to get over depression is a good course of medication, and suddenly, the once depressed person will be back to normal. For example, in a commercial for Pristiq, a woman is shown with her family, obviously uncomfortable and sad, with a voice over saying how hard it was for her to connect with her family and enjoy life. Then they show her after taking their medication, and she is suddenly laughing and playing with her children, clearly enjoying life again. Unfortunately, the drug companies have done too good of a job in spreading their message in commercials like this. Depression medications do not actually work like this in most cases.

What they fail to recognize all too often in these types of commercials is that most medications often take 4-6 weeks to start working, and even then, they will not suddenly cure depression and often have harsh unwanted side effects. Because they are required by law,

commercials do have some of the side effects listed, but always in small, often illegible print on the bottom of the screen for a short time not long enough to fully read them all, or are said quickly at the end of the commercial, as a side note, not intended to be noticed by the viewer. Until 1997, most pharmaceutical advertisements were not on broadcast media in the United States. The FDA started allowing pharmaceutical advertisements on broadcast media without equal time dedicated to risks in 1997, when drug companies' spending on advertisements soared from $700 million in 1997 to $4.2 billion in 2005 (Donohue et al. 2007). This changed the focus of advertisements back from providers to consumers again[5] (Mogull 2008). This direct-to-consumer marketing changed the messages that Americans were receiving about depression. Although the symptoms did become more widely known, they are a dramatized version of the truth, often down play side effects, and do not correlate with most people's experience of depression.

Most Americans are familiar with the idea that medications have side effects, but don't necessarily realize how common they are when it comes to antidepressants or that many people will have to search around for the right medication or combination of medications for them. Each person's brain reacts differently to these medications, and it can be somewhat difficult to find the one that works best for them. Depression medications are not the cure-all that most people believe them to be. This is not to say that antidepressants do not help people, but that they are not as wonderful as the drug companies make them out to be. Antidepressants can be helpful for some people, and many of my participants spoke about the medication they had been taking. Medications were somewhat of a polarizing subject for my participants. Most either refused to take them or were praising their effects and very thankful for being able to take them, although this mainly depended on their attitudes[6] toward their depression.

[5] Until 1938, when the sale of drugs by prescription only began, the focus had been on consumers, and the relaxed laws on advertisements shifted the focus back onto the consumer (Mogull 2008).
[6] Their attitude depended mainly on whether or not they saw their depression as a biochemical imbalance, as they believed that the medications corrected this.

Misconceptions

The thing that makes me the angriest about the way that depression is portrayed in the media is that the misleading depictions prevent people from getting a proper diagnosis. One participant said that she believed these misconceptions, and that it led her on a roundabout path to knowing that she was experiencing depression:

> Before I had a diagnosis, it got to the point where I knew something was wrong, much more physically than emotionally, but couldn't figure out what it was. I was going doctor to doctor, and one even suggested depression [in passing], but with the way I had thought of depression—and I had no idea there was such a physical part to it—I told the doctor I didn't think I was depressed. I didn't feel sad, at least not like the people I'd seen on TV and in medication commercials. I was having trouble with my sleeping and eating. The crying didn't come until later [laughs]…It wasn't until I searched on WebMD that I started to even consider it…yeah, it was nothing like what I expected depression to feel like. – Jessica

The way the mass media led Jessica to see depression was so misleading that even when a doctor suggested it in passing, the way she imagined depression feeling was so different than what she was feeling that she did not think she was depressed. Similarly, Megan saw her mother struggle with depression as she grew up, but did not really understand what she went through until she started experiencing it herself.

> I was always scared of it because I saw what it had done to my mom, and I didn't want that to happen to me, and then it did, so I was, like, very fearful of it, but I didn't expect to [experience depression] because I thought, because she had it, I could learn how to not have it, but that didn't work for me. [laughs] - Megan

Each participant had a very different background, but the common denominator was that almost everyone pointed to this thought, that depression should be something that they should be able to just get over and move on with their lives. Some said they, too, were victims of this misconception before experiencing depression, while others talked about how frustrating it was that people did not understand that they cannot control it, and would, if given the choice.

It is heartbreaking to know that there are people who are not living their life to the fullest because of these misconceptions. I'm not saying that knowing they are depressed will suddenly make them happier, but that they will be able to address it, and eventually will be able to lead a happier life. Often, people don't think that they are depressed because they think that the way they feel is just how life is. If they think that it is just a part of life, they will not be able to feel happier. Life does not have to be this way, but it is difficult to show people this when they are seeing conflicting messages in the media.

Many participants did not have a great understanding of depression before they experienced it personally. Some had learned about it from various media outlets, while others learned about it from relatives who had experienced it. Matthew said that he did not really know anything other than what he learned from the media until he experienced it:

> I didn't know a ton. I had heard all the stereotypical things that you would learn in school, like depression's not just something that you can overpower with willpower, which is true, and then I knew some basic symptoms that you can see, from the internet or word of mouth, but I really knew very little about it until I actually had to deal with it myself.

Jessica discussed a similar level of knowledge and even learned about it in class:

> I think a lot of the things I knew about depression had been from classes I'd taken in college. I don't think I really knew much about it before that. Maybe just what I'd seen in

> commercials, on TV, or in movies…It's funny now that I think about it. Even with the symptoms staring me in the face during lecture, it still took me a while to figure it out. [laughs]

Another participant, David, had not heard very much about depression until he started looking on the internet when he reached high school, and did not figure out he had been depressed until he was coming out of it: "I didn't find out until I reached senior year [of high school], and I started being happy again, I guess. It's like, you contract it, but you don't know you have it. I got it, and didn't know until my actions started changing [back to normal]." He was not the only informant who did not realize they were depressed until after the worst of it. Barbara had a similar experience, ascribing it to puberty at first, and did not realize something was different until she "outgrew the acne but the crying continued." She said that the best way she learned to deal with it was time.

I also asked my interviewees whether or not they felt that the image of depression in the media was accurate for them. They offered similar opinion on this, most agreeing that it touched on some ideas correctly, but other issues that were incorrect were represented more prominently. Almost every interviewee discussed how depression is not just something that they could think themselves out of. Megan touched on this, saying:

> I think that it's like, a lot of people just assume that it's more like a sadness, and that you can just get over it, but you really can't. It's much more difficult than that. It just doesn't take, you know, one talk with a therapist, and all your problems are fixed. Mine stemmed from deep, core issues that I'm still working on today. So that, saddens me that people think it's so easy, and that, you have no reason to feel so worthless and useless.

Representations of depression in the media do not really talk about how someone becomes depressed. In my opinion, this is because there are so many conflicting opinions about this, that

they are afraid of alienating someone with a strong viewpoint. Michael discussed the difference between what the people in the media do to get through depression and what he was doing:

> I think this is gonna sound weird, but I think it's dramatized in the sense that people in everyday life aren't struggling [in the same way that] people in the media appear to be, but on the other hand, almost everyone that has depression is doing what I'm doing, in the sense that they're taking steps that they have to take in order to solve it. So, the media, I feel like, just shows cases of people that are suffering from it and that are in denial and that refuse to get any help, and it's reasonably accurate that that's what it would be like if you refuse to get help, but so many people, like myself, do what they have to do.

Michael talked a lot about this in relation to characters in television shows and movies that are said to be depressed, either explicitly or when it is implied, saying that in the real world, people need to actively work at it, whereas in the movies and on television, the characters that have depression tend to try to ignore it, giving the impression that if you ignore it, it will go away. Riesman (1950:84) argues that we receive these messages from both the mass media and our peers, but also send messages to others ourselves, saying that, "the peer-group stands midway between the individual and the messages which flow from the mass media…but the flow is not all one way." The media plays on what they think people will like or want to see. Pharmaceutical advertisements tend to exaggerate the aspects that they believe will sell their medications, and pay no attention to how they will affect how others see depression, further spreading the misconceptions that exist about depression.

Misconceptions are also perpetuated with other aspects of the mass media. When searching Google for "depression," it comes back with over 265 million results, and although I did not go through every result, the majority of them say the same thing and give answers and opinions from

only one perspective (Google 2012). Most webpages do not go any deeper than just giving the symptoms of depression and, sometimes, some tips for living with and getting help for it.

When I asked my informants if they experienced depression the way they imagined it would be, I got an almost unanimous response that it was much worse and consumed their lives much more than they thought it would. Matthew summed up the typical response:

> I think it was so much more than I thought it would be. I kind of expected to just go to a counselor a couple times and then feel better, but that's not really how it works. There are times when, like, if I were to stop taking my medicine, it's not like I'm healed, like, I would go back to exactly how I was and stuff like that. I guess I didn't realize just how big of a deal it was until I was encapsulated in the situation.

No matter what their background, there was a consensus among my participants that they had expected to be able to get over it much easier than what they ended up experiencing. I also asked what they knew about depression before they knew they were depressed and whether or not it had any effect on the way they experienced depression. As noted before, almost everyone said that their knowledge about depression was lacking before they had personal experience with it. Sarah indicated her lack of knowledge:

> Medically, I don't think I knew very much about it, I mean I know the serotonin levels, and stuff like that, that I knew from anatomy, but other than that, it was probably from lightly used terms like, "oh, he's depressed right now," and it was nothing like you experience when you actually have it, like when someone's sad, there's a difference between feeling sad and feeling like you could die and no one would care.

Some informants said that their previous knowledge influenced them at first and then faded, while some indicated that it did not influence them at all. For those that did not feel that it influenced

them, either the knowledge they had before experiencing depression was so lacking that there was no way it could have influenced how they experienced it or the depression was so consuming that they had no control over how they experienced it. Emily discussed her response to it, saying "you kind of just fall into the symptoms." She said that it was so consuming that she had no choice but to experience it differently than she imagined she would. Others indicated that their previous knowledge may have influenced them at first, but that because they were not really able to control it, that meant that they eventually fell into the depression in a different way than they expected. Michael indicated, "At the beginning, I was getting really frustrated being like, why can't I just shake this feeling, so at the beginning, it wasn't helpful, but it doesn't affect me now really." Even if their knowledge of depression did not consciously affect them after the initial experience of it, it affected the way they think about it.

Pharmaceutical advertisements can be both good and bad. On the one hand, they spread valuable information about treatment options that many people would otherwise not know about. On the other hand, they sometimes spread misinformation about what depression is and what it feels like, and I believe that a lot of the confusion my interviewees indicated is due to these advertisements. According to Metzl (2003), this makes many women believe that if they are feeling overwhelmed with their lives, then they are depressed, but he does not touch on the fact that men are also affected by these same advertisements. Men see these advertisements and believe that depression is a women's disorder (Metzl 2003). Almost all antidepressants advertisements include women who experience depression, but very few include men depicted as being depressed. This contributes to the low diagnosis rate of depression for men. Men believe that it is not masculine to admit to having these depressive feelings, and consequently are not likely to go to a health professional to be diagnosed or treated (Metzl 2003).

Depression and Gender

As with many social and health issues, gender affects the ways both men and women are diagnosed and treated with depression. It affects how they think about it, how they think they should be treated for it, and how others see them when they find out they have been experiencing it. Researchers are currently studying whether or not women actually experience higher rates of depression or if they simply have higher rates of diagnosis, but have yet to come to any concrete conclusions.

Due to the cultural construction of gender and masculinity in the United States, some men may be less likely to admit that they are suffering from depression or may be afraid to go to the doctor for help with a mental illness, and consequently go undiagnosed. The culture of the United States encourages men to be strong and unfeeling, and as a result, they are encouraged to hide their emotions, and consequently, have lower rates of diagnosis of depression. On the other hand, women are encouraged to get help for depressive feelings because society makes women believe that there is something wrong with them if they are unable to be perfect mothers, employees, and friends, all at once. Women feel inadequate if they cannot live up to the expectations of society, and they often seek a fix for these depressive feelings in the form of a diagnosis and treatment with medications. Many pharmaceutical advertisements are aimed toward women, capitalizing on women's culturally constructed emotions of inadequacy, often showing women struggling in their family life, at work, and with friends (Metzl 2003). This encourages women to visit their doctors and request medication if they are having trouble in any of these areas.

Hurt (2007) offers the explanation that women are biologically more susceptible to depression because women are more likely to be diagnosed with depression all across the world. Although it is possible that women are physiologically predisposed to depression, Hurt (2007) does not dispel the idea that women have different social norms and roles than men in almost every

culture around the world, which could affect their willingness or ability to seek a diagnosis or get help. There are social factors that can cause women to be diagnosed more frequently with depression.

Dekker et al. (2008) assert that when all factors except gender, such as race and socioeconomic status, are held constant, men and women experience depression at similar rates and severities. Hurt's (2007) argument that women are more naturally susceptible to depression does not take into account that women are more likely to be poverty-stricken, sexually abused, or single parents, which can be important mental health stressors. Although she was most likely relying on statistics that did not hold these factors constant, she does make some good points. Men and women just have a different path to knowing they are experiencing depression.

This leads to the difference in treatment options that are necessary for women and men. In the past, men and women have been given the same treatments, but depression presents differently in every person, as I have definitely seen in my interviews. Treatment needs to be tailored to each person specifically, and not just to gender. Everyone needs a variety of treatment options to be available to them, as there is no way to know what will be the best for each person until they try. From these two different theories, it can be concluded that gender differences in depression depend on the criteria used to measure depression.

Medicalization of Depression

With the spread of biomedicine, feelings of sadness have become more medicalized. There has recently been debate over whether or not depression should be categorized as an actual disease. Mulder (2008) argues for both, saying that for some people, depression is the correct diagnosis, but that sadness or grief has increasingly become mistaken for depression as it becomes

more medicalized. He argues that the increase in diagnosis of depression has not been to an actual increase in the disease, but that:

> The apparent increase in major depression results from: confusing those who are ill with those who share their symptoms; the surveying of symptoms out of context; the benefits that accrue from such a diagnosis to drug companies, researchers, and clinicians; and changing social constructions around sadness and distress. (Mulder 2008:238)

This is not to say that most people who say they have experienced depression have not actually experienced it. He says that depression is a problem: it is the number one cause of disability burden in the developed world, and needs to be treated, but he contends that the medicalization of depression has resulted in standardized medical treatment for everyone suffering from depression (Mulder 2008). This, he argues is not feasible or desirable (Mulder 2008).

