

**THE USE OF ANTIDEPRESSANTS AND COUNSELLING FOR DEPRESSION:
THE LIVED EXPERIENCE OF
POST-SECONDARY STUDENTS AND COUNSELLORS**

BILL McKAY

BScN, University of Lethbridge, 2006

A Thesis
Submitted to the School of Graduate Studies
of the University of Lethbridge
in Partial Fulfilment of the
Requirements for the Degree

MASTER OF SCIENCE (NURSING)

Faculty of Health Sciences

University of Lethbridge

LETHBRIDGE, ALBERTA, CANADA

© Bill McKay, 2012

I would like to dedicate this thesis to all of those students who are currently managing depression, as well as, those currently suffering alone...don't lose hope.

**Hope is important because
It can make the present moment less difficult to bear.
If we believe that tomorrow will be better,
We can bear the hardships today.**

Thich Nhat Hanh

Abstract

This study explored the perceptions of post-secondary students and counsellors towards the use of antidepressants and counselling to manage depression. Student depression is increasing and antidepressants appear to be the most frequently used treatment by students. The literature reveals that most depressed students are not accessing campus mental health centres, and counsellors are noting increased severity of illness for those that do seek help. Therefore, in an attempt to gain increased understanding of students who use antidepressants as well as counselling, the student and counsellor perspective is essential.

In this study, 10 students and 6 counsellors were interviewed by the researcher. Interviews were digitally recorded and transcribed verbatim. Thematic analysis guided by van Manen's (1990) hermeneutic phenomenology was used. Overall, the themes identified aim to represent the lived experience of the students who are living with depression and to better assist counsellors in understanding and developing interventions suited to student need.

Acknowledgements

The completion of this thesis could not have been possible if not for guidance and support of some amazing people. First, I need to thank all of the students who shared their personal and intimate stories with me in an effort to have their voices heard. Second, I would like to thank the counsellors who shared their experiences of helping those students who are managing depression. Third, I would like to thank my supervisor Dr. Brad Hagen and committee members Dr. Gary Nixon and Dr. Jennifer Copeland for their knowledge, support, and guidance. Finally, I need to acknowledge my family who have been so patient and supportive, Kristin, Klair, & Liam... I have achieved this because of you!

Table of Contents

ABSTRACT.....	iii
ACKNOWLEDGEMENTS.....	iv
TABLE OF CONTENTS.....	v
LIST OF TABLES.....	vii
LIST OF ABBREVIATIONS.....	ix
CHAPTER 1: INTRODUCTION.....	1
Depression.....	1
Treatment of depression.....	1
Problem.....	3
Purpose and Outline.....	4
CHAPTER 2: LITERATURE REVIEW.....	7
Introduction.....	7
Depression among College and University Students.....	8
Suicide among College and University Students.....	9
Antidepressant use by College and University Students.....	10
Mental Health Service Use by College and University Students.....	10
Factors Contributing to Post-secondary Student Depression.....	12
External or situation factors.....	12
Poor grades.....	12
Loneliness or isolation.....	12
Stress and fatigue related to coursework.....	13
Financial difficulties.....	13
Internal or personal factors.....	14
Gender.....	14
Ethnicity.....	15
Emerging adulthood.....	15
Personality characteristics.....	16
Relationship status.....	16
Consequences of Post-secondary Student Depression.....	16
Health related consequences.....	16
Physical ailments.....	16
Cigarette smoking.....	17
Substance abuse.....	17
Academic consequences.....	18
Learning difficulties.....	18
Poor grades.....	19
Treatment Issues for Post-secondary Students with Depression.....	19
Barriers to treatment.....	19
Professional response to student depression.....	20
Web-based interventions.....	20

Psychotherapy.....	21
Campus education programs.....	23
Conclusions and Implications for Practice.....	23
Implications for students.....	24
Implications for counsellors.....	25
Implications for community.....	27
Conclusion.....	28
CHAPTER THREE: STUDENT EXPERIENCES OF USING ANTIDEPRESSANTS AND COUNSELLING TO MANAGE THEIR DEPRESSION.....	29
Introduction.....	29
Literature review.....	30
Statistics on student depression.....	30
Responses to medication as treatment.....	33
Responses to counselling as treatment.....	35
Method.....	36
Participants.....	38
Procedure.....	39
Analysis.....	40
Rigour.....	41
Results.....	42
Split between antidepressants and counselling.....	42
The antidepressant-body component of split.....	43
The counselling-mind component of split.....	45
Challenges along the way.....	48
Tweaking and tinkering.....	49
Rather tell people about antidepressants than counselling.....	51
The other side of side effects.....	55
Discussion.....	60
Implications for counsellors.....	63
CHAPTER FOUR: COUNSELLORS EXPERIENCE OF PROVIDING COUNSELLING TO STUDENTS WHO ARE USING AN ANTIDEPRESSANT.....	67
Literature review.....	67
Method.....	71
Participants.....	73
Procedure.....	73
Analysis.....	74
Rigour.....	75
Results.....	76
Counsellors perceive three types of students.....	76
Students with previous antidepressant experience.....	76

Students with resistance to antidepressants.....	77
Students who could benefit from an antidepressant.....	78
Advantages of antidepressant use by students.....	80
No motivation: They can't get out of bed.....	80
Spinning their wheels: The body has its own agenda.....	81
Disadvantages of antidepressant use by students.....	82
Side effects: Both getting on and getting off can be tricky.....	83
The magic bullet: Just sit back and feel better.....	84
Session time can be focused on antidepressant issues.....	86
Counsellor perceptions of factors contributing to student depression.....	87
Life transitions, developmental stress: from being cared for to caring for self.....	88
Isolated and alone: Experiencing relationship trauma.....	89
Academic pressure, great expectations: "I should be able to do this".....	90
Discussion.....	92
General discussion.....	92
Implications and future research.....	95
CHAPTER 5: DISCUSSION.....	97
Summary of findings.....	97
Chapter 3 discussion.....	97
Chapter 4 discussion.....	100
Implications for practice	103
Limitations.....	106
APPENDIX A: STUDENT POSTER.....	108
APPENDIX B: STUDENT INTERVIEW GUIDE.....	109
APPENDIX C: INFORMED CONSENT/INVITE TO PARTICIPATE.....	110
APPENDIX D: STUDENT DEMOGRAPHIC INFORMATION.....	112
APPENDIX E: COUNSELLOR CONSENT/INVITE TO PARTICPATE.....	113
APPENDIX F: COUNSELLOR INTERVIEW GUIDE.....	115
APPENDIX G: COUNSELLOR DEMOGRAPHIC INFORMATION.....	116
REFERENCES.....	117

List of Tables

Table 1. Student Themes identified from Chapter 3.....	97
Table 2. Counsellor Themes identified from Chapter 4.....	100

List of abbreviations

ACHA-NCHA	American National Health Association-National College Health Assessment II
APA	American Psychiatric Association
BATD	Behavioural Activation Treatment for Depression
BPI	Brief Psychodynamic Investigation
CPA	Canadian Psychiatric Association
CBT	Cognitive Behavioural Therapy
GPA	Grade Point Average
NAMI	National Alliance on Mental Health
NICE	National Institute for Health and Clinical Excellence
PHQ	Patient Health Questionnaire
SSRI	Selective Serotonin Reuptake Inhibitor
WHO	World Health Organization

Chapter One: Introduction

Depression

The World Health Organization (WHO, 2008) estimates that 121 million people worldwide are affected by depression, and further predict that major depression will be the second leading cause of disability by the year 2020. Some of the numerous factors that are believed to cause depression include biochemical imbalances, genetics, personality, cognitive processes, trauma and abuse, and social influences (Cornford, Hill, & Reilly, 2007). However, the causal links between these contributing factors and depression remain relatively uncertain (Eby & Brown, 2009). The symptoms of depression impose extreme difficulties on individuals with this condition, creating great personal distress as they try to meet job requirements, go to school, negotiate social relationships, or even fulfil the normal requirements of daily living (Eby, & Brown, 2009). Depression produces symptoms such as hopelessness, helplessness, worthlessness, pessimism, loss of interest, decreased energy, difficulty concentrating or making decisions, insomnia or hypersomnia, and weight loss or gain, among others(American Psychiatric Association [APA], 2000).

Treatment of Depression

As mentioned, the exact causes of depression are not fully understood; therefore, numerous approaches are used for treatment. Although there are numerous treatments with various effectiveness such as light therapy, exercise, and sleep therapy(Ravidran et al., 2009), the most common treatments include antidepressants, counselling, and a combination of antidepressants and counselling.

Many leading health organizations such as the National Institute for Health and Clinical Excellence (NICE, 2009) and the Canadian Psychiatric Association (CPA, 2005) have recommended that antidepressants be thought first-line treatments for moderate to severe depression in adults. Meanwhile, counselling has been recommended by NICE (2009) for the treatment of mild to moderate depression before the administration of antidepressants, because of the relatively high rate of side effects and adverse events associated with their use.

Anti-depressants alone and counselling alone have demonstrated effectiveness in the treatment of depression; although there is limited evidence that one is more effective than the other (Spencer, & Nashelsky, 2005). Depression can often be chronic, and in these cases, both treatments will often be tried alone or in combination (Van, Schoevers, & Dekker, 2008). Combination treatment appears to be the most effective in severe or chronic depression and less so in non-severe depression (De Jonghe et al., 2004; Keller et al., 2000; Schramm et al., 2007). The potential benefits for those individuals who are managing severe or chronic depression include “improved treatment response, enhanced quality of life, reduced relapse/recurrence rates, and facilitation of lower medication doses, along with enhanced compliance” (Segal et al., 2001, p. 59).