Doctors may have been the impetus for the medicalization of mental illnesses, such as depression, but the media reinforced it. Medication commercials all say to "ask to your doctor" about them, further reinforcing the medicalization of depression, putting it in the sphere of biomedicine. The media serves to spread and reinforce doctors' opinions, but often misrepresents or over-exaggerates them, leading to a misunderstanding of depression among most Americans.

Without doctors to diagnose the disease, the people suffering from it would not be able to get the antidepressants that have become the symbol of its medicalization. Montagne (2001:1263) discusses that once doctors begin prescribing medications for depression, Americans see this, and expect antidepressants as a treatment, and pharmaceutical companies only serve to perpetuate it:

> Collective social knowledge has become instrumental in the development and transmission of perceptions about prescription medications, including psychoactive drugs like Prozac. Social knowledge refers to the cumulative knowing of something, based mostly on available

> information and past experiences. What an individual or group of drug takers knows about drugs, from reading information, listening to the media and promotional campaigns, receiving descriptions of others' experiences, and recalling their own previous experiences, will affect the actual use of drugs.

The widespread use of biomedicine within American society gives authoritative knowledge to doctors, but without the media and pharmaceutical advertisements, doctors' opinions would not be spread as widely as they are.

Americans have changed the way they look at depression in recent years, but old perceptions of depression still persist. Rehm (1977) described depression as a result of a lack of self-control, as do many other books written in the 1970s, 1980s, and 1990s (Bowers 1998, Fredén 1982, Becker et al. 1987, Ainsworth 2000). Although the idea that depressed people lack self-control has largely been discredited today, there are still some people who have this belief. Whiffen (2006) described depression as an inability to cope with everyday stressors, and while this idea has become less widely held, it still persists, especially for those who stigmatize depression.

Depression is what it is in America today because of the way people, both those who are depressed and those who are not, enact it. Society tells us what is properly defined as depression. What we see in commercials, on television, in doctor's offices, and hear from our friends, has a huge impact on what we believe to be depression, but so does the definition that doctors give to depression. The Diagnostic and Statistical Manual (DSM) gives a list of symptoms of depression, defining depression, but doctors' designation of something as a disease does not automatically make it seen as a disease among Americans. It is the respect for doctors and their authoritative knowledge that gives Americans the tendency to believe what they say about health. The way doctors diagnose and treat depression has changed over time, and as the DSM has evolved, so has its definition of depression, thus affecting the way that doctors diagnose and treat it. Although the

specific knowledge that is incorporated into their authoritative knowledge changes over time, the fact that they possess this authoritative knowledge does not change.

Currently, the definition of major depressive disorder in the DSM-IV excludes depressive symptoms caused by the loss of a loved one, but it has been proposed to remove this exclusion criterion in the newest version (Carey 2012). Some believe that this will medicalize grief, pathologizing normal human emotions, and encourage people to take medications instead of dealing with their problems. Proponents of the change argue that they need to recognize a problem that may need fixing and argue that if someone wants to be medically treated for it, they should be able to be treated for it. They argue that, "Depression can and does occur in the wake of bereavement, it can be severe and debilitating, and calling it by any other name is doing a disservice to people who may require more careful attention" (Carey 2012:6). On the other hand, those moments in life when a normal reaction would be to experience grief will be brought into the medical realm and questioned about whether or not they are normal. Opponents of this change claim that everyone in the world will lose a loved one at some point in their life, and asking them to get over it in less than two weeks, the amount of time required to become clinical depression, is not feasible. Including this in the criteria for depression diagnosis will mean that anyone who experiences this normal reaction for just two weeks can be diagnosed with depression.

It is also important to note that although depression has been medicalized, it has not necessarily become completely medicalized. It is still thought about and treated in both a biomedical context and a social context. It is diagnosed by doctors in a medical setting, but often includes treatments like support groups and psychotherapy, which all take place in a setting outside of, but similar to clinical settings.

Confidentiality is a key aspect to healthcare in the United States. The Health Insurance and Portability and Accountability Act of 1996 (HIPAA), a law requiring the "protection of individually

identifiable health information," has become key in protecting patients' information (United States Department of Health and Human Services 2012:2). But why is a law like this even necessary? Lawmakers wanted to make sure that patients were not afraid to tell their doctors something about their health in fear stigmatization or that the information would get out. The stigma against certain diseases, especially mental illnesses like depression, had become a problem. Employers would use the information against their employees and complicated issues arose when friends and family found out about information that they did not want them to know. If people thought their health information was going to be given to their employers, family, or friends, it may have made them more afraid to go to the doctor when they thought something was wrong, especially when it comes to stigmatized diseases like depression.

One of the contributing factors to why my informants were willing to participate in my research was because of the confidentiality and the assurance that I would not tell anyone about the things they told me in a way that could be traced back to them. They may have felt okay about telling this information to me, a stranger they would never see again, but because I did emphasize the confidential aspect of the study, they were probably more comfortable sharing what they did share. If I had not emphasized that everything they told me would be confidential, many of them would not have come to me in the first place or there would have been things they would not have told it to me at all. Similarly, the IRB would not have approved me to do the research if I did not take adequate measures taken to protect the confidentiality of my participants. Confidentiality is more important for depression. Many people with depression do not want others to know that they have been depressed, but if they have the flu, for example, they would probably not have a problem telling others.

## Chapter 2: It's Not My Fault: Proof, Bodily Evidence, Illness, and Stigma

*"It's made me more hesitant to tell people about it, like I'm always afraid they're going to be judging me for it." - Emily*

One thing that has really struck me about doing this research is that I never know what to expect when I schedule an interview with someone. I can usually deduce their gender from our phone conversations or the names on the emails, but there isn't a single "face of depression" that I can use to pick them out from the crowd when I'm standing in the coffee shop or library looking for them in the sea of passersby. I wonder as each person walks past me whether or not they are the person I am looking for, whether or not they are or have ever been depressed.

These thoughts race through my head as I wait for them to show up, never knowing who it will be or what they will end up teaching me. By the end of my research interviews, I had developed a habit of telling the people I was meeting what I looked like and what I'd be wearing before meeting them in hopes that they would return the favor, but there were only a few times when they actually responded in the way I had expected. I worried about finding the right person, about going up to the wrong person and giving away the informant's name, and there was always that little bit of doubt as to whether or not I would even be able to find the right person, but in the end, I always did.

The feeling quickly shifted when I began talking to each person, when each revealed deeply hurtful things that had happened to them that I would never have expected. Going to a high-stress university, I thought I knew what the problems of most students would look like, but someone who had appeared to be a good student that had succumbed to the pressures of a top university became someone who had been raped in high school, someone who had been abused as a child, someone whose sexual orientation alienated her from her entire family, or someone whose family history made it likely that he would eventually experience depression. After hearing about the hurt that

each person experienced, I wanted to do something, to talk some sense into the people who hurt them. But, alas, the realities of the world prevented me from doing so.

In such a short time, I felt that I got to know each informant, to understand what they experienced and how they felt about it, but as we said our goodbyes, I wondered what their openness meant and what would come of it. They had shared intimate moments with me, but some of my participants were more open about their experiences than others. Some had more trouble admitting it than others, but all of my informants discussed the stigma they felt about their mental illness. Amy revealed that she was more willing to tell people that she had been raped than that she had experienced depression after it:

> I'm more open about the rape, not so much the depression diagnosis, because I feel like there's this stereotype against the mental illness. You're just labeled with the tag of crazy. With my friends, I'm fine with that, but the biggest part with that is wanting people to understand, and you can try to get that with your family and friends, but with someone you don't know that well, there's no way you can approach that bridge.

I didn't even have to bring it up. The stigma that surrounds depression is so widespread and significant that the majority of my informants brought it up on their own. It was so prevalent that, although I hadn't originally planned to focus on it for an entire chapter, it was such a key element to their support system and their decision about which of their friends and family to tell, that it felt like there was so much more to it than I originally thought and needed investigation. I don't mean to say that every single person who has been depressed feels stigmatized for it, but that the majority of people do feel at least a small amount. Although, it depended on where they learned about and how they looked at it.

The Nature of Stigma

The fact that there is no way to tell whether or not someone is depressed just by looking at them contributes to the stigmatization of depression in the United States. But what does it mean to be stigmatized, marginalized by society? There can be many different levels of stigma, as defined by Goffman (1963). He describes it as: "an attribute that is deeply discrediting from full social acceptance" (Goffman 1963:3). Some stigmas are more deeply rooted in one's identity, such as gender identity, while others, such as obesity, may operate at a more surface level and are changeable. Some are willingly chosen as a part of the sufferer's identity, such as religion, while others may be forced upon them without their consent, such as a disability. Some are easily hidden from others, as depression is, while others may be more difficult to hide, as with a physical deformity. Those that are due to appearance, that exist, visible on a person's body, are almost impossible to hide, and must be dealt with socially. But those that exist inside one's mind, they may be postponed to be dealt with at a later date, if even at all.

Some people hide their depression well enough that they choose not to tell any of their family or friends while others are unable to hide it in any fashion from those closest to them. Goffman (1963:4) distinguishes between the two types of stigmas, labeling them as either "discredited" / "discreditable," or as apparent / hidden. Depending on the severity of the depression and the person's willingness to show it, the stigma of depression can go in either of the two categories. To the average observer, depression is the second of the two types of stigmas, or discreditable, when they are not aware of a specific person's depression, because it is somewhat easily hidden from sight. To those who look further into a person's actions or who are told, it can become the former type, i.e. discredited, but it does not have to be. In this case, it depends on what others know about the stigmatized individual whether depression is discredited or discreditable.

Not only does stigma come from other people, but it can come from oneself, especially as the fear of stigma. It is possible that the person has internalized their sense of stigma as a result of what society tells them is normal and acceptable. If they do not believe that their feelings are normal, or that it is okay to have these types of feelings, they can feel a stigma toward themselves because of their inability to get away from them. Barbara expressed a wish to be able to get away from her depression, and how frustrating it was for her to not be able to do so: "sometimes what your emotions and what you know contradict each other…Things happen in the world. Jobs can get stressful, and people do things that I can't control, and I want to not react the way I do, and not get real depressed about things, but I can't help it." This type of stigma is almost impossible to run away from. One can also be afraid to tell others about a stigma, such as depression, for fear of stigmatization by others. This can happen even if one does not necessarily stigmatize oneself for their discreditable stigma. One will be less likely to share with others because of one's fear of being stigmatized and, consequently, socially rebuffed.

Becker (1963:1), on the other hand, argues that not all stigmatized people have that stigma against themselves, saying, "But the person who is thus labeled an outsider may have a different view of the matter. He may not accept the rule by which he is being judged and may not regard those who judge him as either competent or legitimately entitled to do so." People who have not experienced depression do not know what being depressed is like, and thus, are less qualified to determine how legitimate it is to feel depressed. Similarly, it is possible to be stigmatized in one area of your life, and be accepted in most other areas. As with some other stigmas, depression can be concealed from others. Depressed people may choose to only let people see their good, non-stigmatized, socially acceptable attributes for fear of being socially excluded. All of my participants were amazing people who deserve credit for being who they are, but their depression often made them feel inadequate or abnormal. For some, concealing their depression from others was a way to

keep their positive attributes at the forefront of the way they present themselves to others (Goffman 1959).

Because depression is not openly discussed very often in American culture, there are many aspects to it that are unfamiliar to people who have not experienced it and, due to media misrepresentation, there are many people who are misinformed about it. Erving Goffman (1963:5) argues in his landmark book, *Stigma: Notes on the Management of Spoiled Identity*, that, "we construct a stigma-theory, an ideology to explain [the stigmatized person's] inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences, such as those of social class." Americans may be especially afraid of the unknown aspects of the person's depression. If someone does not completely understand another person, they may not know how to act around him or her, and consequently construct a reason why they should be considered inferior, further stigmatizing depression.

There are many reasons why a characteristic becomes stigmatized. Goffman (1963) talks about many different types of stigmas, but depression is not one of them. This speaks to the changeability of mainstream opinions and stigmas over time. Depression did not exist in the DSM when Goffman (1963) wrote this book in 1963 (American Psychiatric Association 2000). He discusses race as a stigma, and while some might argue that this is still the case, certainly things have changed since his time (Goffman 1963). Just as the definition of depression has changed over time, so has the stigmatization of it.

<u>Why the stigma?</u>

For most Americans, when something physically hurts, when something on their body looks abnormal, feels funny, or when they just want to make sure everything is working properly, they go

to the doctor. The doctor looks at the areas they complain about, examines them, and runs tests. They tell the doctors all of their symptoms so they can diagnose them and tell them what exactly is going wrong in their bodies. So, when they go to the doctor complaining of symptoms of anemia, a heart attack, or any number of other physical diseases, the best way the doctors know to confirm the diagnosis is to order blood tests. There are certain criteria that they look for in the blood tests that will help them determine if they have the disease in question.

But what happens when they will not be able to see it, when there is no test they can run? Regardless of whether it is a blood test, a pregnancy test, or an x-ray, Americans have come to expect some sort of physical proof of a diagnosis. Unfortunately, depression cannot be diagnosed from a simple blood test, or any physical test at all. Rather, it is usually diagnosed by healthcare professionals based on a clinical interview, without any proof of the diagnosis. As treatments and biomedical research have proliferated, so have ways to test for a wide variety of diseases. Proving that someone has a disease with a physical test has become a way of legitimizing it. Although the disease may still be stigmatized for things such as the way it was acquired, illnesses that are not seen as legitimate are stigmatized just as badly. If we can prove to others that there is a biological difference in our bodies, at least, they will accept the reality of our disease. Because one cannot prove the experience of depression, a particular form of stigma surrounds this condition.

This idea, that it is necessary to have physical symptoms in order for a disease to be real, is called materialism and is especially prevalent in Western medicine. Gordon (1988) defines materialism as the idea that an illness corresponds to the degree to which physical traces show up in the body, and argues that health and illness in American biomedicine are defined in terms of materialistic indicators, such as blood pressure, body temperature, or heart rate, rather than an overall feeling of healthiness. Because biomedicine uses these types of materialistic indicators, it exemplifies materialism, leading to the stigmatization of depression based on the fact that it does

not exist materialistically in the body. Similarly, Rhodes (1996) states that although the body is part of the natural world, it becomes known as a bounded material entity. She argues that diseases are physical entities occurring in specific locations within the body, radically separating body from non-body or mind (Rhodes 1996). The body becomes thought about as knowable and treatable in isolation from the mind.

When classifying health related disorders, biomedicine has a tendency to categorize them as being in either the mind or the body, creating a problem when a disorder involves both. This mind-body dualism, or the assumption that the mind and body have two separate ontological[7] entities, is similar and related to materialism and is especially relevant when thinking about depression. Based on the biomedical system of thought, Americans often assume that if a disease is in the mind, it is not in the body, and if it is in the body, it is not in the mind. Descartes (1988) argues that although the mind and body are distinct, they are related. He claims that, "We need to recognize that the soul [mind] is really joined to the whole body, and that we cannot properly say that it exists in any one part of the body to the exclusion of the others," but that the root cause of the problem is found in either the mind or body (Descartes 1988:220). According to the logic of biomedicine, disorders that originate in the mind are not considered real because if the mind created them, then the mind can get rid of them. This creates a stigma around depression when one cannot prove that it exists in the body because it makes the sufferer's mind look weak.

By classifying disease as being in either the mind or the body, it assumes that the disease is present in either the mind or the body, and that there is no overlap between the two. Only when doctors cannot find a physical cause do they look to psychological causes for the disease. This is because physical causes are seen as legitimate; doctors will assume that when the patient comes to them complaining of something, they are legitimately experiencing a physical disease. But when

[7] Ontology is defined as "a particular theory about the nature of being or the kinds of things that have existence" (Merriam-Webster2012).

they cannot find a physical cause, they resort to giving it a psychological cause, often questioning the reality of the illness in the process. Psychological causes are not seen as real, and can therefore be cast aside and stigmatized.

Another problem of mind-body dualism is that by assuming the disease is in either the mind or the body, assumes that the disease is fixed and presents the same in everyone, assuming an unchanging ontology. This leads to not taking into account the patient's perceptions of the disease and the lived experience, contributing to the stigma associated with depression. Disease depends on everyone and everything that is involved while it is present, and so should the treatment of that disease. When one treatment is applied to someone with depression, such as medications or therapy, and it does not work the way it is expected, their experience may, again, be written off as fictitious. Because the disease presents differently in each person who experiences it, there will not be any one presentation of the disease for the public to see. Because of this, anyone who does not present with the "typical" symptoms, as defined by the media, will not necessarily be considered to be truly depressed, and their experience as a depressed person may be brought into question.

When dealing with a disorder that affects both the mind and body, there becomes more of a range of somatic responses. In biomedicine, doctors and scientists assume that all bodies will react in the same way based on a common biology. This belief is carried over to diagnosis and treatment. Because the sadness and crying aspects of depression are usually stressed in the media, other aspects of depression are often discounted. My participants indicated experiencing a range of symptoms, citing a decrease in appetite as the second most prevalent symptom, behind sadness. We know that psychologically, there are all different types of reactions to any given situation, so when a disorder involves both the mind and body, there are a wide range of both somatic symptoms possible and ways to treat them. This can lead to stigmatization that the disease is not real because it is in the mind.

This type of classification does not take into account the patient's perspective or experience of the disease, time in which they live, and contexts of the social environment, which reflects the wider cultural organization. Diseases can be enacted differently in each person, depending on the person's perspectives, experiences, and life. Each person has a different experience of the world, which is probably what causes the differences in experience of depression. Thus, this categorization as mind or body assumes that disease has a fixed ontology, creating a problem when the disease is enacted differently in different people.

Hacking (1996:31-43) discusses the enactment of diseases known as fugue and hysteria. He says, "Hysteria has been called the body language of female powerlessness. Fugue was a body language of male powerlessness" (Hacking 1996:31). The manifestations as fugue or hysteria were products of the environment in which they were enacted. Nowadays, fugue and hysteria are not considered mental illnesses by psychiatrists because the biomedical environment does not allow it (Hacking 1996:33). It was manifest this way in that time because people at the time were told that these feelings were symptoms of the then considered "modern" malady of fugue (Hacking 1996:32). The knowledge that other people were experiencing the same type of disorder and the way they were experiencing it made people believe that this was how they were supposed to act if they were experiencing fugue. Riesman (1950:48) argues that, "Early ideas regarding the nature of depression were products of the predominant philosophies of their times, just as current theories reflect the scientific philosophy of the present time." The American public tends to see "real" diseases as unchanging and stagnant, and tend to largely ignore that this does not feasibly happen for any disease. There have been advances in biomedicine that are incorporated into their practice every year. Because depression has changed so much throughout its time in biomedicine, more than most diseases, it would not be considered as legitimate as a disease that has not changed in its definition, such as a broken arm, further stigmatizing it.

Scientists now believe that depression is the result of a chemical imbalance in the brain, something we can see (Leventhal 2009, Deacon and Baird 2009); this finding has somewhat reduced stigma and radically changed the ways that many people see depression, as well as the ways doctors and health professionals diagnose and treat it (Deacon and Baird 2009). This is a somewhat new finding, so not everyone is aware of it or completely believes it. There is still an inability to test for depression, but now that doctors are saying that there are biochemical differences in the brain that cause depression that could theoretically be found with the proper imaging techniques, more people believe in the legitimacy of depression as a disease. Because depression historically did not exist as a legitimate disease and the cause was thought to be unknown for the most part, many people still believe that it is a character flaw or sign of weakness. As scientists have learned more about biology and depression, and include genetic, chemical, and environmental causes, the ways that people have experienced it have changed, even though there are still no tests to confirm this condition.

Because of the mind-body dualism with depression, some people may believe that depression originates in the mind as stress, and is manifested in our body, as the somatization of stress. Similar to scientists, many of my participants believed that their depression was caused by a chemical imbalance in their brains. Most participants could point to something that initially caused their depression, and some thought that they were like a bomb ready to explode with any trigger. This can contribute to the stigma of depression, especially if people believe that the somatization of stress is the depressed person having a weak mind.

Many people painstakingly look for a diagnosis, whether or not they think there will be a cure. Having confirmation from a doctor, a usually well-respected authority on disease and illness, that the disease is not just "in their head" is important. Depression is considered a mental *illness*. This creates consequences and stereotypes, often placing the label of "crazy" on someone diagnosed

with a mental illness. There becomes a dualism in the terms "illness" and "disease." Disease is the pathological state whether or not it is culturally recognized as real, and illness is a person's own perception and experience of the socially disvalued states, including, but not limited to disease. Szasz (1998: ch. 5) and Sedgwick (1982:30) in Bowers (1998:7) discuss the duality:

> On the one hand Szasz claims that 'mental illness' is a metaphorical phrase and that all illnesses are physiological malfunctions or not illnesses at all (Szasz 1987: ch. 5). On the other side of the divide Sedgwick claims all illnesses or diseases are socially defined, suggesting that 'there are no illnesses or diseases in nature' (Sedgwick 1982:30). Others have looked to definitions based upon psychological or cognitive malfunctions as the key criteria to 'mental illness'. (as cited in Bowers 1998:7)

This shows that there is a lot of debate about the validity of this disease/illness dichotomy, but I will be using the definitions as laid out above. Based on the biomedical model of the body used in the United States, a doctor's diagnosis of a disease may overlap with the patient's experience of an illness, but does not have to. Doctors are given the authoritative knowledge[8] to diagnose depression because they have the education that society values.

The fact that doctors in America have the authoritative knowledge makes their opinions about disease respected in the United States. One of the biggest reasons why there is such a stigma against depression is because doctors cannot point to any one thing in a person's body that definitively says that they have the disease, "depression." There is no way to prove they have been experiencing depression other than when they say they have. Doctors have the scientific knowledge and technology that Americans value so highly, which supports the respect and authoritative knowledge they are given. Behavioral therapy and medication are the most commonly used treatments in biomedicine today, neither of which uses the technology that doctors

[8] Authoritative knowledge is defined as the knowledge system that the most is culturally valued (Davis-Floyd 2004).

usually use to treat other diseases, such as dialysis or radiation therapy. It is because of this that many people do not believe that depression is a physical disease, but that it exists in the minds of those experiencing it. Many doctors, with all their science and technology cannot find it in their bodies, so they think it must not be real. Because Americans rely so heavily on the biomedical model of disease and disease prevention, if there is no proof, there is no value.

Another aspect of depression that may contribute to the stigma is the fear of the unknown that many people have when it comes to depression. The strongest conclusion I have been able to come to as a result of my interviews is that depression affects everyone differently. As I began doing my research, each interview I did made me start to think something completely different about depression. It made me realize how different each person's experience is with it, that not only is there no single "face of depression" but there is no single experience of depression. The stigma associated with depression partially comes about because most people, and society in general, do not know how to characterize it or how to act around people who are depressed. Sarah indicated this in her interview: "My parents didn't exactly know what to do when I first told them, but then again, I don't think that I was really in a place to know what I wanted them to do back then," showing a lack of knowledge in both the people who are depressed and the people charged with supporting them, especially because this can vary extensively among people who have experienced depression. As definitions of depression, such as that in the Diagnostic and Statistical Manual, keep changing, people come up with new ways to learn about, assess, and treat it. This creates an ever-changing way of supporting people through depression, making it especially difficult to keep up with for people who are not directly affected by it. This creates a sense of confusion and ignorance about depression and how to act around people experiencing it.

If someone tells another person that they are depressed, especially someone close to them that they care about, that person will most likely want to do everything they can to make their

friend or family member feel better. People can be painfully unaware of how to do this, especially if they are not depressed themselves. They may be uncomfortable around them while they try to figure out how to act. As Anne, the mother of someone who experienced depression, explained, "sometimes, it's a little frustrating because there are things I know she should be doing about it that she doesn't always do, that she should do in her best interest, and it hurts me, not knowing what to do." As a friend or family member of someone experiencing depression, it can be especially difficult at first trying to figure out how to best approach the relationship with this new dimension. Most people recognized the fact that their relationships could never go back to what they were before the depression. It served as an eye-opening experience for many of my informants, and some indicated that they learned valuable information about their friends and family and even that they would not want to go back to the way things were before experiencing it.

Those who have not truly experienced depression may believe that it is the same as the sadness that they have experienced and, because sadness is considered a part of life that everyone experiences, consequently, see depression as the inability to cope with it. This can lead to stigmatization of depression as someone having a weak mind when they are not able to get over it as quickly. As with heart disease, there may be some things we can do to help get rid of it, but we can never be sure it will be cured. Hurt (2007:26) argues that depression is seen by others as preventable if "the person who suffers through it has determination and strength." People who have never been depressed may think that the sadness they have experienced is the same kind of sadness as that of depression, and that because they were able to overcome it, that everyone should be able to as well.

This brings up the question of where you draw the line between normal sadness and depression. Doctors have come up with a set of requirements to be clinically diagnosed with depression, as indicated in the DSM, but people outside of the medical profession do not necessarily

know and follow these guidelines. People who have not been depressed do not understand that it is not something that people can just stop feeling, the same as someone with cancer cannot just stop having cancer. People in the study consistently pointed to this idea, that they cannot stop feeling the way they do and "just get over it," as one of their major frustrations with people who have not experienced depression.

In everyday life, people use expressions, such as, "I feel so depressed right now," or, "That's so depressing." These are phrases we all know, and most of us have used, but how often are they actually used to describe the illness of depression? Everyone feels sad at some point in their lives, but most of them are able to lift themselves out of it and feel better within a matter of minutes, hours or days. When depression takes over, those experiencing it are unable to get out of it for weeks, months, or even years, but may feel a pressure from others to be able to stop feeling the way they do. Because some people who have not experienced depression think they understand what it means to be depressed, there is a trivialization of the symptoms of depression. Whenever something makes Americans sad, they say that it is "depressing," whether or not it is actually representative of the illness of depression. They do not know the true experience, and that people experiencing depression are not able to stop whenever they choose to.

The word is thrown around casually nowadays, and has become synonymous with a normal amount of sadness. This means that when someone is clinically depressed and unable to change the way they feel, their experience is seen as more trivial than other diseases, with the thought that if they wanted to badly enough, they would be able to get over it right away. I, too, am guilty of using phrases, such as, "that's depressing," "shoot me now," or making a fake gun with my hand and pointing it at my head, that trivialize depression when something is upsetting or unpleasant to me, but in reality, it is no laughing matter, and adding suicide to the mix is even worse. When we use

phrases like these and joke about suicide, depression can be trivialized and make people who have experienced depression feel stigmatized for feeling that way.

Because the way people see depression has a lot to do with the way they learned about it, people who have experienced it often have completely different ideas about it than people who have never known anyone who has experienced it. An informational brochure from a doctor's office, a health-related magazine, a pharmaceutical advertisement, a character in a television show, and an academic article may have very different tones toward depression, affectively shaping the stigma in the reader's mind, showing them how it is to be enacted and how it should be thought about. The tone and accuracy of what we know about depression makes the difference between a positive view and a stigmatic one.

Not only does the tone used in each source speak to society's ideas about depression and its treatments, as well as the author's opinion on the acceptability of depression, but it also speaks to what the author expects from its reader. Especially in magazine articles and advertisements trying to sell a product, the author is trying to get their audience to agree with them, and they may alienate their readers if they say something that contradicts what they already believe. The authors of non-academic articles are more likely to perpetuate the status quo, and if they believe that there is an illegitimacy involved with depression, they will help further that idea. On the other hand, academic articles written by doctors and researchers have much less emphasis on what they believe their audience will want, and more emphasis on what they believe to be scientifically or factually true. This shows that American culture has given doctors and researchers the power to decide the proper treatment of depression and to impose these views. Unless they appeal to the emotion of the readers and adequately convince them that their way is either better than another option or supported by doctors, an author will not be as successful in changing people's views.