Some research has shown that antidepressants work quicker in improving patient symptoms than counselling in the initial phases of treatment, while counselling had more of an effect after the initial phases (Keller et al., 2000). Indeed, NICE (2009) recommends that if depressed individuals have demonstrated no response to medications or psychotherapy alone, combined therapy should be considered and a referral should be made to an appropriate health professional. However, the CPA (2001) recommends that

sequential addition of an antidepressant to psychotherapy only be considered after persons show no improvement after eight weeks or partial response after 12 weeks to psychotherapy. This recommendation has implications for college and university counsellors who have limited session time with students being treated for depression.

The Problem: University and College Student Depression

Young adults have the highest rates of depression of any age group, with as many as 25% of them experiencing depression by 24 years of age (Kuwabara, Van Voorhees, Gollan, & Alexander, 2007; Van Voohees et al., 2005). The debilitating symptoms of depression can be extremely detrimental to the identity development of young adults attempting to develop healthy foundations for their future (Kuwabara et al., 2007).

During this developmental period, many young adults enter university or college, where they encounter numerous stressors from academic requirements, social life, and financial pressures (Cooke, Bewick, Barkham, Bradley, & Audin, 2006; Dusselier, Dunn, Wang, Shelley II, & Whalen, 2005). These stressors can increase the difficulties that young people suffering from depression experience (Megivern, Pellerito, & Mowbray, 2003). For example, a national health assessment conducted by the American College Health Association's National College Health Assessment II (ACHA-NCHA II, 2011) demonstrated that over 30% of students surveyed had felt so depressed that it was difficult to function during the previous year, and that 10.7% of students surveyed had been diagnosed or treated for depression during the previous 12 months.

Unfortunately, it appears that the majority of depressed students are not accessing the help they need. The American Foundation for Suicide Prevention Screening Project found that 85% of students who screened positive for moderate to severe depression had

not been treated by antidepressants or counselling (Garlow et al., 2008). Additionally, Eisenberg, Golberstein, and Gollust (2007) found that just over one in three students who screened positive for major depression had been treated during the previous year. Their finding is similar to that reported by the 2008 ACHA-NCHA II that reported 35% of students surveyed were currently taking medication for depression. Comparatively, the same study reported that only 25% of students chose therapy to treat their depression. So, why are antidepressants the most common treatment for post-secondary students with depression? Why do students prefer antidepressants over counselling for the management of their depression? Why are depressed students not accessing the help at their schools mental health centre?

Purpose and Outline

Given the relative paucity of research on students' perceptions of antidepressants and/or counselling for treating depression, the purpose of this research study was to conduct a phenomenological inquiry into the lived experiences of students who use both antidepressants and counselling to cope with depression. To achieve a more complete understanding of the student experience, I have researched the experience from the student's perspective and also from the college and university counsellor's perspective.

To this end, my research questions are:

- 1) What are the lived experiences of college and university students using both antidepressants and counselling combined to cope with depression; and
- 2) What are the lived experiences of counsellors providing counselling to college and university students relying on antidepressants and counselling to cope with depression?

The first research question is the crux of the study, as discovering how post-secondary students experience depression—with its most common treatment modalities—could offer potential insights regarding the factors they feel contributed to their depression. In terms of the first research question, this study hopes to explore the following: if students believe their antidepressants and counselling helps them, both alone and in combination; what are their preferences for treatment; what stigmas are associated with treatment in post-secondary life. The second research question complements the first, as it allowed the researcher to explore the experiences of counsellors who work with students coping with depression. College and university counsellors witness both students who are experiencing depression for the first time as well as students who may have begun their post-secondary education with pre-existing depression, diagnosed or otherwise. The findings of this study have significant implications for mental health professionals who work with post-secondary students coping with depression. In addition, the findings could help mental health professionals develop interventions that effectively reach the large percentage of students who are not accessing their help. As Cox-Dzuree, Allchin and Engler aptly state, “Assessing the nature of students’ experiences and designing relevant interventions to help them cope with adversity may make an important contribution to stemming the rising tide of depression among college and university students” (2007, p. 551)

Overall, this thesis consists of five chapters. The first chapter is an introduction to the problem; it outlines the general topic and the research questions. The second chapter is a review of the literature that discusses the scope of the problem, the contributing factors and consequences of student depression, and current work by colleges and

university mental health service centres to manage the increases in student depression on campus. The third and fourth chapters are written in article format and report on the lived experiences of both the students (third chapter) and the counsellors (fourth chapter) through thematic analysis using van Manen's (1990) guided hermeneutic phenomenological philosophies. The fifth and final chapter consists of a discussion section, which will review and contrast the student and counsellor experiences; it also outlines potential implications for practice, for counsellors, other health professionals and students.

Chapter two: Literature Review

Statistics affirm depression as an increasingly prevalent health concern among both general and specific populations. In 2008, the World Health Organization estimated that 121 million people worldwide were affected by depression, and further predicted that major depression will be the second leading cause of disability by the year 2020. Of the millions affected by this mood disorder, young adults have a high likelihood of experiencing depression as 25% of individuals experience it by age 24 (Kessler & Walters, 1998). This trend is also conspicuous among Canada's 1.5 million college and university students (Statistics Canada, 2009). Depression is the leading reason cited by students seeking help at post-secondary mental health service centres (Eisenburg, Golberstein, & Gollust, 2007). The increasing incidence of depression among college and university student populations is significant to administrators, to mental health professionals—both within post-secondary institutions and in community clinics --and to the families and friends of those affected.

This article summarizes the scientific findings on this issue, and offers insights to professionals who help affected individuals. First, I review the increase of student depression and subsequent treatments—including the use of antidepressants and counselling—that students use to manage their use to manage depression. Second, I present current understandings about the causes of depression in the student population, and I investigate subsequent health and academic consequences for students. Third, I examine barriers to treatment as well as current professional responses to the increase of depression in the student population. Finally, I present the implications of this rising tide of depression for students, counsellors, and the community.

Depression among College and University Students

Research over the past few decades is increasingly revealing that college and university students have much higher rates of depression than any other demographic age category. In the late 70's, Oliver and Burkam (1979) found that one in six post-secondary students had suffered from depression during the college years. Almost a decade later, a study by Westefeld and Furr (1987) indicated that 80% of the students surveyed had experienced depression since beginning college. Throughout the 90s and into the new millennium, studies have consistently demonstrated high levels of depression among college and university student populations at levels ranging from 12% to 53% of the reported sample (Bouteyre, Maurel, & Bernaud, 2007; Furr, Westefeld, McConnell, & Jenkins, 2001; Hurtado et al., 2007; Michael, Huelsman, Gerard, Gillian, & Gustafson, 2006; Mikolajczyk, Maxwell, Naydenova, Meier, & Ansari, 2007; Moo-Estrella, Perez-Benitez, Solis-Rodriguez, & Arankowsky-Sandoval, 2005; Roberts, Glod, Kim, & Houchell, 2010; Soet, & Sevig, 2006; Swanholm, Vosvick, & Chwee-Lye, 2009; Tjia, Givens, & Shea, 2005; Wong, & Whitaker, 1993). The most recent American College Health Association National College Health Assessment II ([ACHA-NCHA II], 2011), found that of more than 34,000 students, 31.1% "felt so depressed... it was difficult [for them] to function" during the previous year; also, 10.7% had been diagnosed or treated for depression during the previous year. Four decades of research has shown that compared with the general population, college and university students continue to have exceedingly high rates of depression.

Suicide among College and University Students

Concurrent with the high incidence of depression in post-secondary students are elevated reported rates of both suicide and suicidal ideation on campuses in North America. The most recent National Survey of Counselling Centre Directors (Gallagher, 2009), which surveyed 302 institutions in the United States, reported 103 suicides during the previous year, 80% of the victims having previously dealt with depression (Gallagher, 2009). A Canadian survey of college and university counselling centres found that of the 34 participating institutions, 27 suicides had occurred during the 2002/2003 school year (Crozier, & Willihnganz, 2005). Unfortunately, 85% of these suicides were or had been counselling centre clients (Crozier, & Willihnganz, 2005). These figures suggest depression is directly related to increased suicide rates in the student population.

Other studies indicate similar trends. For example, one study of 12 mid-western campuses, reported 261 suicides, or 7.5 suicides per 100,000 students between 1980 and 1990 (Silverman, Meyer, Sloane, Raffel, & Pratt, 1997). A more recent study by Horton et al. (2009) found that 11.8% of students surveyed had reported an attempted suicide at some previous point in their life. Even though these rates appear alarmingly high, Schwartz (2006), who reviewed data in 13 studies published between 1920 and 2004, found that the suicide rate in the same population had decreased from 14.3/100000 students to 6.5/100000 students. Although it is impossible to predict if these decreases in suicide rates will continue, the statistics for the precursor to suicide, suicidal ideation, suggest otherwise. Recent studies reveal that between 20% and 43% of students have experienced suicidal thinking at some point (Horton, Diaz, & Green, 2009; Moo-Estrella, et al., 2005; Tija et al., 2005). Also, the ACHA-NCHA II (2009) reported that 6.1% of

students had “seriously considered suicide” at some point during the previous year. Other known, related factors to suicide include negative feelings of hopelessness, helplessness, loneliness; relationship issues; grade problems, and depression (Westefeld, & Furr, 1987). Of these factors, depression is the predominant risk factor for suicide (Moscick, 2001).