Consequences of Stigma

*"No one's afraid to listen, but I guess I'm embarrassed to tell them about it, so I don't." – Sarah*

Because there is such a social stigma associated with depression, there are many consequences as a result. The most common consequence of this stigma, by far, that I have come across in my research is the hesitancy to tell others about one's depression. People who have been depressed have seen the negative ways others have been treated and the reactions that they have had to deal with. They may be afraid that they will be treated in the same negative way, both by their loved ones or by strangers. Often times, the worry itself that comes along with the stigma, in addition to the burden of bearing this secret can be just as concerning for people with depression. As a result of not telling very many people, informants experiencing depression are less likely to receive the full amount of support that they need from their friends, family, coworkers, and peers.[9] On the other hand, participants indicated that they were already dealing with enough of their own problems with the depression that they did not have the ability to add this to their concerns. If they did not tell anyone, then they would not be discriminated against or stigmatized, and would not have to worry about it.[10]

People are also much less likely to admit to experiencing depression or to go to the doctor to be treated for it if they feel stigmatized. If people believe that it is an illness that is just in their heads, there is more likelihood that they will feel more control over their depression. This can be both good and bad. They may feel more empowered to search within their own bodies to control and deal with their depression, but will be less likely to seek professional help and blame themselves if they are unable to sufficiently get over it on their own. Matthew indicated that he

[9] This will be explored more in depth in Chapter 3.
[10] This will be explored more in depth in Chapter 4.

probably would not have sought help for it if he had known a lot about the stigma before he experienced it:

> I kind of just learned as I went, which was probably a blessing in disguise because as scary as it was at first, I feel like I would have taken a lot longer to—like, if I had looked at the media and the images that are given off of people with depression, which is certainly not a pretty thing—then I think I would have almost wanted to remove myself from that group, from that stigma. I think the fact that I didn't know what it was until I was already getting help for it was a big thing.

This can make a huge difference in their outcomes and overall wellbeing. As Amy thought, "I don't know where I'd be today without the help of my therapist and the support of my family and friends. They made a huge difference." She admitted that she did feel some stigma when first telling her family and friends, but with their helpfulness, was quickly able to overcome it with them. To this day, she is still hesitant to tell people who do not already know about it, especially strangers. David had a similar experience telling one of his friends: "He acted like he thought I wanted to be like this, to feel this way, but it was the opposite of that. It's not my fault. I was doing everything in my power not to be depressed." He said he felt that there was a tendency for people to think that it was his fault that he was depressed, and felt stigmatized because of it.

Confidentiality in treatment is a huge factor that influences someone's decision whether or not to seek treatment from the doctor, as well as their opinions about whether or not the doctor will even be able to effectively treat them. The person's own beliefs about what is causing their depression influences what they think will be an effective treatment. If they think that there is a biomedical cause, they are more likely to seek a biomedical cure, while if they believe it is a social cause, they are more likely to seek a social cure. Their perceived stigma against their depression will affect whether or not they feel comfortable with sharing their diagnosis with a doctor. If they

believe that telling their doctors will be beneficial, they are likely to tell them, a decision that is made easier because of the confidentiality in American biomedicine today.

There also becomes less of a sense of how prevalent depression is when people are not open about it. Because no one really talks about it, those who are not experiencing it do not believe that it is as much of a problem. As Jessica said, she was not aware of how prevalent depression was, even among her own friends, until she was the first one to open up about it. This situation—that since people do not talk about a stigmatized practice or condition and hence assume that it is not common—was described as "The Prevalence Paradox" by Kumar et al. (2009). While Kumar et al. (2009) focused on the prevalence of abortion, the paradox is applicable to other stigmas, such as depression. The paradox begins when people "underreport and intentionally misclassify" their behavior (Kumar et al. 2009:5). This leads it to be "thought to be uncommon (non-normative), and because of this, "a social norm is perpetuated that [it] is deviant" (Kumar et al. 2009:5). People then face discrimination because it is considered deviant, causing them to "fear stigmatization for engaging in [this] behavior," and, finally, this leads back to underreporting the behavior and perpetuates this paradox (Kumar et al. 2009:5). The silence about these stigmatized behaviors that arises from the paradox makes it very difficult to know what the true prevalence of the behavior or illness actually is in a community, and makes it difficult for someone who is suffering from depression to tell others. They can feel forced to put on a happy face for others and hide their stigmatized qualities.

The stigma associated with depression also leads people to search for a physical cause, in an attempt to legitimize the illness. This has led to an increase in research on depression in the United States in recent years (Deacon and Baird 2009). As scientists are finding more information about the biological implications of depression, doctors and patients are treating it differently. According to Dekker et al. (2008), in the past, the patriarchal assumption was that men and women

experienced depression in a similar way, but now, they argue that men and women can expect to experience different symptoms, and they can also expect to treat it differently, both in terms of social expectations, therapy, and clinical treatments. They found that when all factors were held constant, men and women experienced similar severity of depression, but each dealt with the symptoms differently, a finding I definitely confirmed in my own research (Dekker 2008). The men that I interviewed tended to have a more biological explanation for their depression, most likely due to cultural constructions of masculinity. Because men tend to be stigmatized for revealing their feelings, they must have felt that their depression was less stigmatized if they could point to a biological cause for it, and were probably more likely to admit to being depressed, go to a doctor for diagnosis, and therefore, participate in my study.

Without this biomedical description for why they feel the way they do, it can make those experiencing depression also blame themselves for their diagnosis, or it can make them unwilling to admit that they are experiencing it, either to themselves or to others. As some people do not recognize depression as a biologically based disease, they do not believe that anything is wrong with them any more than what they believe to be normal. They are more likely to believe that it is a character flaw or something wrong morally within themselves, and not look to external causes which can set them free from blame. They internalize the stigma that is taught to them by society, and they can sometimes even be harsher against themselves than others. This self-blame can make them feel even more stigmatized for their depression, and thus, make them feel even worse than if they were just experiencing the depression.

American society values men who are both mentally and physically strong, and women who experience depression are often seen as having, "defective bodies and passive minds" by others (Hurt 2007:4); this can further the stigma against depression, teaching those affected by it that they contribute less or are a burden to society. Because men are expected to hold down a job and

provide for themselves and their families, there is more of an expectation for men to be strong (Hurt 2007). This further discourages men from being diagnosed because society will see them as weak, and they may be valued less by society, increasing their self-stigma and the burden they feel to stop being depressed. Often, as long as women can still perform their motherly duties, society will still highly regard their contributions, so the stigma affects men worse in this aspect (Hurt 2007). There are social factors that can cause women to be diagnosed more frequently with depression. Researchers continue to investigate the reasons why women are diagnosed with depression at higher rates, but the stigma or gender dynamics may have something to do with it (Hurt 2007).

The cultural stigmatization of depression and other mental illnesses stems from the inability to prove a physical difference in the body when someone develops the illness, even while tools for diagnosis have been made more concrete (ie., the DSM IV). Furthermore the parallels that can be drawn between the illness and what can be considered a normal amount of sadness and melancholy can make it hard to distinguish the two. The trivialization of depression in everyday conversation, how we learn about depression from friends and family as well as society, and the uncertainty involved when dealing with something unknown also affect how we learn about depression and its associated stigma. This situation contributes to a fascination with new research, a sense of guilt for one's own feelings, differential stigmas, a decrease in social support, and ultimately, a hesitancy to share openly.

Upon revealing a depression status, many people worry that they will be judged, which is why most people who experience depression make careful decisions about to who, when, and how they reveal their depression status. Of the people who participated in my study, most had told only those closest to them, and there were even a few people who hadn't told any of their friends or family. What causes a person to keep such a burdensome secret to themselves? They may fear that

they will be judged, fear that their loved ones will think less of them, or fear that they will not believe them.

## Chapter 3: Support: Can a person be as good as a medication?

*"You can go and talk to a psychologist, and they'll remain stoic. They're not allowed to share personal experiences or anything of that sort, but I don't know, you can tell when somebody actually cares, and when they* have *to listen, and I think that real support is when they care and they do what they can to help you." —Emily*

The first question generally on someone's mind when they are diagnosed with any type of biomedical disorder is how they will go about treating it and, eventually, get over or cure it. Some people choose to follow their doctor's orders by the letter, believing that the doctor knows best. While others choose to do what they think is best because, after all, no one knows you better than you know yourself. Because depression is such an individualized disease, experienced differently by each person, the social support that one person might find helpful might be completely different than what another person would find helpful. Many people have very strong opinions about what depression is and how to treat it before they themselves are touched by it. Some people believe that depression is a biochemical imbalance in their brains, trusting that medications are the best option. Others believe that it is a personal weakness in their own minds, opting for therapy. And even others will deny that it is a disease and opt for no treatment at all, thinking that through will-power, they can work their way through it.

It is commonly held in biomedicine that what will treat one person will treat another person, but there is not necessarily a single best way to treat depression.[11] There is an assumption that all bodies will react in the same way to biomedical treatments, but each person has a different experience of depression, and therefore, a different opinion on what they might find helpful. Treatment is tailored specifically to each person depending on their own needs, and can change over time, even for the same person. This huge variance in treatment preference will translate into a huge variance in the social support they find most relevant. Some people refuse to take

[11] See Chapter 2.

medications, opting to "power through it" on their own, as Emily decided to try, while others, like Matthew, feel that medication is the best option. Some people choose to talk to a therapist, like Amy, while others opt to attempt to get better on their own through changing behaviors such as diet and exercise, like Sarah. Some people choose to deal with their depression by asking for support from their friends and family, like Michael did, and others use a combination of different approaches as Megan did.

This chapter focuses on social support from friends and family. Most people will at least agree that *something* needs to be done for depression, even if they disagree on *what* needs to be done. Whether it is from medication, therapists, psychiatrists, family, or friends, everyone needs support to get through depression. Medications often cause side effects such as nausea, sleepiness, or thoughts of suicide; however, many people do not realize that using people as a support system, both in combination with or instead of, medication can also have unwanted side effects and problems as well.

## Depression, Support, and Relationships

Relying on friendships as therapy can place extra strain on the relationship, especially if the other person has never experienced depression and does not understand what the person experiencing is going through. They may not completely understand why people who are experiencing depression act the way they do. As many participants indicated, when they were depressed, they tended to be more "touchy" or sensitive to things they would not have normally reacted to. Friends and family members are faced with the challenge of being extra understanding and supportive, but when the relationship becomes all about this, some people will give up. Maria, whose friend had been depressed, said that she was supportive and understanding up to a point:

> I'm usually happy to listen, but sometimes it gets to the point where I can only tell her the same thing over and over again so many times. Sometimes it starts to feel like she's not even listening anymore, and saying it again won't do anything, so I stop.

Samantha echoed this idea:

> I took care of as many of her needs as I could, and was there to listen. I mean, it was never fun. Even when it was like, "Oh God, I need to be doing something else." I was like, "Shut up, she needs this more. It's okay." But that's the thing about someone being upset versus someone being really depressed for a long period of time. Her consistent issues, that she wants to talk about over and over again, I just can't deal with it. I don't have time or the mental energy to constantly reassure her, or constantly tell her what I think even though I've already told her a billion times. And I think that's where therapy comes in because that's the therapist's job, you know, that's what they like to do, what they intentionally spend their time on.

This strain can be especially harsh if they confide in only a few people and depend on these people more than others. Amanda said that her now ex-boyfriend kept his diagnosis to himself most of the time and confided in very few people, leading him to confide in her a little too much and start to take her support for granted:

> He's kind of unintentionally selfish because he expects me to talk to him when he's having a panic attack or if he's really sad or he wants to cry. He expects me to be there for him, and that to me seems kind of selfish because I don't feel like I owe him anything, everything I do for him is a favor, and when he just expects me to do things, that kind of annoys me even though I know that he doesn't mean to be selfish or anything.

She is describing a relationship that has become very unequal, where it should not be and was not before depression came into it. Once he decided to tell her that he had been experiencing depression, the relationship became more one sided and beneficial to him. She went on to describe how exhausting it was for her to continue to be there for him, and ultimately points to this as the reason for their break-up. She said that she was no longer getting anything out of their relationship and felt that they would be better as friends. This way, she explained, he would be more likely to depend on other people as well, not just her.

As I found in my research, people especially need support from friends and family members during the middle of a depressive episode, but it is also a time when people are least likely to be at a place to get this support. Many participants spoke about changes in their relationships due to their depression. Katie and Amanda, when discussing their support of their now ex-boyfriends through depression, said that because their ex-boyfriends were both extremely cautious about who they told, they became the main support person for them, which Katie described as being exhausting. Matthew also discussed his break-up with his girlfriend in the middle of his most recent depressive episode. Most of interviewees who were not depressed themselves discussed a change in their depressed friend or family member. Some of the participants who had been depressed said that they were more sensitive about certain topics around other people. Emily described an especially delicate subject for her: "The thing that pisses me off the most, and I never get upset, I'm a really calm, mundane person, but, when somebody asks, "what's wrong with you?" I just get really angry." Because Emily had not told any of her friends that she had been depressed, they would bring up these topics without realizing how they would affect her. Sarah also described getting in fights with her family when they approached what she considered to be sensitive subjects. The only person in Sarah's family that she had told about her depression was her mother, who knew which subjects may be more sensitive to her and knew to avoid them. Other family members did not, and ended up bringing out the worst in her at times.

We need people to fall back on during the hard times, but we don't always realize it until we need them the most. Sometimes the best thing can be having someone to be there, and this can become especially noticeable if they aren't there. Fredén (1982:99) described a study that found that people who did not have proper social support from friends or family members had a harder time recovering from depression:

> They did not seem to have been able to find support or help anywhere, and there was nothing to stop the negative cycle: their self-esteem was impaired, they could not bring themselves to act, they received no reinforcement of their own worth, their self-esteem was reduced even further.

People may not realize how important this reinforcement can be. The aspect that people found exhausting and annoying can become one of the most important parts of supporting someone with depression.

A lack of support can intensify depression or sometimes can even be a contributing factor in causing it. Danielle pointed to problems in her relationship with her best friend as a possible cause to her depressive feelings:

> My relationship with my best friend kind of wavered a little bit, in that I didn't really speak to her as much as I normally did. And instead, I grew tighter with another friend of mine that I hadn't been as close with, but am now very close with, because the result of that. It made me really sad to be thinking about a relationship with my good friend, that I wasn't able to talk to her the way that I wanted to. I felt inhibited for some reason about speaking to her about certain things, and that made me feel very…different.

Although this relationship was probably not the entire cause of her depression, it definitely contributed to its continued presence over the course of an entire semester.

Jessica expressed that she thought she had a good support system set up until she started experiencing depression. When she finally began to need the support from her friends, she realized that the network she had was not as good as she originally thought it was. After experiencing depression, she found that the strength of her relationships with friends declined, while she became closer with her family. Other participants had similar experiences as well. In fact, most people found that the relationships with their family members strengthened while the relationships with their friends weakened.

Who is the best support?

Family and friends need to be open with one another in order to get the proper kind of support from each other. If someone does not know that their friend or family member is depressed, they cannot understand and empathize with them, which was something many people described as being supportive. It is not necessarily required to tell others in order to get support from them, but it is much more difficult for them to reach out to someone who is depressed when they don't know that they are depressed or what is really going on.

When I asked my informants who had been depressed if they thought that others understood what they were going through, they had mixed opinions on the subject. Some believed that others cannot understand what depression is like until they actually experience it themselves, while others said that the people who supported them knew them so well that they could understand well enough. The majority of people that I interviewed who had not experienced depression indicated that they felt that they could understand what their friends and family members were going through, but to a point. Maria, who has been supporting her friend through depression for seven years, said that she thought she understood to some extent what her friend was experiencing:

> [I can understand] somewhat. I mean, everybody gets moments of low self-esteem, but for her it wasn't moments, it was weeks, so it would be kind of like, "oh, I had a bad day, you know, somebody yelled at me, I got bad marks on a test, I look like crap, blah, blah, blah," just a bad day that isn't just a day anymore, and it goes on and on, and eventually, you can only do so much for it. It's just like, I never want to get out of bed. That's the feeling I imagine, just never wanting to get out of bed.

As she said, it was always an idea that she was imagining and not actually feeling that she was feeling. Because she cannot feel what her friend feels, she has no way of knowing for sure that she understands. In *Culture and Depression*, Arthur Kleinman (1985:183) touches on this:

> Now, it is true that feelings cannot be seen; the only feelings we have direct experience of are our own feelings. I do not feel your feelings as you feel them and indeed I have no way to know for certain that you have feelings at all. I know that you move your face in complex ways, and change your posture and utter words like "pain" and "anger," but faces, postures, and words are not feelings—and it is the feelings that interest us though they cannot be seen.

This situation brings up the question of how well we can actually understand what other people are going through. We can only imagine that we know what someone else is feeling, and there is no way to know for sure what they are feeling. We can see the expressions on their face and equate them to how we have felt in the past and the expressions that we made while feeling those emotions, but how can we know if it is a feeling that we ourselves have never felt? Every one of my participants had a difficult time describing how it felt to have depression, rendering it almost impossible for someone who has not experienced it know what it feels like. Michael discussed this, saying that "most people don't get a sense of full understanding, they just kind of feel bad for you,

like, oh, it's the sad kid," and that most people will fall into believing the stereotypes portrayed in the media about depression.

On the other hand, most of my informants who have experienced depression described an understanding with other people who have been depressed. Emily discussed her thoughts:

> I think more people understand than I know. I think that, around here especially, like around college campuses in general, a lot of people are going through it. I read this statistic, and I don't remember the exact number, but it's a fairly large percentage of college freshmen that go through depression, so I feel that a lot more people go through it who can understand, but a lot of them are embarrassed or ashamed to admit to it, so I don't know who they are.

Here, Emily discusses the idea that other people who have experienced depression will be better able to understand what she herself has felt, that they are the most able to empathize with her. Emily, who experienced depression as a freshman shortly after starting college, is also describing what I have touched upon earlier, that there is no way to know who has experienced depression just from looking at them and that people do not generally talk openly about depression. There becomes a sense that someone else has to be the one to tell that they have been depressed, and they are not always willing to admit to it. This creates a barrier to finding others who truly understand. Emily went on to say that she thinks her parents understand what she is going through sometimes because, "They know me so well, at least the way I was," saying that she has changed enormously because of her depression. Her parents, maybe, have not completely realized this, and she suggested that they would better understand it if she told them.

Similarly, a few participants spoke about not wanting to dump their problems on people or be a burden to others, proving that we get most support from people we are willing to be vulnerable with, trust enough to show our true emotions to, and who we feel comfortable putting in

what can be a tough position. This seemed to be a theme especially with people who had a more pronounced self-stigma. Emily, who seemed to have the strongest sense of self-stigma said that she didn't mind other people talking to her about their problems, but that she felt uncomfortable with it herself, saying "I do not ask for help. There's nothing wrong with it, like if someone asks me for help, I'd be more than willing to help them with anything, but I guess I'm just stubborn." Sarah, who also seemed to have a high level of self-stigma, indicated a similar feeling toward asking for help, but said that she felt more comfortable asking her mother or best friend, indicating that they often offered support even when she did not ask for it specifically. Her best friend especially, would offer suggestions she felt would be beneficial when she saw that Sarah was starting to "withdraw from life" and immerse herself in the symptoms of depression. She even went to the trouble of "forcing" Sarah to get out and do something with her.

Alternatively, some participants talked about people expecting too much of their friends and family members, dumping their problems on them, and expecting them to be fixed, as Samantha and Maria pointed out earlier. Danielle was careful not to put too much on any one friend:

> They're just there when I need them which is nice to just hang out, drink a glass of wine, like watch a chick flick, whatever needs to happen to get my mind off whatever, they'll be there to help me out. I feel like that's really valuable to have those kinds of friends who you can call up if you need to get something, like get out of the house somehow, so it was good to have that kind of relationship with other people, and that way, it wasn't really bogging down on any people, on any of those relationships, and that wasn't the topic of discussion, my problems weren't the topic of discussion. It was just like, "we're chillin' or eating food together. This is how it should be." So, I feel like that's always nice to have those relationships too.

If someone does dump too much on their friends, the friendship may buckle under the pressure, but if a friend or family member does intervene too much and offers to do too much, this can become less supportive than forcing them to deal with their situation. Lauren indicated that she had this problem with her sister:

> sometimes someone who is depressed will try to make it someone else's problem and put the burden on them rather than dealing with it themselves, and you know, wash their hands of it, and think, "oh, it's up to this other person to take care of it," and sometimes, they might even go to a professional, and think, "oh it's up to the professional to take care of it," but really, you have to do it yourself to take care of it. You can get help, but you have to do it yourself.

She indicated that her sister initially tried to leave it up to her to solve all her problems, but that she felt it was best for her sister if she did not do too much. Michael indicated that his family, especially his mother were supportive, but not too supportive, saying that, "They don't baby me, but they know what's going on. If I'm feeling really down, they'll try to help me out, feel better." They were able to support him without doing things for him.

On the one hand, interviewees tended to tell the people who were closest to them, who were the most capable of offering the best support because they already knew them very well. This was often a close relative, best friend, or partner. On the other hand, anyone is capable of being supportive. One does not necessarily need to be close with someone to be supportive of them during depression. Many participants found that even just the little things that other people did for them made a big difference in how they felt, like what Megan said of her friends: "they'll do these small things that just make me smile, and that helps some." Conversely, it could also be the little things that people did that would not be supportive, like when Emily's parents asked her how she

was doing all the time or what was "wrong" with her. She felt that the constant reminder of her depression, even when they were unaware they were doing it, was very unsupportive for her.

People can help and hurt

Because there are such a variety of experiences with depression, there are a wide variety of ways that people can help with it. Most of my informants said that the people they told were more supportive than they expected. The stigma that they had felt from strangers or had seen others go through did not turn out to be as bad as they believed it would be. This is likely due to the fact that there is a big difference between the nameless, faceless depressed person people see in the mass media and the person they know and care about. This can be especially strong when they are sharing something vulnerable like depression.

Just knowing that there is someone there who cares enough to listen was supportive for most of my informants. As Jessica said, "Just having someone there that cares enough to listen and just to talk to is the best thing for me." Most people found that it was supportive even when a friend or family member was there just to listen and cared enough to offer suggestions. Some informants indicated that they thought that it was supportive to have someone there to help guide them through it. Jessica said of her mother, "She helps me talk though what I'm feeling and helps me know what to do next." Sarah echoed this idea, saying that, "It's good to have someone there who seems to have everything all figured out and under control, so they can catch you when you fall."

On the other hand, depression can make someone feel like they are the only one who feels depressed, and having someone else there who has gone through or is going through what they are going through can be just as helpful or supportive as when there is someone there who knows exactly what to do guiding them. It can be crucial to have someone who knows how one feels

without having to explain it to them. Sometimes, people experiencing depression do not want to have to explain things to other people, or someone who has gone through it may have words of wisdom that others may not. Because they know how it feels, they may better know what is supportive and what is not and may be in a better position to offer it to them or at least offer suggestions.

This is especially relevant within families. As biomedicine argues that there is a genetic component to depression, it tends to affect multiple people in a family, so the members of an older generation can help those in the younger generation, when they first experience it. It can also be within a generation, as with siblings. Michael said that he often went to his older sister, who had previously experienced depression, explaining that when he was in need of support, "I'd call her and see what she had to say." He said that because she had experienced it and knew what it was like, she often had good things to say, but even when she couldn't offer him specific suggestions, just talking to him on a bad day was supportive for him.

Most informants also indicated that just having someone keeping track of their progress and monitoring them in case they started to slip back into their depression was supportive. Sarah suggested that, even when she did not specifically ask for help, her best friends were there to help:

> There's one or two close friends that are generally checking in on me, and I let them know how it's going, and I kind of feel like that's a sentiment toward seeking out help, is I actually let them know honestly what's happening, and sometimes I'll allow them to say, "okay, we're gonna go to the gym and you are going to do something."

They were constantly trying to help her out of it, but they were not doing too much or doing things for her, as this can become unsupportive.

Not everything that other people do initially is supportive. The lack of information about how to support people with depression can lead people to use trial and error, which can be difficult to deal with. If the relationship was not strong to begin with, it is more likely to fall apart when put under a stress like this. I can personally attest to how difficult it can be to support someone who is feeling depressed. They probably won't know what to say at first, and the learning curve can be pretty steep. There is not always something a support person, or anyone, even the person feeling depressed, can do to make it go away. Sometimes they just need someone there to help them through the pain, encourage them to get better, and reassure them that it *will* get better.

Conversely, when someone has to go through depression alone, it can be especially eye opening for them, and make them feel incredibly alone. Having friends or family that do not care or understand can also be unsupportive and lead to a worse sense of depression. Barbara had to go through her depression mainly on her own after living out of the country for many years. She said that because she moved around a lot, once she started to get comfortable and making friends in one place, she would end up moving again and starting all over. In her case, people were not supportive, and did not necessarily have a chance to help her. She said that she mainly depended on her doctors to help her through her depression, prescribing medication for her, although, this was not always the case when she was out of the country dealing with other medical systems that she did not necessarily understand and that did not understand her. This absence of support from friends can make people feel worthless, and as Fredén (1982) indicated, this lack of support can lead to people feeling worthless and lose their sense of self-esteem.

<u>What constitutes support</u>

Support, especially in relation to depression can be difficult to define. Each person found different things supportive, but most agreed that someone was supportive when they showed that

they cared and could offer suggestions to help, but did not necessarily do everything for them. Michael defined it:

> It's not necessarily them doing a bunch of stuff for me, it's just someone being there for me, being what I need them to be, but at the same time being responsible enough to not let me completely indulge in depression, and, in that, I mean someone who can know what's best for me, and not many people do.

He went on to describe what his family does to support him:

> They want to make sure I don't mess it up, school-wise here. They're worried about me, but they know, because like I can't sometimes step outside myself, that it will end, so they want to keep me in the best position I can be in when it's over, so even though sometimes I can find it unsympathetic, they are kind of helping me power through it and get stuff done.

Anne responded similarly, saying: "you want to be there for them and listen, but then you have to make sure that you're not doing too much for them. They have to learn to rely on themselves." Brittany indicated a similar definition:

> Just giving them what they need, maybe not 100% of the time what they want, but, whether it's spiritually helping them, giving them resources so they can help themselves, or it can be like making them a cake to make them feel better, or something like that, just being there to listen to them, just being a good friend.

Almost everyone used some form of the phrase, "be there," to describe how people supported them, but what does this mean? Is it about being there emotionally? Being there physically? Some people talked about family members or friends being supportive over the phone if they lived in another city, so, although it can include this as one aspect of it, it is not just about being there physically.

Most people seemed to indicate that it meant being there for them emotionally and caring about whether or not they were okay or how their life turned out.

Schneider (1968:51) provides a similar definition for support, especially in relation to the family, which can be in the best position to give it:

> Enduring, diffuse solidarity, or love, in its most general sense in American culture is doing what is good for or right for the other person, without regard for its effect on the doer. Indeed, its effect on the doer is good and beneficial by virtue of the good it does. What this may consist of as a specific act is not given in the symbol of love or of enduring, diffuse solidarity, but is instead located in all of the other context-defining symbols of American culture. The right thing to do for a middle-aged man may be the wrong thing for a child. What is good for an upper-class woman may be bad for a woman of lower class. What is kind to a farmer may be an offense to an artist.

Thus, it can be concluded that support is doing what is best for the person, not necessarily what they want, although what they want usually coincides with what is best for them. It is similar to a child being told that they cannot have dessert every night or making them take naps when they don't want to, although I am not saying that depressed people are children or that they should be treated as such. They may not always want or know what is best for themselves, and may need help figuring it out. If they are allowed to ruminate in their own head, as some participants said they were prone to do, they might be unable to see it and only get worse.