Antidepressant Use by College and University Students

Since the early 90s and the advent of Prozac and other selective serotonin reuptake inhibitors (SSRIs), antidepressant medication use has been widespread and is escalating. In the Fall 2011 ACHA-NCHA reference group data report, 3044 students reported to have been diagnosed or treated for depression in the past year; of these, over a third were currently taking medication for depression. Additionally, Kadison (2005), Chief of Mental Health Services at Harvard University Health Services, reported that students are more often relying on stimulants and antidepressants to maintain their competitive edge in college. He estimated that 25% to 50% of students seen by counsellors at student health centres were on antidepressant medication (Kadison, 2005). Interestingly, he suggested that increasing numbers of students take antidepressants because of the myth that antidepressants boost energy. He postulated that if students do not receive the medication they seek from a campus mental health centre, they may go elsewhere to obtain antidepressants. Post-secondary students are taking more antidepressants for various reasons, including for depression.

Mental Health Service Use by College and University Students

Although studies indicate the number of students using antidepressant medication is rising, other research indicates that the need for these medicines is much higher than

current usage levels. For example, Eisenberg, Golberstein, & Gollust (2007) reported that only 36% of students who screened positive for major depression in the Health Minds Study had used medication or therapy during the previous year. Results from the American Foundation for Suicide Prevention Screening Project paint an even more troubling picture, as 85% of those students with moderate to severe depression in their study were not being treated (Garlow et al., 2008).

Despite low mental health service use by students screening positive for depression in the above studies, counsellors in North America are seeing increased numbers of students presenting with more severe psychological issues. For example, in the United States, Gallagher (2009) reported 93.4% of the counselling directors surveyed had recently observed more severity in mental health issues in their clients than in previous years. While in Canada, Crozier & Willihnganz (2005) found that over three quarters of centre directors believed they were also noticing more students with severe psychological issues. Of the increased psychological issues students are presenting with at campus mental health centres depression appears to be the most commonly seen. Canadian counsellors note that more than one-third of students seen in their offices are coming for help with depression (Crozier & Willingnganz, 2005). The Canadian reported rates of students in therapy for depression appear to be higher than in other national studies. While on average, 25% of students who had been diagnosed with depression were currently in therapy for other mental health issues in the ACHA-NCHA studies (ACHA, 2000; ACHA, 2009); and other studies have demonstrated numbers less than the reported national findings of 25% by the ACHA (Furr et al., 2001; Michael et al., 2006; Soet & Sevig, 2006).

Factors Contributing to Post-Secondary Student Depression

Depression in the post-secondary student population appears to be multifaceted and unique. Factors contributing to depression in this population have been studied individually and as a demographic set. For clarity, these factors may be classified as 1) external, or situational factors, or 2) internal, or factors intrinsic to the students themselves.

External or Situational Factors Contributing to Student Depression

Poor grades.

A primary reason college and university students may experience depression is the attainment of poor grades. In Furr et al. (2007) over 50% of the students surveyed cited problems with grades as the principal reason for depression. Some researchers have questioned whether poor grades lead to depression, or if depression leads to poor grades, as depressive symptoms have been shown to be significantly correlated with low grade point averages (Ridner, Staten, & Danner, 2005) and with lower perceived academic performance (Mikolajczyk et al, 2008). Although the direction of the relationship between the two factors is unclear (Deroma, Leach, Leverett, 2009), poor course performance may cause a decrease in self-esteem, leaving students vulnerable to depressive symptoms (Bostanci, 2005).

Loneliness or isolation.

The same study by Furr et al. (2001) identifies loneliness (51%) as the second cause of depression symptoms. Other studies during the past decade confirm that loneliness and isolation are major contributors to student depression. Mikolajczyk et al. (2008) found that isolation was the strongest determinant of depression. Bitsika,

Sharpley, & Rubenstein (2010) postulated that students feel lonely, isolated, and stressed due to separation from the life that they had with friends, family, and others prior to college. Additionally, almost 60% of the students who had participated in the Spring 2011 ACHA-NCHA II reported that they had “felt very lonely” in the past year. These feelings of loneliness may directly impact a student’s ability to handle the pressures and demands of university and college (Cox-Dzurec, Allchin, & Engler, 2007).

Stress and fatigue related to coursework.

Because post-secondary students are under constant pressure to perform well and to maintain passing grades, students often report constant strain from their studies in general (Adalf, Gliksman, Demers, & Newton-Taylor, 2001), from specific coursework and exams (Mikolajczyk et al., 2008), from fatigue (Bitsika, Sharpley, & Bell, 2009), and from overwhelming negative emotions (Cox et al., 2007). Unfortunately, students who felt increased fatigue or stress during college and university were more likely to drop out (Pritchard & Wilson, 2003)

Financial difficulties.

The immense financial demands accrued by post-secondary students and their families can affect students’ academic performance and leave them vulnerable to depression (Andrews & Wilding, 2004). Furr et al. (2001) reported that 50% of students who had been diagnosed with depression cited money problems as a contributing factor. In an effort to remedy financial burdens, students often seek employment. One study demonstrated that more than half of students needed to work full time or part time to meet the financial demands of post-secondary education (Swanholm et al., 2009). Full time work, as well as volunteer work with more than an average number of hours

(Lindsey et al., 2009), is associated with higher depression levels than either part time or casual work (Khawaja, & Duncanson, 2008;). Additionally, students from families at a lower economic status (Eisenberg et al., 2007) were also at higher risk for depression. Contrary to these findings, Swanholm et al. (2009) found that having a job may actually shield students from depression by providing increased social opportunities and better financial stability.

Internal or Personal Factors Contributing to Student Depression

Gender.

The literature presents conflicting views on the prevalence of depression in each gender. Although most studies of the general population demonstrate that women suffer from depression at a higher rate -- at a ratio of roughly 2 to 1 -- than do men (Antonuccio, Danton, DeNetsky, Greenbert, & Gordon, 1999; Nemeroff et al., 2003; Stoppard, 1999), depression is not always present in female college students at a rate double that of their male counterparts. Some research has reported depression in a higher proportion of male students than female students (Grant, Marsh, Syniar, Williams, Addlesperger, Kinzler, & Cowman, 2002; Michael, Huelsman, Gerard, Gillian, Gustafson, 2006). At the same time, numerous studies report no significant differences in the rates of depression between the two genders (Boggiano & Barrett, 1991; Bostanci et al., 2005; Bouteyre et al., 2007; Dixon & Robinson Kurpius, 2008; Kelly, Kelly, Brown, & Kelly, 1999; Khawaja & Duncanson, 2008; Leino & Kisch, 2005; Swanholm et al., 2009; Wong & Whitaker, 1993). Further investigation may clarify the actual rates of depression in each gender.

Ethnicity.

Similar disjunctions exist in the literature on the link between ethnicity and student depression. Several studies have found no significant difference in depression scores based on ethnicity (Swanholm, et al., 2009; Tjia, et al., 2005; KKBK, 99), while others have demonstrated that ethnicity is a factor in college student depression (Eisenberg et al, 2007).

Emerging adulthood.

The median age of students attending universities and colleges in Canada is 21.6 years (Statistics Canada, 2010), and therefore could be classified as young adults, defined as those transitioning between dependent teenager-hood and fully emergent adulthood (Arnett, 2000). This period may include a variety of potential stressors, such as increased independence from parents and home life, increased opportunities to develop a new identity and roles, increased financial responsibilities, and increased opportunities to develop new relationships (Arnett, 2000). Although these factors may be exciting and liberating for some students, others may respond to these stressors by exhibit signs of declining mental health due to loss of social support, changing relationships, and vast life changes (Liem, Lustig, & Dillion, 2010).

Because this age group is disposed to highest incidence of depression (Kuwabara et al., 2007), life stressor-- such as those discussed previously--may weaken the mental health of this population. Students who are not able to handle the dynamics of this life stage in addition to the responsibilities of school and who drop out of school are often more depressed and exhibit lower life satisfaction than their peers who manage to graduate (Liem, 2010).

Personality characteristics.

Vrendenburg et al. (1998) has suggested that depressed students have personality characteristics that make it difficult for them to be successful in post-secondary study. Among these traits are insufficient coping skills, the lack of self-control, inadequate interpersonal skills, and the tendency to place unrealistic demands on themselves (Vrendenburg et al.). Although these characteristics may place some students at risk for depression, Vrendenburg et al. further noted that the additional, unique demands of being a student and attending a college or university may, in fact, trigger depression in this population.

Relationships status.

Depending on the state of a student's relationship, the relationship can either decrease or increase depression levels. Swanholm et al. (2009) found that romantic relationships had a positive effect as they may shelter some students from depression. However, the status of a relationship became predictive of depression if the relationship included emotional abuse (Leino & Kisch, 2005). Interestingly, in their study on the effects of demographic variables on student depression, Khawaja and Duncanson (2008) found that relationship status had neither a positive nor a negative effect on depression.

Consequences of Post-Secondary Student Depression

Health-Related Consequences

Physical ailments.