<u>Consequences of using people as medication</u>

When one depends on one's social system for support, many negative consequences can result from depending on it too heavily or too little, but people can also be the source of excellent

support. If a depressed person expects their friends and family to get them through their depression and depends on them too much, they can become dependent upon them and unable to support themselves. On the other hand, by coping with depression with other people, one can become even closer to them, adding a new dimension to the relationship and increasing the bonds. These two extremes embody the range of consequences that can result from using people as they would medications. People are not necessarily meant to be used in this way, so it is best to utilize multiple people and multiple approaches to treat depression.

Having friends that do not care or understand can be just as detrimental as not having them in the first place. Barbara was not happy with the support that she had received from her family and friend throughout her experiences with depression. Because of the absence of any family and friends in her life, she lacked a real support system. Conversely, Jessica said of her depression after a falling out with her friend that, "It really showed me who my real friends were." She describes her friend who was not supportive at all:

> I had one friend who said something like, "when is this going to be over so we can get back to normal?" or something like that, and I was just like, "Seriously? This is kind of my life now, and you want to know when it's going to be over?" So, that was definitely not supportive. She just kind of ignored it the whole time, especially when it was at its worst…I don't think we've really recovered from this, even to this day.

She went on to say that it took her until then to realize that this relationship had already been "unhealthy" and that she was actually glad that she realized it. "It wasn't exactly the ideal circumstance, but I'm really glad that I finally realized it. Depression was like that thing that makes you look at your friends in a new way." It would have been better to have figured it out before experiencing it, but depression was that impetus for her to do so. Going through this at that time added to the stress that she was feeling, detracting from the support she felt from other friends and

family because of the extra difficulty to deal with. It was not ideal, but she was very happy that she figured it out. It is obviously a very stressful process to lose a friend, but she was able to get away from this stressful relationship in her life and focus on the more supportive ones that she still had.

Many informants indicated that the relationships that they had with their families became closer after experiencing depression. As Schneider (1963) discussed, the unconditional love from a family member will make them better capable of giving the proper kind of support. A family member will not worry about hurting the feelings of the person who is depressed. A friend, on the other hand, will take this into consideration, and may be less likely to tell the person experiencing depression what they need to do and more likely tell them what they want to hear. This conflicts with the definition of support that most participants gave.

Because depression does add a different aspect to a relationship, I found that not a single one of my informants said that their relationships did not change as a result of depression, whether or not they told a lot of people. Emily found that even though she did not tell anyone about her depression, she was changed as a result of it. She felt differently and acted differently because of it, which changed the dynamics of her relationships. There were certain things that her friends and family would say that she would react to differently after experiencing depression, which changed her relationships with them. Similarly, as with Michael, who told most of his family and friends, said that his relationships with them changed. He found that he grew closer with his family, especially his mother, who he felt was the most supportive:

> I get really mad at her when she is like, because I'll be in the middle of a super rant, and she'll be like, "what school work do you have," and I'll be like, "we're not talking about my schoolwork, blah, blah, blah," but she's trying to get me to be interested in something, which is good, so she's been the most supportive, she has helped me out the most, she's the most worried about me, so my mom has definitely been the most supportive.

He also said that his relationships with his friends changed, saying that there were times when they were there for him, but there were times when they were not there for him: “My friends, we’re all like 18, 19 years old, were all going through angsty times in our life, so we're all a little self-indulgent, so I totally understand them not being able to help me all the time because wanting help all the time is self-indulgent too.”He said that his family was always there for him when he needed them, saying, “no one blows me off.” His friends, as he explained, had other things to do besides help him with his depression, saying that they were there for him most of the time: “They try to like help me get my mind on different things, they’ll be like, “oh let’s go play basketball, let’s go do this, let’s go do that,” force me to leave my dorm room or something. They’re doing what they think is best for me, so they’re being helpful.” Although he said that he felt a stronger support system with his family, he still had a positive view on the support that his friends gave him. As long as the other people are there and trying to help, it is difficult to fail in those relationships. The times when the relationships disintegrate are when the person is unable to talk to the other person or be there for them in the right way.

Because the person who is depressed does not always know what they want, and sometimes just knows that what the other person is offering is not what they want, there can become a rift in the relationship. As Erica said, her friend who had been depressed, “didn’t bring it [depression] up because he thought I didn’t want to talk about it because I never brought it up, but really, I didn’t bring it up because I thought he didn’t want to talk about it because he didn’t bring it up.” She said that she did not think that he knew what he wanted her to do, so she did not know either. Because of this, she explained, she was not able to be there for him as much as she would have liked.

Similarly, the depressed person has to be willing and want to get better. If they are not receptive to others people’s help, no matter what they do, it will not help. Amy discussed a friend,

saying: “she probably has admitted it to herself, but not to me, and that prevents us from being close.” Although we cannot experience what others experience or know for sure what they feel, as noted by Kleinman (1985), paying attention to our friends and their feelings can help us know what is going on in their lives, hopefully, encouraging them to be more open.

## Chapter 4: Putting on a Happy Face: Deciding whom to tell

*"Once I started telling people I had been depressed, they really opened up to me. It was so much more common than I realized…Everyone has a story, and only some people are willing to tell it."*
*- Jessica*

When someone is diagnosed with depression, they can often feel totally alone, and Jessica touches on a detail of depression that people don't often realize until they start to talk to other people about it: it is a lot more common than most people think, and this is especially true on college campuses. The Center for Disease Control estimates that about 1 in 10 American adults report being depressed (Center for Disease Control 2008). And that is just those who report it. On college campuses, it is even higher: about 45 percent of female and 36 percent of male college students reported feeling "so depressed that it was difficult to function" in the past 12 months, and 18 percent of college students had been clinically depressed, as defined in the DSM IV in the past 12 months (American College Health Association 2006). The difficulty here is that people are afraid to talk about it, and thus, do not hear about other people in similar situations. College students on campus are far from alone in these feelings, but because there is such a perceived stigma around it, people are reluctant to share their diagnoses, thus decreasing the perceived prevalence of depression and creating an even bigger gap in perceptions.

It is almost impossible to tell when someone is depressed just from looking at their physical appearance (Kleinman 1985). In fact, the only way to know for sure that someone is depressed is if they tell you themselves. I was struck by the same thought that Jessica mentioned when I began doing my research. I, too, began to realize how little I could tell of a person's personal experiences from seeing them on the street, in class, or at work, even every day. There is so much more to a person than what they tell you or show you day by day. As I sat in a lecture of over 400 students, I began to think about how, statistically, about 80 of them were currently experiencing or had experienced depression in the past year. I began to think about how high this number seemed,

when I spotted one of my participants, eliminating any doubt I had in the enormity of the statistic. She had been very hesitant to tell others that she had been, and still is, experiencing depression, as are many students across campus, giving further credibility to the prevalence paradox (Kumar et al. 2009). Similarly, in *The Presentation of Self in Everyday Life*, Erving Goffman (1959:1) shows that Americans have a desire to know about others and argues that,

> When an individual enters the presence of others, they commonly seek to acquire information about him or to bring into play information about him already possessed…For those present, many sources of information become accessible and many carriers (or "sign-vehicles") become available for conveying this information.

For those who are depressed, however, they may seek to hide this information. Most Americans like to give off an impression of normalcy, not of deviance, to others and due to the stigma around it, disclosing feelings of depression would be considered deviant (Goffman 1959). This leaves Americans with the task of determining who they think is depressed based on appearance. There are no characteristic marks or rash on the skin. There are no stuffy noses or coughs. There is no symptomatic outward expression of depression that would cause a person to look "depressed" that could only be caused by depression. The way that Michael talked about his appearance showed a deviance from the "normal" appearance, but this deviance could have been caused by any number of things:

> I guess, what a lot of people don't understand is, when you're depressed, everything that you've done before just goes out the door. Like, let's say you cared about how you looked. You don't care about how you look. This is disgusting, but I don't really care right now. I think the longest… I went probably eight days without showering…You still know that you're not being clean, but you don't care as much. It's the most disgusting thing ever.

He talked a lot about how he no longer cared about a lot of other things as well, not just his appearance. This could possibly be an indicator of depression for someone looking for it specifically, but the difficulty with this is that a decrease in appearance could be due to any number of factors other than depression and not all people who are depressed have this problem. Emily pointed to her ability to keep up her appearance, such as dressing as she always did, wearing makeup, and putting on a happy face, while she was in the worst of her depression as one of the reasons she felt she was able to hide it from her friends and family.

Depression as an Invisible Illness

Depression is not like a broken arm where the effects are visible on the body; they are usually hidden inside a person's body and mind. Although some of the symptoms of or actions because of depression, such as loss of interest, lack of appetite, or depressed mood, not caring about looks, not wanting to be around people, or not feeling like getting out of bed, can be apparent once pointed out, to someone who is unaware that they are depressed or that their friend or family member is depressed, most of these behaviors can go unnoticed or seem relatively normal at first. Because of this, it can be relatively easy to hide from others. Emily had at least thought that she had successfully hidden it from everyone she knew. Other than me and the therapist she had seen twice, she had told no one. She said she had only spoken with her friends and family about depression in general, and had given no indications that she had ever been or felt depressed. She said she thought she did a good job of covering it, although admitted in the end, that there was a chance someone close to her had figured it out, citing her appearance and willingness, although not necessarily wanting, to go out with friends as the key to her disguise.

It is harder to hide depression from those with whom a person is closest. Some of my interviewees said that they were not the first ones to notice their depression. Rather, it was

someone else, usually a parent, who was the one who encouraged them to seek a second opinion. Sarah said her mom was the one who first noticed her depression:

> It was actually my mom who decided I needed to get checked out for it…I didn't notice it so much because I'd always kind of felt that way, but I guess I started more visibly showing people that I just didn't care about stuff. [laughs]That sounds so terrible. From what she said, I went from being very outgoing and wanting to talk to people, and then, I kind of just stuck with the people I knew, and I stopped attempting even to talk to people at family gatherings and stuff like that. What I thought was that they didn't care for what I had to say, so I wasn't going to say anything, and I guess I didn't really think that I was depressed until someone told me this might be a problem. And then it dawned on me that, yeah, I had changed a little bit.

Her mother was one of the people who knew her best, and made her realize what she herself couldn't see. Once it was pointed out, she could start to see the differences and realize that it could get better.

This is something many people run into: they do not know that they are depressed because they have always had these feelings to some extent and do not know that other people do not feel this way. Sarah had this impression until her mother pointed out that she might be depressed, saying, "What I had always taken it for is: it's normal, it's how life goes, everybody goes through these periods, and it wasn't until learning that some people can be moderately happy all the time—I get really jealous of them—that I was able to accept it." This is a common feeling for people with depression, and due to gender norms in American culture, it is even worse in men. Men feel like they cannot show their true feelings, and especially feel unable to show feelings they consider vulnerable, such as sadness (Flynn et al. 2010). In a study by Flynn et al. (2010), men were found to suppress emotions much more often than women, and because men do not tend to show feelings of

sadness, they start to believe that there is something wrong with them if they do because they do not think other men normally have these feelings and do not see them express it. This notion can be especially prevalent in populations that are male dominated. For example, Schwenk et al. (2007:602) found that 63% of retired football players were unaware that they were suffering from depression as defined in the DSM IV or knew about it but did not seek help for it because they thought that the way they were feeling was just "a part of life." While the perceived inability to show emotions would be worst in groups of men like this, these types of opinions are common for other people as well. Because so many people are under the impression that depression is something that everyone goes through at some point in their lives, people who are experiencing it may be less likely to tell others about it in fear that they will think that they are not normal or think less of them. Similarly, because everyone feels sad at some point in their lives, they may think that they know what depression is like without having experienced it, and because they were able to get over it and feel better very soon after, they might expect someone who is depressed to be able to do the same thing. If someone who is depressed expects this kind of reaction, they will be much less likely to share their experiences with them.

This situation raises questions about what it means to be normal. How sad can someone feel before it becomes "depression" and for how long? The answer to this question can get very complicated. Goffman (1963:5) defines "normals" as "those who do not depart negatively from the particular expectations at issue," but this definition is specific to stigmatized groups and misses an entire part of the population: those who deviate positively from expectations. One can deviate from normal in a positive way as well, although in this case, depression is a negative deviation. Euphoria, for example, is generally a positive deviation, but is not considered normal. Warner (1999:53-54) contends that numbers are used to tell what is normal, arguing that "Under the conditions of mass culture, [Americans] are constantly bombarded by images of statistical populations and their norms, continually invited to make an implicit comparison between themselves and the mass of

other bodies." Although numbers cannot be used to quantify feelings, as is the case with depression, it is the smaller numbers of people who experience depression that makes it deviant, or not normal. Warner (1999:54) continues:

> Numbers metamorphose almost inevitably into the kind of evaluative thinking that makes people who belong to the statistical majority feel superior to those who do not…by that standard, we might say that it is normal to have health problems, bad breath, and outstanding debt. One might feel reassured that one is not the only person to have these things, but the statistics only help with one's embarrassment; they say nothing about the desirability of the things themselves.

The designation of depression as not normal does not make it stigmatized in itself. Rather, it is the undesirable qualities of depression that make it stigmatized, such as overwhelming sadness. Some deviation from baseline levels of happiness is normal. Good and bad feelings come and go, but when a depressed mood is present for long periods of time, it can become depression. Realizing this deviation can be tricky for people, especially the first time it happens. The official definition in the DSM IV (1994) says that the symptoms must persist for at least two weeks, but most people will not necessarily know something is wrong or seek help after only two weeks. These emotions and somatizations can be so new to the person experiencing them that they do not know that anything is wrong or what to do about it. Most of my interviewees said that they waited a period of months before they initially realized they were depressed or started seeking help for it.

This can make it that much harder for someone who has been depressed to tell others about their experiences. If it was difficult for them to see anything wrong in the first place, they might be more worried that others will not be able to see it either. Other people may not notice anything different about them, and may not think anything is abnormal, contributing to the stigma and misconceptions about depression. According to Goffman (1963:2), Americans feel a pressure to

give an impression that they are average, but seek to categorize others at the same time when in their presence:

> Society establishes a means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories…When a stranger comes into our presence, then, first appearances are likely to enable us to anticipate his category and attributes, his "social identity."

Americans are evaluating other people all the time, no matter what the situation or possible stigma. According to Thomas, "we live by inference" (Thomas 1951:5, cited in Goffman 1963:3). We have no way of knowing for sure how other people are going to act, but we can infer that our friends will not steal from us, for example, but we cannot know for certain (Goffman 1963). Goffman (1963) argues that whenever Americans are in a social context with other people, they are constantly trying to figure out what kind of people they are and how they will act. In the context of depression, depressed people evaluate whether or not other people, their friends and family members especially, will acknowledge that their depression is real. People who are not depressed are also evaluating whether or not others are depressed, and what that might mean to them.

There are many different ways we can figure this out, including physical appearance, what other people say, and how they say it. Goffman (1963:2) distinguishes between the expressions that people "give" and the expressions they "give off":

> The first involves verbal symbols or their substitutes which he uses admittedly and solely to convey the information that he and the others are known to attach to these symbols. This is communication in the traditional and narrow sense. The second involves a wide range of action that others can treat as symptomatic of the actor, the expectation being that the action was performed for reasons other than the information conveyed in this way…The

individual does of course intentionally convey misinformation by means of both of these types of communication, the first involving deceit, the second feigning.

There are large portions of our way of being that we have control over, but there are also aspects that we cannot control. It can be concluded then, that although there is no "look" of depression, when searching for it specifically or when one already knows it to be present, there are some clues that can distinguish them from "normal." Most people who deviate from the norm in one aspect will consider themselves normal in at least one other way. Goffman (1963:130) argues that, "The role of normal and the role of stigmatized are part of the same complex, cuts from the same standard cloth." Although not in relation to the same aspect of themselves, people can play both roles, normal and stigmatized, at the same time. It is when they reveal this stigma, such as that of depression, to someone else that the stigmatized aspect becomes more apparent and that they are able to completely judge them for who they are, and it can be very scary to be this vulnerable with another person.

What goes into a decision

Choosing to reveal that one has experienced depression can be a difficult decision made after careful consideration, but it can also be a decision made instantly in the moment. Before one reveals a depression status, many different things must be taken into consideration, but what makes it so difficult is that a decision like this is final. Once it is disclosed, even if the other person reacts poorly, there is no way to get it back. Information like this can either end a relationship or strengthen it, mostly depending on the reaction of the other person. This is why such careful consideration is put into this decision.

One of the most influential factors that affect a person's decision about whether or not to tell a friend or family member is how they think the other person will react to their news. The stigma associated with depression is cited as the main reason most people will keep their feelings of depression to themselves. According to Goffman, "the stigmatized individual may find that he feels unsure of how we normals [in this case, people without depression] will identify him and receive him" (1963:13). If they believe that the other person will react negatively to their news, they will be much less likely to tell them, but if they believe that the other person will react in a positive and supportive way, they will be more likely to open up and share their information and feelings, in hopes of receiving that support from them and possibly growing closer in the process. Emily recalled talking to her father, who she had not told about being depressed:

> I mentioned it to my dad. I talked to him the other day, and he basically said that he doesn't believe it's a real—and I mean a lot of people have this viewpoint—he said he doesn't really consider it to be a disorder, that basically, everyone goes through a depression, but he didn't know about me. If he did, I think he would have opened his mind more. He was just following the typecast, what's portrayed in the media, things of that sort. He basically said that everyone goes through difficult times, but you just have to find the strength to get through it, which is true, but it's limiting in a sense.

Emily knows her father well, and she did not feel that telling him would have benefitted either herself or her father, especially after this discussion with him. Although she thought he would not be as harsh on her if he knew that she was depressed, his reaction to depression in general, without knowing she was depressed, did not indicate that he would react supportively to her experience of depression, so she decided to avoid the negative reaction she expected and the stress that would consequently come with it. She said that, because of her decision to go to the University of Michigan over a smaller, less prestigious school against his recommendations, she felt that telling him would

have felt like admitting that she was wrong about her choice, that she should not have gone to the University of Michigan, and she was not willing to admit it.

If someone already knows that their friend has a negative view of depression, they don't expect that that person will suddenly change their mind about it just because they now know someone who has gone through it. As Emily mentioned above, she expected that her father would have "opened his mind" if she told him that she had been depressed, but she did not think that he would completely change his mind about it. Most interviewees, when asked whether or not they thought their friends and family could understand what they were going through, said that they thought others could generally understand without having actually experienced depression themselves, but they did not think that other people could completely get it until they had actually experienced it. There was a general consensus that there was a range of how understanding their friends and family were, and that they would be more likely to tell people who they think will understand what they are experiencing. Brittany said that she had never really been around someone who had been depressed until she met her friend her first year of college:

> It's just really shown me how much depression can impact your life and affect a person because none of my friends flat out told me that they struggled with depression in high school or anything, so she was the first one that I really had a close relationship with. Just being able to see how much she struggles, because sometimes depression is looked at like, "oh you're making it up," just to see how much one bad day can throw you into a nose dive. It's really shown me how much depression is a true disease.

Brittany felt that she could understand what her friend was going through to some extent, but because she had never experienced it herself or really been around someone who had, she really had no idea what her friend was going through. Even though she was not able to know what she was feeling, she was still accepting of her friend's depression as "a true disease." Brittany's friend

had actually shared that she was experiencing depression the second time they had met, in a church-related small group. She had not had a good experience with past friendships, but she said that because the context in which she shared was much more open and accepting, she could expect a level of understanding and approval. She said that it made it much easier for her to share her experiences because she knew that she would not be judged harshly like she might have been in another context. Whether or not someone will choose to share in a moment depends on the context as well as what they know about the person they are telling.

There are many different reasons why someone will choose not to tell a friend or family member, and each decision is made based on an evaluation of their own personal relationship with each individual specifically. Michael spoke about his decision not to tell all of his friends about his depression, saying that with some friends, "we just don't have that kind of a relationship." This speaks to the fact that there are some people with whom sharing a diagnosis of depression would be more appropriate and others with whom it would be less appropriate. With the exception of one participant, at least one person in each participant's family knew about their depression, but there were four participants who had not told any of their friends and even fewer who had told more than a few of their friends. Americans are more likely to tell a family member than a friend about something that can be stigmatized, like depression, because the "blood relationship" we culturally construct seems to be stronger than a friendship that we know can be terminated at any time. As Schneider (1968:46) remarks, "Americans say you can pick your friends but not your relatives: you are born with them…One may be lucky or not so lucky, but there are no refunds or exchanges or second chances where blood relatives are concerned. One takes what one gets." There is a sentiment that family members have to love each other, no matter what they tell each other:

> With relatives, it is who one is and not how he does or what he does that counts…I do not mean that a mother who does a bad job of it is above reproach or beyond criticism. I mean

> that she cannot lose her position as mother no matter how badly she does it. She may lose custody of the child, but she remains its mother. (Schneider 1968:47)

There is an attitude that friends are more likely to leave us if we suddenly seem undesirable, but family is stuck with us; they have to love us. Americans believe that telling a family member about something unappealing will not terminate a relationship with them, but may believe that telling a friend about their depression could be a factor in the relationship either declining or completely terminating. They will be much less likely to tell that friend.

On the other hand, because we do not choose our friends, we might feel a stronger connection to them because we had something in common with them and enjoyed their company and, thus, chose to have a relationship with them. Stone (2001:285) explains that we relate to each other "either through shared beliefs, ideologies, or blood." As we tend to share the same beliefs as our friends, they may be more likely to understand and react in a positive way. A good relationship, in which two people connect really well, can encourage openness, but there are some relationships that are more open than others. If someone experiencing depression feels that a friend or family member will be especially accepting and supportive of their depression, they will be more likely to be open.

Participants also seemed to be more likely to open up about their depression if they had been "officially" diagnosed by a doctor. Of the ten people I interviewed that had been depressed, three of them did not have a confirmation from a doctor that they had been depressed. One of the three was Emily, who had not told any of her friends or family. Similarly, Danielle had not told anyone at first, although she revealed that her parents had figured it out and that she later told a few close friends. The last of the three, David, had told his parents and a few of his friends, but said that he did not regularly discuss it with them. Of the other seven participants, all had told at least one friend and one family member. Because doctors look at depression through a biomedical lens,

participants who went to a doctor were more likely to give a biological explanation for the cause of their depression. Alternately, those who may have already had a biological explanation for their depression would be more likely to go to a biomedical doctor to be treated. Regardless, having this biological cause to fall back on lessens the stigma they feel and makes them more likely to share their diagnosis because they believe that the causes and solutions are external to themselves, removing the blame from themselves, and putting it beyond their control. If they feel that the person they are telling would have a similar explanation for their depression, they would be less likely to react in a negative way and, thus, would be more likely to open up.

A negative reaction to opening up will make someone think twice before telling another person again. When Jessica began telling her friends about her depression, at first, "they were mostly ok with it," so she started to feel more comfortable telling other friends. After these favorable reactions, she described the negative response of one friend and how she was hurt by it, saying that she, "realized how bad it feels when someone doesn't believe you or understand what you are telling them." She said she was more hesitant and selective about who she told after she experienced this negative reaction from her friend, explaining that she did not want to go through the stress and hurt of having a friend who was not on her side again. "One was enough," she continued:

> I don't think I could have taken it if I found out another person didn't believe that what I was feeling was worse than the sadness and stress that they felt in their everyday life. I told her because she was one of my best friends, and if telling one of my best friends didn't help, telling someone I wasn't as close with probably wouldn't be a whole lot better.

She was able to choose who did and did not know about her depression, opting to tell the friends whose reactions she expected would not make her feel even worse than she was already feeling.

When someone is depressed, they have the choice of whether or not to give others the knowledge that they are depressed. Because many people often do not feel in control of their depression, being able to choose who knows can make them feel more in control of their depression. They can at least have control over this aspect of their life. According to Luhrman (1989:137):

> All knowledge is a form of property, in that it can be possessed. Knowledge can be given, acquired, even sold. It may seem like less property than objects because lies are common and mistakes easily made, and because it is not divided when shared. Nevertheless, knowledge can be owned and held. And like the difference between private and public property, it is secret knowledge that evokes the sense of possession most clearly.

The circumstances under which someone shares this knowledge that they have been depressed are often specific and confidential. Everyone keeps secrets for one reason or another, and each secret has a reason behind it. Usually it will be because they think others will stigmatize them for it or that it is not their secret to tell. If it is not explicitly stated, it is usually implied by the situation that the knowledge that they have experienced depression is a secret for the person experiencing it to tell, not for their friend or family member to go around telling others. They possess the information and choose who is allowed to posses it as well. Concealing information about one's depression gives the possessor of the information more control, or at least perceived control, over situations involving it.

Because the possessor does not have to share their information, it can also mean a lot to the person being told the secret state—depression—when one does end up sharing. Lurhman (1989:136) also states that, "The existence of this special property distinguishes possessor from nonpossessor and alters the attitudes of both toward the thing possessed." This secret knowledge may alter their attitudes toward their friend or family member, and they may regard this

information more highly when they do finally possess it. Luhrmann (1989:138) also discusses this idea in that, "The way knowledge is acquired affects the way you feel about it. When the knowledge is hidden, and revelation demands hard, painful work, but brings status in its wake, one treats these secrets with overvaluing awe." When a friend shares a secret like this, many people will react positively to their friend or family member based on the fact that they trusted them enough to tell them, in hopes of encouraging them to do so again in the future.

Interviewees often described a mixed emotional reaction from their friends and family members, but most did not react negatively overall. It is unclear whether this is due to the fact that they withheld the information from the people who they expected would have reacted poorly or because their own self-stigma is worse than the stigma other people ascribe to it. According to the College Student Mental Health Survey (American College Health Association 2006), twenty-eight percent of college students indicated a very high level of self-stigma, saying that responses such as, "I would feel inadequate if I went to a therapist for psychological help," described how they felt. This echoes the idea that some interviewees described, saying that it was okay for someone else to get help, but did not feel that it is okay if they themselves to got help. As Emily said, it would be admitting that she could not do it on her own, and America strongly values a sense of individualism and gives pride to people who can be mentally "strong" and stick it out themselves (Hurt 2007).

After telling a friend or family member, participants also indicated that it was important to be able to get away from the constant reminder that some friends and family members gave when trying to support them. Although it may have been well-intentioned, many participants found that constantly being asked about how they were doing was not supportive, so this was also a factor in who my participants told. As Jessica said:

> After I told my mom about it, I could hear the pity in her voice every time I talked to her after that. Don't get me wrong, I'm happy I told her, and I would do it again in a second—I

> mean, she's my mother—but even if it's not on purpose, I just wish she wouldn't keep reminding me of it every single time I talk to her. She just makes it so I can't forget about it when I'm talking to her.

Participants seemed to feel that telling those that they see or talk with often, such as friends and family, would almost be like making sure that it is on their mind whenever they are around. Emily said her parents were already frequently asking her what was wrong, and she felt that telling them that she was depressed would mean that they would relentlessly be asking and she would never be able to forget about it. Their concern, although coming from a good place, would be a constant reminder of her depression, even after she got better. Even if it did come up in normal conversation, she said, any concern on their part would come off as a way of figuring out if she was still feeling depressed. Danielle similarly found that it was good for her to have a group of friends that did not know she was depressed, and, "just kind of hanging out with them and having a different kind of energy around me was very valuable for me at that time." It was good for her to be able to get away from it for a while and focus on other things.

Depression is not usually something most friends talk about in normal conversation, so when I asked Michael if any of his friends had been diagnosed with depression as well, he said he knew of one, but had "never really asked." He, like so many of my participants, just assumed that because no one had ever told him about experiencing depression, that none of them had experienced it. Although he had not told all of them, of all my participants, he was probably the most open with his friends about his depression. He said that most of them knew what was "going on," but that they usually helped him by making him come out of his room and hang out with them, usually without specifically saying it was because of the depression. He said that depression usually only came up in conversations with his friends when it started to become a problem.