Students with poor mental health are at increased risk for acute infectious illness, including bronchitis, ear infections, sinus infections, and strep throat (Adams, Wharton, Quilter, & Hirsch, 2008; Rawson, Bloomer, & Kendall, 1994). Additionally, students

with increased levels of depression are more likely to experience chronic health problems which may include headaches, nausea, body pains, allergies, frequent colds, and infectious diseases (Hojat, Gonnella, Erdmann, & Vogel, 2003). Further, depressed students are more likely to report physical health related ailments as a cause of academic impairments (Lindsey, Fabiano, & Stark, 2009). Finally, depressed students have a higher incidence of risky sexual behavior (Swanholm et al., 2009), which can often lead to sexually transmitted diseases.

Cigarette smoking.

Depression and cigarette smoking are clearly linked in the literature. Students with high levels of depressive symptoms smoke more cigarettes than students who experience a low amount of depressive symptoms (Kenney & Holahan, 2008; Ridner, Staten, & Danner, 2005). Cigarette use has also been shown to be correlated with moderate depressive symptoms (Roberts, Glod, Kim, & Houchell, 2010); additionally, it is predictive of a diagnosis of depression (Leino & Kisch, 2005). Further, Lenz (2005) found that if students had received a diagnosis of depression during their lifetime, they were seven times more likely to use tobacco. Unfortunately, research does not indicate whether or not cigarette smoking can cause a depressed mood, or whether students use smoking as a coping mechanism to manage a depressed mood (Roberts et al., 2010). As with other factors, the causal relationship between smoking and depression is unclear.

Substance abuse.

Substance abuse has been found to be significantly correlated with depression in college and university students. Both alcohol and drugs have been implicated in increased rates of depression in this population. Roberts et al. (2010) as well as Lindsey

et al. (2009) found that students who had used drugs such as marijuana, cocaine, or psycho-stimulants were more likely to have increased rates of depression, while daily alcohol consumption employed as a coping mechanism and depression were linked in other studies (Flynn, 2000; Gonzalez, Reynolds, & Skewes, 2011) and later alcohol abuse (Camatta & Nagoshi, 1995). However, in contrast to the findings of Camatta & Nagoshi (1995), both Roberts et al. (2010) and Lindsey et al. (2009) found that depressed students were not at greater risk of alcohol abuse than their non-depressed peers.

Academic Consequences

Learning difficulties.

Unfortunately, students who are managing depression often have difficulty exhibiting the independence and motivation required at the post-secondary level, and their grades may suffer. One analysis demonstrated that almost 45% of undergraduate students and 41% of graduate students reported mental or emotional difficulties which affected their mental health, often resulting in missed academic obligations (Eisenberg et al., 2007). More directly, depression has been demonstrated to have a significant negative relationship on academic performance (Deroma, Leach, & Leverett, 2009; Haines, Norris, & Kashy, 1996). Depression appears to affect many aspects of students' cognitive function, and as such, limits students' ability to manage the everyday pressures of academia, preventing them from achieving academic success (Vrendenburg et al., 1988).

Poor grades.

Lower grades are an unfortunate consequence that university and college students managing depression face (Ruthig, Haynes, Stupinsky, & Perry, 2009; Vrendenburg,

O'Brian, & Krames, 1988). In fact, individuals diagnosed with depression often score a half letter grade lower on their grade point average (GPA) (Hysenbegasi, Hass, & Rowland, 2005) and perform more poorly on exams (Andrews & Wilding, 2004) than students without depression. Additionally, Haines, Norris, & Kashy (1996) found that students who had depressive symptoms at the beginning of a semester failed to achieve good grades throughout the rest of the semester. Poor grades appear to be both a contributing factor for depression in students as well as a consequence of depression (Mikolajczyk et al., 2008),

Treatment Issues for Postsecondary Students with Depression

Barriers to Treatment

Few studies have investigated the barriers students face when they seek treatment for depression. Tjia, Givens, and Shea (2005) cite the reasons students do not access help for depression as a lack of time, an inadequate number of sessions with a university-based counselling service, stigma for seeking counselling services, fear of adverse career and academic implications, fear of being recognized, and the belief that counselling would not help them. Further, the Health Minds Study demonstrated that many students report being unaware of the mental health services offered at their institution; while other students do not perceive a need for help (Eisenberg, Golberstein, & Gollust, 2007; Hunt & Eisenburg, 2010). Additional factors preventing students from seeking help for mental health problems are as follows: the stigma attached to such services (Quinn, Wilson, MacIntyre, & Tinklin, 2009), the need to travel to campus for students living off-campus, the stigma of seeking help for male students, and the ignorance of such services that students in their first few years often have (Yorganson, Linville, & Zitzman, 2008).

Demographically, students who are less likely to use campus mental health services include international students, Asian American students, and students from lower socioeconomic backgrounds (Hunt & Eisenburg, 2010).

Conversely, the literature identifies characteristics of students who do seek help from a campus mental health clinic: they have moved from a home town other than that of the college or university, they are older, they are enrolled in graduate studies, and they have already seen a non-psychiatric physician regarding their difficulty (O'Neil, Lancee, & Freeman, 1984).

Professional Responses to Student Depression

Although the rates of depression in the student population have been increasing annually, the quantity of studies investigating the efficacy of current interventions by campus mental health clinics is astonishingly low (Cox-Dzurec, Allchin, & Engler, 2007; Reavly & Jorm, 2010). However, the literature describes some common interventions employed by campus mental health clinics, including web-based strategies, life-skills workshops, and psychotherapy. I will address each of these strategies in the following paragraphs.

Web-based interventions for students with depression.

Web-based interventions appear to be a novel way of improving the ability of post-secondary counsellors to reach students requiring their services. Studies on web-based counselling strategies in the general public have demonstrated their effectiveness for managing diabetes (McMahon et al., 2005), substance abuse (Copeland & Martin, 2004), and depression (Christensen, Griffiths, & Jorm, 2004).

More specifically, investigations into how college students use the Internet to obtain mental health information and support have demonstrated that although a majority of students ultimately preferred face-to-face interaction with a counsellor, some welcomed a more anonymous and less judgmental process of discussing their mental health—something the Internet can offer (Horgan & Sweeney, 2010). In one such study, Hass et al. (2008) asked students to complete a nine-item depression scale in a Patient Health Questionnaire (PHQ) on the Internet, after which the students were ranked according to their depression severity scores. Students deemed a high to moderate risk for depression were encouraged to see a counsellor for an in-person evaluation (Hass et al.). The same students were then given opportunity to engage in online dialogue with a counsellor, who either helped students manage their issues or encouraged them to visit a counsellor in person for further evaluation (Hass et al.). The web-based outreach by counsellors appeared to be effective; that is, students who used the online dialogue session were three times more likely to participate in an in-person evaluation and to subsequently enter treatment (Hass et al.). Overall, more than 60% of the high risk students and nearly 40% of the moderate risk students participated in the in-person evaluation; in fact, three quarters of them stated they would not have seen a counsellor without the web-based intervention (Hass et al.).

Psychotherapy.

Within the general population, psychotherapy has been proven effective in helping people manage depression (Schulberg, Raue, & Rollman, 2002). Thus, using psychotherapy in campus mental health clinics would appear to be an effective means of assisting post-secondary students cope with depression. However, this measure presents

some challenges, including budget restrictions that require institutional counselling centres to use cost-effective interventions and time demands that limit student willingness to book counselling sessions (Kitrow, 2003). Both factors have facilitated the need for campus counselling centres to find novel ways to deal with depression using abbreviated yet successful methods.

The literature includes three examples of brief yet effective approaches used on campuses. The first, employing the longest duration of the three, was a six-week Cognitive Behavioural Therapy (CBT) approach. At the end of treatment, participants demonstrated greater improvements in self-esteem, less negative thinking, and fewer depressive symptoms than in the control group (Peden, Rayens, Hall, & Beebe, 2001). Benefits experienced by this group were still evident 18 months after the study had finished (Peden et al.).

The second study explored using Brief Psychodynamic Investigation (BPI) over four weeks (four sessions) (Luc, Drapeau, & Despland, 2003). Preliminary results demonstrated that BPI was effective in reducing depression and anxiety in the student sample, although follow-up studies were not completed (Luc et al.). Due to the limited number of sessions and its demonstrated effectiveness, BPI may be useful in post-secondary mental health services to manage short term crisis and situational issues while remaining cost-effective (Luc et al.).

The final study, which had the shortest in duration of the three, required students to participate in either one 90 minute session of Behavioural Activation Treatment for Depression (BATD) or one control group session (Gawrysiak, Nicholas, & Hopko, 2009). At a two-week follow-up session, students in the BATD group demonstrated a

significantly greater decrease in depression scores on the Beck Depression Inventory-II (Gawrysiak et al.) than their counterparts in the control group. These findings suggest that BATD may represent an economical yet effective option for managing increased demand for post-secondary mental health services and mitigating the time restrictions felt by both counsellors and students (Gawrysiak et al.).

Although the above studies demonstrate varying levels of effectiveness, additional studies are required to find effective psychotherapy interventions which consistently prevent or intervene at the early stages of student depression, as well as provide positive long-term results.

Campus Education Programs.

Increasing awareness of student depression and suicide rates in post-secondary institutions is prompting many universities and colleges to offer depression and suicide education workshops, aimed at heightening student knowledge of the symptoms, stigmas, and suicide risk associated with depression as well as the resources available to students. Although education campaigns have proven effective at increasing the use of mental health services, more education is needed, as the lack of perceived need and unawareness of services are the most cited reasons students give for not using available services (Eisenberg et al., 2007 ; Hunt & Eisenberg, 2010).

Conclusions and Implications for Community Mental Health

The multi-faceted nature of depression combined with the complexity of post-secondary studies has created critically high levels of college and university students struggling with mental health issues. Although more research is required, the literature

highlights numerous potential implications for students, counsellors, and the communities in which the students reside.

Implications for Students

Efforts to slow the increase of depression within the post-secondary student population should begin by encouraging students to become involved in preventing depression as well as urging their friends to receive treatment. The prevalence of depression in the general population means many students have been touched by depression at some previous point of their life, whether their own or others, whether at home or at school. By sharing their personal experiences with depression, some students may help others manage difficulties in their life or their studies. Further, students who share their own experiences with depression would augment the knowledge of depression; their valuable information would enhance the attempts of post-secondary institutions to reach students who are currently depressed. Students currently suffering from depression in isolation may be more willing to seek help once they meet peers who have successfully managed or are managing depression.

Additionally, student representatives could be trained in some rudimentary tools for assessing depression. These representatives could be given opportunity to sit on committees that develop depression education campaigns, and they could provide valuable feedback and advice to institutional policy makers. Student representative would become an important and intimate link between the students, a population who can be difficult to engage, and the help providers. Student ideas and insights may spawn education campaigns that can potentially destroy current barriers that exist between counsellors and students.

Finally, students could be used in peer support groups, that is, in both face-to-face and web-based initiatives. Peer support groups, like the ones formed by National Alliance on Mental Illness ([NAMI], 2011), offer intimate face-to-face assistance, which many students crave while dealing with depression. These groups provide opportunity for depressed students to connect with others and build a social support network, which is instrumental in managing depression. While some students crave the intimate nature of peer support, other students managing depression may be more willing to use the confidential, faceless support that a web-based initiative may offer. Through involvement in peer support initiatives, students will be helping students and potentially decrease the stigma of depression on post-secondary campuses.

Implications for Counsellors

Foremost, post-secondary mental health clinics must be proactive. Universities and colleges are in the unique position of being able to impact a vast number of students at an important life stage; as well, these institutions can help students recognize, prevent, and manage mental health disorders (Hunt & Eisenburg, 2010; Reavley & Jorm, 2010). Counsellors must fully understand the issues affecting students within their school and subsequently design outreach efforts that are both cost-effective and successful. The first step may be to complete a needs assessment to determine the most immediate requirements of the current student population. A needs assessment would not only determine need but would also help guide potential depression education interventions. Also, information gathered would bolster requests to top-tier administrators for increased funding. Additional funding will be necessary for interventions such as the peer support groups, web-based interventions, and depression education campaigns. Many post-

secondary mental health clinics may have to rigorously evaluate their infrastructure and determine better ways to allocate their current resources to best manage the mental health of students in their institution.

Second, counsellors must be more creative. They must gain stronger understandings of the complex and numerous contributing factors of student depression and implement strategies that are interest-provoking, relevant, and effective. Counsellors may enlist student representatives to sit on their committees and design ways to implement their ideas. Teams must explore ways to creatively use the Internet, text messages, or social networks to reach students with depression symptoms. Web-based strategies such as these could provide instant access to support for individuals in need. Hass (2008) reports that strategies such as these may bring post-secondary counsellors closer to the students than ever before. Modern media allows counsellors to communicate with post-secondary students located outside their office doors, which may help ease student fears and encourage more students to seek counselling.

Finally, in addition to providing depression education to students and staff, counsellors must be willing to further educate themselves. Should post-secondary mental health clinics decide to tackle the rise in depression within their institutions, counsellors must be prepared to handle an increased variety of difficult student situations. Increasing the preparedness of campus mental health clinics may include reviewing the education and experience qualifications of counsellors who currently staff the clinic. Should the staff lack experience in managing depression or lack knowledge of available treatment options, including antidepressants, then post-secondary institutions should provide time for those staff to attend workshops and training sessions. Counsellors must be able to

identify appropriate individualized interventions for each client. Additionally, increased knowledge of contributing factors and successful interventions might decrease the amount of time a student needs for counselling.

Implications for Communities

Although students spend countless hours at school, a major portion of their non-study time is spent working, recreating, and living life in the community in which their school resides. Students contribute to the financial viability of local businesses, both as workers and customers. When students are debilitated by depression, their illness has far reaching consequences for both the student and the community. Communities can be involved in the process of helping students manage depression by increasing awareness of the severity and frequency of depression, aiming campaigns at decreasing the stigma and fear associated with depression, and increasing funding to community mental health agencies, that can subsidize clients needing financial assistance.

Community counselling centres have an advantage in that students may be less likely to associate the same stigmas and fears they associate with campus counselling centres; therefore, they may handle greater numbers of student clients facing depression. Additionally, should increased student-focused education campaigns in both schools and communities be successful, community counsellors would likely experience an increase in the number of students they would see. Thus, community counsellors would be wise to further educate themselves on the complexities of student depression, such as the numerous contributing factors, the treatment options that students prefer, and the common psychopharmacology treatments. As well, community counsellors may benefit from meetings with post-secondary counselling centres to understand the specific issues

occurring within the institution. Further, community and campus counsellors must improve their communication links to help students who complete the allotted treatment sessions with one counsellor, yet require further assistance, or to help students who simply want their depression to be managed outside the school. In this way, the needs of students struggling with depression can best be met.

Conclusion

Student depression on university and college campuses is complex with numerous contributing internal and external factors, and subsequently, the student endures many health and academic consequences. Although efforts to decrease student depression are currently being implemented in post-secondary institutions, more work must be done. Students, faculty, and staff required deeper awareness of the severity of student depression, and support must to be shown by top-level administrators in institutions through increased funding (Kitrow, 2003). Better awareness can be built through educational campaigns aimed at all sectors of a university population; these campaigns can increase knowledge about recognizing and helping those with mental illness (Kitrow, 2003). Complex potential contributing factors that lead to student depression represent several access points for which depression can be identified and managed (Swanholm, Vosvick, & Chwee-Lye, 2009). As such, universities and colleges mental health services must focus on implementing strategies that reduce health risk behaviours that are directly correlated with depression (Kenney & Holahan, 2008).

Chapter Three: Student Experiences

Introduction

Although many of the roughly 1.5 million students who enrol in Canadian universities and colleges each year (Statistics Canada, 2009) will describe their postsecondary studies as the best years of their life, other students will remember these times as painful because of the depression they experienced. Some of these students will try to manage their depression without assistance, while others may seek a counsellor or general practitioner for help. Studies such as the most recent American College Health Association's National College Health Assessment (ACHA-NCHA, 2011) and conclude that depression is a major issue facing postsecondary students and the preferred treatment of these students is antidepressants, therapy, or both.

While many quantitative perspectives of this phenomenon exist, such as the ACHA-NCHA (2011), qualitative accounts of postsecondary students experiencing depression are noticeably missing. Qualitative study yields insight on the personal impact that depression can have on the lives and studies of postsecondary students, a factor often referred to as the *lived experience* (van Manen, 1990). Also, qualitative data augments the understanding of why students with depression do or do not use the treatments available to them, an understanding that enables professionals to better design outreach efforts to these individuals.

This paper reports qualitative data collected on postsecondary students with depression. In this study I elicited and analyzed the accounts of postsecondary students with depression for two reasons: (a) to gain a more detailed understanding of the lived

experiences of students with depression and (b) to discover why these students use or avoid the treatments available to them.

Literature Review

Statistics on Student Depression

Quantitative studies on depression in university and college students have shown that nearly one-third of all postsecondary students have “felt so depressed that it was difficult to function” (ACHA, 2011). In fact, almost 20% of students who responded to the 2011 ACHA-NCHA II survey reported that they had been previously diagnosed with depression, and 10.7% had been diagnosed or treated in the past 12 months. Numerous other smaller scale studies affirm similar depression rates for postsecondary students in both North America and overseas. A generalized scan of studies on student depression reveals rates as low as 12% and as high as 53%, a range of 31% (Bouteyre, Maurel, & Bernaud, 2007; Furr, Westefeld, Hurtado et al., 2007; McConnell, & Jenkins, 2001; Michael, Huelsman, Gerard, Gillian, & Gustafson, 2006; Mikolajczyk, Maxwell, Naydenova, Meier, & Ansari, 2007; Moo-Estrella, Perez-Benitez, Solis-Rodriguez, & Arankowsky-Sandoval, 2005; Roberts, Glod, Kim, & Houchell, 2010; Soet, & Sevig, 2006; Swanholm, Vosvick, & Chwee-Lye, 2009; Tjia, Givens, & Shea, 2005; Wong, & Whitaker, 1993). Furthermore, an oft-referenced study by Westefeld and Furr (1987) found that 8 in 10 students experienced depression at some point during college. Regardless of the varied rates, these studies demonstrate the prevalence of depression in college and university students.