For the most part, the more comfortable someone was with their own depression, the more likely they were to share with others that they were depressed, although most people whom I interviewed did not specifically verbalize this. Emily, who had told no one, seemed to have the strongest self-stigma and seemed to constantly be defending her actions and her family and friends' choices and opinions, as if she expected everyone, including me, to be judging her for admitting that she had been depressed. Americans tend to think about themselves more than other people and may feel the glare of others, and over exaggerate or over think it, making it into something more than it actually is (Hurt 2007). Michael, on the other hand, seemed to be very easygoing about his depression and had told most of his friends and family. He may not have been happy about being depressed, but he had accepted it as part of his life. This was probably due to the fact that a lot of his family members had been diagnosed with depression before he was. He had grown up seeing how it affected them and how they dealt with it, and had grown more comfortable with being around it. When I asked if he had ever expected to experience depression, he responded "I'd always joke about it in high school, like "oh, my whole family has it, I'm going to get it," but never really anticipated it, and then when it happened, it just happened, and you'll sometimes stop and think, "this can't like be going on like this long," but it is." Emily, on the other hand, only knew of one person, a friend, who had experienced depression, so depression was still very new to her when she first started to experience it. When I asked her the same question, she responded simply by saying: "never." It seemed that the longer someone had been around or experienced depression, the more comfortable they were with it and, thus, the more open they were with their friends and family.

Someone might also keep depression to themselves, at least at first, is because they are still trying to deal with it and come to terms with it themselves. Before they have the strength to tell another person, they need to figure out how they themselves feel about it and get a better handle on it before they can have another person telling them what they think and what to do.

Piazza and Bering (2010) posit an alternate reason for not telling someone something like depression. For them, "secrecy functions primarily as a defense against stigmatization by suppressing information about oneself or one's kin that evolutionarily has been devalued in mating and social exchange" (Piazza and Bering 2010:290). Although being secretive with a depression diagnosis may be due to this at a deeper level, most people do not discuss it or are not aware of it. While Piazza and Bering (2010) talk about evolution and the emergence of secrecy, this secrecy is not just about reproduction. It is also about social interaction; it is about friends and family; it is about happiness and life. It is very difficult to be happy without other people in one's life with whom to share the good times, as well as the bad times, but if one is afraid to share this with them, one can miss out on closer relationships. Many of my participants talked about how telling the friends closest to them brought them even closer than they already were.

On a similar note, it can also become about job possibilities. It can be harder to get a job after suffering from depression, especially if the possible employer knows about it and thinks that it might affect future job performance. They might think that people who have been depressed will be less motivated or productive than those who have not, and be less likely to hire them. Ainsworth (2000:113) discusses this in her self-help recommendations to people experiencing depression:

> Self-Care Tip #8: Be circumspect when confiding information about your depression. While the support of family and friends is an important component of your recovery, you are not duty bound to disclose details to casual acquaintances and colleagues. If you believe your depression is impairing your performance at work, you may choose to discuss your concern with your supervisor…Do not discuss your depression in a job interview unless you feel the condition will be an issue in the interview process. It is probably best not to discuss your depression in a work-related environment, but if you must do so, discuss your strengths first and then comment simply on the temporary limitations you are experiencing and on

> what would help you perform well. Your personal life remains your own property, and it is your choice as to whether or not you disclose the details of your illness to anyone other than your doctor or therapist.

This recommendation, from a psychiatrist, further proves that people who have experienced depression have to control who they share their experiences with for more than just social support reasons. Many different things can come about after disclosing that one has been depressed.

Consequences of Sharing

The most obvious reason why someone would choose to share possibly stigmatizing information like depression is if they felt that they would end up receiving support and empathy from their friend or family member. This is one of the main motivations for sharing, as well as wanting to be close with friends and family and for them to know what is going on in their life. Whether or not they actually know what depression feels like, having a friend understand that depression is not easy can be extremely helpful. This adds a deeper level to the relationship, which can bring them closer and promote a more supportive relationship. It is very difficult to support someone who is depressed if others do not know that they are depressed or if they are not open about it. When I asked my study participant whether or not people who did not know they were depressed had been supportive. Many spoke about teachers or professors who had been especially understanding. Depression can often affect a person's performance in school, so this must have been particularly important in helping them get through their schoolwork.

Many also answered that, by not sharing with everyone, they were able to get away from it for at least a short time. It was helpful for them to have a reminder that some things in their lives were still the same, that depression is not everything, and that they will get better. Because

depression can take over one's life, it can be hard for them to see that they will not always be depressed, and having someone who does not know, someone they can be normal around, can help them feel normal. Megan said of the people who did not know that she has experienced depression, "they're not just like, "oh she's depressed, I'll help her," it's just more like they'll do these small things that just make me smile." She said that the people who did know that she had been depressed had a different mindset in supporting her and were able to help her in a different way than her other friends who did know.

It can be very difficult to know what to do when someone reveals that they have been depressed. Depression is not something that most people think about on a daily basis, so when a friend or family member comes to them with this news, it can be overwhelming. Barbara indicated that when she first started experiencing depression, she did not know what to do for herself, but now, thirty years after first experiencing it, she said, "I'm smarter now. If something like this happens, I know what to do now. Twenty years ago, I didn't really know what to do. I certainly deal with it better now, just by experience." This can be even worse for someone who has never experienced depression and is responsible for supporting someone who has. If this is the case and the other person has no idea what to do, their reaction might not be purposely hurting them, but they might be forced to make an educated guess about what would be supportive, and they can easily guess wrong. They might not be thinking about it in the same way, with the same mindset, or be thinking about what they think they would find helpful in the same circumstances.

A negative reaction can worsen it, and send the sufferer into a deeper depression. This is why most people avoid telling someone who they expect will react poorly: to avoid the added stress that comes from an unsupportive friend or family member. People experiencing depression often find their thoughts spiraling in a negative direction where they would not have otherwise done so, and if someone reacts negatively to their depression, it can become that much worse. Therefore, if

someone suspects that a friend or family member will react poorly, they will withhold the information, keeping to the hope that maybe they would not actually react that way, and keeping that relationship on the best ground possible. For example, Megan did not tell many of her friends until she started college because she believed that they would not be supportive. The reaction she had gotten from her family was not supportive, and did not expect that her friends would be any better. She felt a better connection with her friends in college, so when she finally told them, different friends than in high school, she said that they were much more supportive than she expected, was pleasantly surprised, and that she was very happy that she told them. On the other hand, if someone with depression does end up telling someone who turns out to be unsupportive, they will often avoid talking about the subject with that person, and will not receive much support from them. They are rejecting the notion that they need help and might be embarrassed or uncomfortable around the person. Depression is a very vulnerable state to reveal, and telling them is taking a risk. If they violate the trust of the information, they will most likely not take that risk again.

The response from the first person people tell affects them for the rest of their life. Pulling together the courage to tell someone that they have been depressed is hard enough, but if someone has a bad reaction the first time they open up, they will most likely be more careful telling others about it for fear of further negative reactions. On the other hand, if the person they tell first has a good reaction, it can be encouraging, and they might be more likely to tell additional friends and family members, especially if the reaction was better than they expected. Megan was very hesitant to tell her friends at first. Although it was not the first time, after constantly being let down by the people in her life, when she finally decided to open up about her depression to her friends in college, she was pleasantly surprised at their reactions:

> I didn't really open up about it until I came to college. I was just really closed off in high school, but I came here, and I was really open with some of my friends, and they had never really met someone who had been depressed before, and who had attempted suicide, so they were kind of shocked. So I just told them how I experienced it, like, how it affects me day-to-day still, but they were just really helpful, and it wasn't what I was expecting. They wanted to know more about it so they could help me if it ever came back.

She said it was not hard to open up to her other college friends after this because the first ones she told had such a positive, supportive reaction. Ainsworth (2000:111-112), in her self-help book suggests:

> Self-Care Tip #4: Do not allow your depression to socially isolate you. Although you may feel uninterested in other people and their mundane conversations, push yourself to maintain contact with your family and close friends. They care about you and will be supportive of you even when you are not yourself.

Although I do not think any of my participants had read this book, it might have been beneficial for them to know that their family and friends would probably end up being more supportive than they expected. Megan found that she actually got something positive out of telling them, which she had not expected, making her more likely to tell other friends in the future. She said that she did not regret telling them like she had telling some of the members of her family.

Regret can also be a consequence of telling someone. Especially if someone reacts negatively, it may be a response to want to go back to the way things were before telling them, or even, such as in Emily's case, when she told her doctor: "I can't figure out if it's just me being paranoid, but I could have sworn that when I told my doctor—a different one than the one that diagnosed me—I could have swore that he was judging me. He got really quiet and just kind of nodded his head. It kind of made me wish I hadn't said anything." In America, there is the idea that

doctors are supposed to be easy to talk to about health problems, but she felt that she should not have told him. Because she said she did not think she had a medical reason that required him to know, she could have left it out. Had he been more understanding, she might have thought it was worth it to tell him, but ended up wishing she hadn't. Jessica indicated a similar regret after telling the friend that she felt reacted negatively, which she said influenced her decision to be more mindful of who she told afterward.

These ideas of secrecy and trust can be translated from other areas of life as well, and vice versa. If someone who has experienced another stigmatized aspect of themselves experiences depression, they will take what they have learned from other situations and apply it to depression or take what they learned from depression and apply it to those situations. Barbara came into the interview knowing that she was going to be talking about her depression, but I do not think that she had originally intended to reveal her minority sexual identity. Evading it in the beginning, I could see a sense of trust develop throughout the time we spoke she became more comfortable revealing that part of herself to me as the interview went on. Although she did not say that the stressful family relations that came of it were the only reason for her depression, she did cite it as a factor in making it that much worse, saying, "my brother, he's got a bunch of kids, and he doesn't like me around his kids because I'm gay. I don't know, he's afraid it's going to rub off or something, so there was always this tension at family gatherings and stuff like that, but now we just avoid each other." She was able to translate people's reactions to her sexual identity to how they would have reacted if she had told them that she was depressed. Because most of the reactions to her sexual identity were negative, she chose to keep her depression to herself and a few close friends and her sister.

Perhaps some people may find sharing a secret about a stigma as a bond, while others may be repulsed by being associated with a stigma, afraid that they themselves will be stigmatized. Associating themselves with someone who has a stigmatizing characteristic about themselves can

make the person who associates themselves with them feel stigmatized as well. They may feel that because others view their friend or family member in an unpleasant light, they will be seen the same for associating themselves with them. Swim et al. (2010:61) found that people were more likely to disagree with someone if they had a prejudice against some aspect of their social identity, such as sexual identity, saying that, "people can distance themselves socially by expressing beliefs that are dissimilar to another person's beliefs, regardless of whether they agree with the other person." A similar thing can happen to people when they reveal that they have been depressed. If someone reacts negatively and stigmatizes the other person for being depressed, they are more likely to want to distance themselves from that person.

Depression can be extremely polarizing. It will either bring friends and family closer together or break them apart, often depending on how they react to the depressed person's shared vulnerability. If someone reveals that they have been depressed and the other person reacts negatively, they will be much less likely to want to associate with that person, tearing them apart. On the other hand, if the other person reacts supportively, they will be more likely to open up even more and become closer through this shared information. Many of my participants indicated that this response helped them determine who their true friends really were.

Hiding one's depression can be very difficult, but there is always a reason to hide something like this from friends and family. Although so many college students are suffering from depression, they are not always aware of it, and hiding it from others is one way to defend one's self from the possible negative reactions of other people. My participants have done many different things to diffuse the stigma they expected to experience from revealing that they have been depressed. Once they share such personal information with their friends and family members, they are more likely to come to them with their own problems and information. By managing who knows that they are

depressed, they can feel that they have more control over their depression, and consequently, the stigma they feel because of it.

# Conclusion

This has been one of the most significant personal growth experiments I have ever undertaken. It has changed the way I look at depression and the world. It really emphasized to me that you can't just assume that you understand what someone's life has been like, no matter how well you know them, or that their experience of the same situation is the same as you. Although the media depicts it as a single experience, I found that there is not a single experience you can point to and call the characteristic depression experience. Each informant experienced their own depression in a completely different way from my other informants.

My research also served to emphasize that people make snap judgments about people they do not even know, stigmatizing them for things that they do not fully understand. A few of my participants defended other people's reactions to their depression, like when Emily defended her father's stigma against depression, even though she herself was afraid to tell him about her depression. If you think about it, it is really not okay for people to be so prejudiced against others, no matter what characteristics they have or what they do to acquire them. Kumar et al. (2009:7) argue that, "Stigma can only be created by over-simplifying complex situations," a finding that was proven in my research. This served to emphasize to me that Americans should make decisions about what kind of person other people are after they get to know them, not before they know anything about them like is the case with stigma.

I also found that everyone finds different things supportive in relation to depression, and that it does not necessarily have to be what the person expected to be the most helpful. In the future, it might be interesting to talk with people who have not experienced depression or been around those who have and compare it with people who have experienced depression and their friends and family members. This could help figure out ideas that would make it easier for friends and family to support people with depression, especially for those who have never experienced it.

They will probably need help knowing what to do to be supportive and to figure out how to communicate the experience to other people who have not been around it. Stigma comes from people not knowing, and they might be able to understand it better if they knew more about it.

It might also be interesting to further research possible ways that the stigma against depression, and other disease or social qualities, can be reversed. Regardless of the stigma people feel from others, depression is a debilitating disease that changes a person's life. Many of my informants spoke about how much stronger they thought they became because of their depression, just as, I imagine, writing this thesis made me stronger. Emily said of her depression:

> I kind of learned a lot about myself through it. I realize that I'm a lot stronger than I thought because I dealt with it instead of succumbing to the typical typecasts I mentioned earlier—being sad all the time, not including yourself in the activities where you'd be surrounded by others. I always forced myself outside of my comfort zone, and that's helped a lot, like, I would never ruin my relationships, or stop going out, but I did notice changes in myself despite all my efforts.

Jessica echoed a similar thought, saying "Part of me just says bring it on. I'm stronger now because of it, and I wouldn't give that up for anything. I know I can take anything life throws at me now."

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