The literature highlights numerous contributing factors to student depression. Many factors are directly related to the inherent stresses of the student lifestyle: poor

grades (Deroma, Leach, Leverett, 2009; Furr, Westefeld, McConnell, & Jenkins, 2001; Mikolajczyk et al., 2008, Ridner, Staten, & Danner, 2005), loneliness or isolation (Bitsika, Sharpley, & Rubenstein, 2010; Cox-Dzurec, Allchin, & Engler, 2007; Furr et al., 2001; Mikolajczyk et al., 2008), stress and fatigue (Adalf, Gilksman, Demers, & Newton-Taylor, 2001; Mikolajczyk et al., 2008; Bitsika, Sharpley, & Bell, 2009; Pritchard & Wilson, 2003), and financial difficulties (Andrews & Wilding, 2004; Eisenberg, Golberstein, & Gollust, 2007; Furr et al., 2001; Khawaja & Duncanson, 2008; Lindsey, Fabiano, & Stark, 2009).

The realities of the common human experience may also contribute to depression in students. These factors include gender factors (Boggiano & Barrett, 1991; Dixon & Robinson Kurpius, 2008; Kelly, Kelly, Brown, & Kelly, 1999; Khawaja & Duncanson, 2008; Leino & Kisch, 2005; Michael, Huelsman, Gerard, Gillian, Gustafson, 2006), ethnicity factors (Dion & Giordano, 1990; Eisenberg et al., 2007; Young, Fang, & Zisook, 2010), emerging adulthood factors (Kuwabara, Van Voorhees, Gollan, & Alexander, 2007; Lein, Lustig, & Dillion, 2007), personality characteristics (Vrendenberg, O'Brien, Krames, 1988), and relationship strains (Leino & Kisch, 2005). Many of these dynamics also affect the general population; however, when the stress of student life and the pressure to prepare for a competitive job climate after graduation culminate, the stressors of human life can become intensified.

This cacophony of stressors can trigger various outcomes. First, the literature reveals that students who must navigate depression while managing an academic workload face health consequences. The health related consequences of depression include physical ailments (Adams, Wharton, Quiler, & Hirsch, 2008; Hojat, Gonnella,

Erdmann, & Vogel, 2003; Rawson, Bloomer, & Kendal, 1994); cigarette smoking (Kenny & Holahan, 2008; Lenz, 2005; Leino & Kisch, 2005; Ridner et al., 2005; Roberts et al., 2010); and substance abuse (Camatta & Nagoshi, 1995; Flynn, 2000; Lindsey et al., 2009; Roberts et al.).

Second, depression can trigger academic consequences, including cognitive difficulties (Vrendenberg et al., 1988) and poor grades (Andrews & Wilding, 2004; Haines, Norris, & Kashy, 1996; Hysenbegasi, Hass, & Rowland, 2005; Ruthig, Haynes, Stupinsky, & Perry, 2009; Vrendenberg et al., 1988). A poignant but unfortunate reality of this burdensome combination of health and academic consequences is that students with depression often drop out (Eisenberg, Golberstein, & Hunt, 2009). Those who remain in school must find ways to navigate the additional complexities that depression brings into their life.

Research shows that few students with depression seek professional help, but those that do appear to rely on antidepressants. On average, 25% or fewer of students diagnosed with depression are currently in therapy (ACHA, 2000; ACHA, 2009; Furr et al., 2001; Micheal et al., 2006; Soet & Sevig, 2006), and as many as 85% of students who screen positive for moderate to severe depression in the Foundation for Suicide Prevention Screening Project have not been treated (Garlow, et al., 2008). However, many students with depression appear to prefer antidepressants, as affirmed by the Spring 2011 ACHA-NCHA which found that over 7000 students with a previous or current diagnosis of depression were currently taking medication; this compares with the just over 2000 students who were attending therapy alone. Kadison (2005) affirms the domination of antidepressants as the preferred treatment for depression by students; he

estimated that as high as 50% of students seen by counsellors at student health centres were already using antidepressant medication.

Therefore, although quantitative research has conclusively identified depression as a prevalent medical condition in the postsecondary student population, qualitative research could assist in identifying reasons students with depression refrain from seeking counselling help or why they rely on antidepressants alone to treat their condition. Student use of antidepressants as apparent first-line treatment is contradictory to the recommendations of organizations such as the National Institute for Health and Clinical Excellence [NICE] (2010) who recommend counselling before antidepressants because of the poor risk-benefit ratio associated with their use. Gaining an increased understanding of the lived experiences of students with depression could promote higher rates of counselling utilization. Unfortunately, a sufficient volume of such research does not exist. One first step in addressing this lack of evidence, therefore, would be to investigate the responses that members of the student population have to depression: why some use antidepressants, why some seek counselling, or why some seek both to manage their depression.

Responses to Medication as a Treatment for Depression

Social factors often prevent people with depression from using medications. Before treatment can begin, individuals must first acknowledge the existence of a problem. Karp (1994) describes the process by which people wrestle as they “com[e] to grips with an illness identity” (p. 22). During this process, individuals embrace a biochemical explanation for their illness, while they reject the suggestion they have had a mental illness; as a result, this process allows them to avoid the victim role (Karp, 1994).

Some individuals may view the medications route negatively because they feel “looked down on” (Waite, & Killian, 2008, p. 191) or perceive that others think they are fragile and unable to cope (Grime, & Pollock, 2003). Many people with depression symptoms in the general population feel they should be able to handle their emotions without chemical aid and eventually discontinue medication treatment because they perceive medications as a sign of weakness (Knudsen et al., 2002; Pestello, & Davis-Berman, 2008). Other research indicates that some people question whether or not they would be seen as an addict or drug abuser (Knudsen et al., 2002). Some people are afraid that if they start taking anti-depressants, they will no longer be themselves, but rather will become reliant on medications to function (Grimes, & Pollock, 2003). Additionally, many felt that they were safer if they continued on with antidepressant use than stopping their medication use due to the fear of harmful side effects (Verbeek-Heida, & Mathot, 2006). These perceived stigmas often lead to a premature end of treatment or to an avoidance of medications altogether (Cooper-Patrick et al., 2002).

On the positive side, studies have demonstrated that although people may resist medications because they want to avoid the label “mentally ill”, some people with depression gain a sense of relief after a diagnosis allows them to put a name to their negative feelings (Knudsen et al., 2002; Grime, & Pollock, 2003). Antidepressant use has also been reported to have helped people develop a more “positive self view”, and help them become more in control and involved in their lives (Knudsen, Hansen, & Eskildsen, 2003, p. 164). Additionally, antidepressant use was seen by some individuals to “facilitate” their ability to attend and be involved in counselling (Kwintner, 2005, p. 43).

Responses to Counselling as a Treatment for Depression

Although qualitative data on depression is noticeable missing from the literature, one qualitative study by Gallegos (2005) highlights the positive outcomes of counselling for individuals with depression. In this study, clients who had received counselling for depression evaluated how well counselling relieved their symptoms. Many of the study's participants assessed the knowledge their counsellor offered in positive ways: "he gave effective advice," "he noticed and took action on the psychological problem," and "he taught communication skills" (Gallegos, 2005, p. 369). Participants also appraised the safety, trust, and support they felt from their counsellor in positive ways: "I completely trust him," "She was encouraging all along the way," and "I always had my therapist" (Gallegos, 2005, p.369). This study concluded that a majority of participants appreciated their counsellor's ability to be non-judgmental and to help them understand how their psychosocial history could affect their current self and dysfunction. Participants from the Gallegos study also reported increased personal confidence from applying the skills they had learned from counselling, they enjoyed improved interpersonal skills, and they experienced symptom relief because they could resolve the problems that had first prompted them to seek counselling. This study highlights the perceived benefits of counselling from a client's perspective; however, the conclusions from one study alone cannot be taken as a universal perspective given the lack of additional studies.

Gallegos's findings are exciting because they not only demonstrate the ability of qualitative research to reveal the potential benefits of counselling for individuals with depression, but they also provoke parallel research into the benefits of counselling for postsecondary students experiencing depression. Gallegos (2005) advocated qualitative

study, stating it can provide “scientifically accurate client perspectives” that surveys and questionnaires cannot provide (p.358). Gallegos’ perspective points to the wide open potential of qualitative study on postsecondary students with depression. Potential qualitative investigation could probe, for example, what students believe caused their depression, how they describe their depression, how their attitudes and beliefs towards depression and treatment are formed, why students describe a treatment as helpful, what their treatment preferences are, what their previous experiences with treatment have been, and numerous other findings. These insights could help professionals better tailor treatments and interventions to individuals with depression and would enhance the efficacy and adherence to current treatment regimes (Kennedy et al., 2001). Given the urgent nature of this public health issue, the potential for qualitative research in this area is considerable.

Thus, the immediacy and urgency of additional qualitative data in the field of depression among postsecondary students prompted my endeavours. I pursued qualitative analysis because of its ability to reveal new understandings of postsecondary students with depression: their lived experiences as well as their direct relationship or non-relationship with various types of treatment. This study analyses the experiences of 10 students, who recounted their experiences of managing their depression with both antidepressants and counselling.

Method

Max van Manen’s hermeneutic phenomenology philosophies (1990) guided the methodology of this study. Van Manen’s approach is both descriptive and interpretive, allowing participants in this study to speak about their experiences themselves; it also

allowed me to represent participant experiences in language that is “inevitably an interpretive process” (van Manen, 1990, p. 181). Another reason this approach suited my study was “the aim of phenomenology is to transform lived experience into a textual expression of its essence—in such a way that the effect of the text is at once reflexive re-living and a reflective appropriation of something meaningful...” (van Manen, 1990, p. 36). Thus, I chose van Manen’s approach because it allowed me to present student experiences in the most immediate and non-filtered way, while still allowing me to make helpful analytical conclusions.

Qualitative inquiry, as employed in hermeneutic phenomenology, is common in health professional studies; therefore, this approach is a suitable tool for inquiry as “nursing practice is enmeshed in the life experiences of people” (Streubert, & Carpenter as cited in Nieswiadomy, 2002). Munhall (2007) agreed that phenomenological studies are an appropriate instrument to provide understanding of the meaning of an experience and an important means of applying the resultant understandings in the form of newly designed interventions. Inquiry for this study began by identifying and interpreting van Manen’s six research activities (van Manen, 1990, p.30), as follows:

(1) Turning to a phenomenon which seriously interests us and commits us to the world (I fulfilled this step by choosing to study depression in postsecondary students, whom I both teach and am a student myself.);

(2) Investigating experience as we live it rather than as we conceptualize it (I investigated student depression as the research participants experience it rather than as I perceived it.);

(3) Reflecting on the essential themes which characterize the phenomenon (After analyzing student accounts their experience with depression, I identified the primary themes which characterize depression in the campus student population.);

(4) Describing the phenomenon through the art of writing and rewriting (I fulfilled this step by transcribing my interviews with study participants, rereading the texts multiple times, and then eliciting dominant themes in the text.);

(5) Maintaining a strong orientation to the phenomenon (I maintained a strong relationship to my subject through continued reading, engagement with students, and consultation with my supervisor.); and

(6) Balancing the research context by considering parts and whole (I evaluated my findings both in terms of depression in general as well as depression in the student experience.).

Participants

Students were recruited from a university and college located in a small city in Alberta, Canada. Information was posted (Appendix A) on campus bulletin boards in both the university and the college, including a student mental health clinic at each campus. An advertisement for the study was also placed on the university's website bulletin. Additionally, my supervisor and I participated in an interview, which was summarized in the university campus newspaper, to focus attention on the rising trend of student depression and to seek the participation of students with depression in the study. Inclusion criteria included the following: (a) English speaking, (b) Individuals had to be currently enrolled as a post secondary student at either institution, and (c) individuals had to have used both antidepressants and counselling to treat their depression. An actual

diagnosis of depression was not required for participation, as students did not always need such a formal diagnosis to receive either antidepressants or counselling for their depression. My proposal was reviewed and approved by the University of Lethbridge's Human Subject Research Committee.

Procedure

The researcher communicated with potential participants by telephone or email to briefly confirm the aforementioned inclusion criteria, review the informed consent process, and address any concerns or questions that they had. If students expressed interest in participating in the study, subsequent meetings were arranged at a place and time convenient to each participant to obtain informed consent and begin data collection. Students were informed that their participation in this study was voluntary and that their personal information and interview data would be kept confidential. The researcher obtained written consent from all participants prior to interviews.

In all, 10 eligible students participated. Data was collected during face-to-face, audio-taped interviews. The interviews lasted between 45 and 90 minutes. The researcher used an interview guide (Appendix B) to focus the narrative on the experience because "the interview process needs to be disciplined by the fundamental question that prompted the need for the interview in the first place" (van Manen, 1990, p. 66). All interview audio-tapes were sent to a professional transcriptionist – who had signed an oath of confidentiality -- for transcription, and the transcriptions were carefully reviewed by the researcher for errors or omissions.

Participant identities remained anonymous through the process. A self-chosen pseudonym ensured anonymity during the referencing and dissemination of the findings.

All data were assigned identification numbers, and only my supervisor and I knew which identification number matched each participant. Consent forms (Appendix C) and lists of participants were kept separate from the transcripts. Participants were encouraged to speak with the researcher if concerns arose about the interview process or particular statements the students had made. Further, participants were encouraged ask their counsellor whether their personal issues were of such a serious nature that their personal wellness would be jeopardized by my study; if the counsellor affirmed so, those students were encouraged to withdraw. If interested students were not currently seeing a counsellor, the researcher offered those students a list of counsellors within the university and the community. In this study, one participant requested the list. The individual requested the list because she felt her current counsellor was not right for her.

Participant demographic information (Appendix D) was gathered to enrich the findings and facilitate data analysis. Demographic information included the participants: (a) age and gender, (b) length of post secondary study, (c) current program of study, (d) length of depression, (e) length of time on antidepressants, (f) previous experiences with antidepressants, (g) number of previous counselling sessions they had attended, and (h) how long they had used counselling.

Analysis

Themes were elicited using three approaches offered by van Manen (1990). First, the transcripts were read in their entirety and efforts were made to capture the essence of each participant's transcript in a single phrase, a step that van Manen identifies as wholistic reading, or the sententious approach. Second, each transcript was re-read using van Manen's selective reading approach, which encourages researchers to give the texts

several readings to elicit particularly revealing statements or phrases. Finally, the transcripts were read once again employing van Manen's detailed, line-by-line approach to reveal significance in each sentence or paragraph. Significant segments of text were assigned a theme name. Groups of text with identical themes were then grouped for further analysis using NVIVO 9.

Rigour

The rigour of this study was assessed using some of Lincoln and Guba's tenets of trustworthiness: credibility, confirmability, and transferability. Credibility refers to "confidence in the truth of the data" (Loiselle, & Profetto-McGrath, 2004, p. 317). I addressed credibility by completing interviews until an understanding of the phenomenon was attained. I addressed dependability, "data stability over time and over conditions" (Loiselle, & Profetto-McGrath, 2004, p. 317), and confirmability, by developing a thorough audit trail that could be reviewed by an external reviewer. Transferability refers to "the extent to which the finding from the data can be transferred to other settings or groups" (Loiselle, & Profetto-McGrath, 2004, p. 318). Although hermeneutic phenomenology is not meant to be generalizable, a purposeful sample that represented the phenomenon of depression in postsecondary students was obtained in hopes that their stories would resonate with other students managing depression.

Additionally, subjectivity, as described by Young and Collin (1988), was fulfilled as I identify myself as being an implicated researcher who is both a student in a university and an individual who works in a mental health facility and has previous experience with personal stories of antidepressant and counselling use. Further, validity,

as seen as being conferred by the reader (Young, & Collin, 1988), will hopefully be found as the themes of the studies resonate with those individuals who read this thesis.

Results

During the analysis phase, several themes emerged that reflected the experiences of students using antidepressants, counselling, or both. The first theme was *split between antidepressants and counselling*, which included the subthemes *the antidepressant-body component of the split* and *the counselling-mind component of the split*. The second theme was *challenges along the way*, which included three subthemes: *tweaking and tinkering*, *struggling with stigma*, and *the other side of side-effects*. These themes and subthemes will now be discussed in turn.

Split between Antidepressants and Counselling

The initial goal of this study was to examine the experiences of students who manage their depression with antidepressants, counselling, or both simultaneously. As the interviews progressed, it became apparent that most students had actually compartmentalized how they saw the respective effects of counselling and antidepressants, whereby each treatment was perceived as affecting distinctive parts of themselves and their depression. That is, students described a strikingly Cartesian split between mind and body, whereby counselling had its main influence on the mind part of depression, while antidepressants acted primarily on the body segment of depression.

Ali, a 19 year old female, reflected on this dichotomy:

Antidepressants take care of the physical symptoms, not so much of anything else, I found. Counselling takes care of the [mental] rumination: the suicidal ideation, the compulsions, the...just everything else. The antidepressants make me able to function physically, so that I can do the counselling strategies to stop all the negative thoughts.

Remarks by other participants reiterated this belief in the split purposes of these treatments: first, the physical or body component that antidepressants seem to address, and second, the mental or mind component that counselling seems to address.

The antidepressant-body component of the split. Participants often linked antidepressants with the physical or body aspect of their depression, that is, their genetic or bio-chemical selves. Because many participants were science students, many had read the biological and genetic theories of depression. Thus, during the interviews, many commented on how these theories resonated with their own personal experience.

First, many participants attributed their depression to genetic factors. For example, Bella, 21, found that a genetic view of depression fit her own situation of having several family members who had been diagnosed with depression: “a lot of people in my family have depression, and it just needed to be triggered in my case.” Ali, 19, also found that the genetic theory validated—or gave her “proof”—of her own depression after she was diagnosed:

Well, they’ve [researchers] shown a family history of depression running in families and what not. And I didn’t know about it, but when I got depressed at the time, I didn’t know that it ran in my family.

While genetic theories of depression held true for some students, other participants relied on biochemical theories to explain their depression. Sophie, 24, shared how information from her family doctor on bio-chemical causes of depression helped her understand her own depression: “Well, he basically was suggesting that the feelings I were having were because I was depressed and that that could be caused by a chemical imbalance, so he was going to try the

antidepressant.” Similarly, Cleo, 38, was informed by her family doctor that the antidepressants would alter her brain chemistry to improve her mood:

Well, I mean, my doctor explained how it happens—chemically. Like the chemical serotonin...helps you feel better, and stronger, more confident. I guess that’s changing...my brain chemistry is changing. I mean, I don’t feel it that way but I just feel better.

The majority of participants who believed their depression was caused by a chemical imbalance in their brain affirmed that a *physical solution for a physical problem* made perfect sense. For example, Ali, who had taken a few neurosciences classes, explained, “Since I can see all these scientific reasons for my depression, it kind of helps that I understand that I need the antidepressant, because [for a] scientific reason [I needed a] scientific solution.” Participants who had adopted the chemical imbalance theory preferred a treatment to achieve what they called “the right neuro-chemical balance” first and deemed other types of treatment unnecessary. Cleo held this type of mind set:

From what I understand, it’s just a lack of dopamine or serotonin or nor-epinephrine or whatever. I guess genetically I just have maybe a little less chemicals than maybe I should have and that [the antidepressant] just got me to the level I should be at. And so, I think any efforts to feel good without the right neuro-chemical balance would be just counterproductive because it [the depression] was too hard.

Many students who attributed their depression to body mechanisms such as chemical imbalances also suggested that antidepressants helped them manage secondary physical ailments such as sleep and energy problems. Henry, who found that counselling helped him become less fearful of his depression, admitted he needed the energy provided by an antidepressant to attend counselling:

...the energy level, like school, was doing okay but still I just couldn't get over the sleep. Like I was wasted. Like I was sleeping for like 14 hours...sometimes I was just drained and I don't know why. And nothing was helping there. And I was trying to eat a little better, but there wasn't any change and it was just, it was just constant. And so then she's [girlfriend] like, okay well if you want, you can try pills. So I did the pills...and the anti-depressants helped the energy, for me. And the counselling helped umm, [pause] just with the fears of depression, for me.

John, like Henry and Ali, found he had increased energy and better sleep while on an antidepressant; however, he also thought the antidepressant was a "band-aid" for the physical problems he was having and wanted a more permanent solution.

While other participants expressed their belief that an antidepressant provided them relief from physical symptoms, allowing them to more involved in their life. For example, Bella stated:

I think it [counselling] helps but I don't think as much as the antidepressants. Its just—like you're able to talk about things and you're able to get advice from somebody but it [counselling] doesn't give you the ability to shut off your brain at night so you can sleep. It doesn't give you the ability to concentrate better at school. Or participate in life. It doesn't give you patience with kids.

The counselling-mind component of the split. Similar to the student belief that antidepressants only provided relief to the physical ailments of depression, students also believed that counselling only assist in managing their mind. Participants who attributed their depression to contextual or situational factors linked counselling with the mental or mind aspects of their depression. All participants in this study, including those who believed their depression was caused by body or biological causes, identified psychological and/or contextual factors that they believed had contributed to their depression. Study participants focused particularly on factors associated with student life as contributing factors to their depression. However, some students believed the

contextual factor *school* was the main cause of their depression, while others believed this factor was a secondary cause. For example, Henry believed his depression stemmed primarily from the “purely social” aspects and stresses of being a student:

[My depression was caused by] just being away, just the change. I come from a small town where everyone was friends, and in a matter of 4 months, you're split up. Just coming down here and not knowing anyone. And then to have this [depression] hit you; you just assume everyone's got it. You don't know that this is different for you...Another thing, too, was the cash and the stress. You are worried about whether or not you are in the right degree program. And it is a lot of money too, and I didn't get much help. My parents aren't super wealthy, and so I had to save up over the summer and budget; there was a lot of pressure.

Bella, a nursing student, also attributed stressful school circumstances as the primary cause of her depression:

Probably just moving to a different city on my own and not knowing anybody at all. Moving in with a roommate, who[m] I met the day I moved in and then going to school, and the first year is really hard. So it was super stressful. And money's stressful now because I am student, and I used to work full time and I had all of the money in the world, and I went to having pretty much nothing. I think a lot of different stressors built up...I think nursing takes a lot of your energy, and you're required to do so many things, and it just stresses you out.

Some students attributed their depression to personality factors. Darryl, who admitted to being a Type A personality, stated his perfectionist tendencies led to his depression. In my interview with him, he recounted how he forced himself to be isolated, so he could focus on studying; then, he surmised that this preoccupation with getting good grades caused him to “forget about some of the basic things like hanging out with your friends, or just enjoying the moment.” However, Darryl also focused on the factor *student life*, stating his grades had faltered because of his depression:

I wasn't enthusiastic about the things that I normally would be or would normally enjoy. It [the depression] just led to poor study skills, or I just

didn't study, and so I now I am left with trying to deal with learning how to study again.

While participants felt the stressors of *student life* and other associated factors contributed to their depression, others identified situations that existed prior to postsecondary studies as causes of their depression. For example, Cleo, who had worked for numerous years prior to returning to studies, believed her depression was caused by what she termed an "imbalanced life":

Looking back on it, a few other things happened at the time: my boyfriend broke up with me, my two best friends moved away. I had a few different things happen all at the same time. And I was really sick for awhile, and I took sick leave from work. I think it was burnout from having an imbalanced life and putting everything into my work...I didn't realize that I was depressed.

Taryn, who saw her grades "negatively affected" due to her depression, believed her depression was caused by challenges with her sexuality:

I just felt like my life was going nowhere, and I was pretty depressed because of the things I was holding back at the time. I guess it was just because I knew that I was gay, but I wasn't telling people about it. I'd told a couple of people but just the holding back from some people and having to deal with that, and just the feeling that nobody wanted me and that kind of thing. I didn't feel like people valued me or my contributions or even wanted me around.

Not only could participants identify contextual factors contributing to their depression, all could identify how counselling could have or did help them manage their own depression. Many of the students considered counsellors to be guides or personal coaches who helped them learn about their depression and develop coping skills. While describing how counselling helped him, Henry jokingly stated he felt like he was being taught "mind control" by the counsellors:

She [his counsellor] said, “Just start to recognize when you’re getting negative, steer yourself away from that.” She had mental exercises to instantly recognize it [the depression] and just try to pull yourself out of it. [For example, she urged Henry to say, “Just stop” aloud.] ...and I was like, “Ahh, that’s so stupid,” and she’s like, “Just try it.” And it did help.

For Darryl, who admitted to having perfectionist tendencies, counselling gave him the opportunity to work on the “negative thought patterns” contributing to his depression, something his antidepressants did not do for him:

I was never achieving to my fullest, I guess. It was just not a healthy pattern of thought there. Cause I was never maybe fully happy with anything regardless of how big an achievement it was, so I would kind of beat up on myself...I think knowing that I have those tendencies definitely gave me a reason to seek counselling because it was more than just a chemical imbalance; there’s some psychological kind of thought patterns that I think are contributing to it [his depression].

Ali, who shared how she had attempted suicide on a few occasions, counselling provided the skills that helped her survive her depression:

Counselling gives you the tools to smush it [depressed suicidal thoughts] into a tiny corner of my mind. Kinda like, put it in a box in a safe, wrap chains around it, and just lock it away versus the antidepressants [that don’t] give you the skills to do that. It [antidepressants] just gives you the energy to act on the thoughts.

The majority of participants found their counsellors “non-judgmental,” “non-opinionated” people who provided “reassurance” and “knowledge.” The participants frequently discussed the changes counselling produced on their thinking processes. For example, Marly said counselling helped him “organize my own thoughts and get some structure and flow to them.”

Challenges along the Way

As participants discussed their experiences, they spoke about numerous challenges they faced in managing and overcoming depression. Three themes describe

the primary challenges students with depression face: *tweaking and tinkering, struggling with stigma, and the other side of side effects.*

Tweaking and tinkering. This theme describes the on-going effort participants used to adjust their treatments, so they could obtain the greatest relief from their depression. Rarely was either counselling or antidepressants deemed “just right,” on first try; rather, participants described a sometimes elaborate and lengthy process of modifying the treatment to meet their needs. All participants had to fine-tune their counselling arrangements as well as their antidepressant medications.

Tweaking the fit of counselling. Numerous participants noted they had to experiment with various counsellors until they found the right fit between them, the counsellor, and the counsellor’s approach. For example, Ali, 19, who had seen many counsellors, discussed the approach she took in every first session with each new counsellor: “[With counselling] it’s all personality and the fit... I was always told that for the first session you have with them, it’s more interviewing them to see if it’ll work for you.” Similarly, Bella, noted:

I have more knowledge of how to deal with my depression now. But I think getting the right people, the right doctor, and the right counsellor is—it makes a huge difference. And being able to find that is...it takes a bit of looking right?

Several participants noted that if the fit with a counsellor did not feel comfortable, they would begin looking for a different counsellor or perhaps start seeking a different form of treatment altogether. John described this process:

I just felt like it [seeing that counsellor] was a waste of time. I wasn’t getting any benefit. I felt like I was going over the same talks I had with my doctor and my family. All of the things that we were talking about I

think about or look into or talk with my family or doctor about—it just felt like I was going over the same path [with the counsellor].

Similarly, Taryn felt she needed to keep searching for the right counsellor for her, as her first two counsellors did not offer the exact help she wanted:

I am not talking about either one [either counsellor] in particular here; they both did this a little bit. They'll sometimes suggest things that you have already tried and that can just feel a bit redundant, and hopeless—when they're suggesting things that you have already tried, and they're [the strategies are] not working.

Tinkering with antidepressants. Although finding a good fit with a counsellor can be challenging, participants described that it was even more difficult to find what they termed as the “right antidepressant.” That is, most participants described a lengthy and complicated trial and error process of trying to find the right kind, dose, or both of antidepressant. Typically, this process involved being initially placed on one antidepressant and encouraged to wait several weeks for results, only to discover that the medication did not work and their dosage had to be increased or they had to be started on a new medication—a process that was often repeated numerous times.. Cleo, 38, recounts this kind of experience:

I was resistant to taking [antidepressants] because I wanted to kind of get over it myself but it wasn't working and she [her doctor] suggested that I try Venlafaxine or Effexor...And then after a few months, a month or something, she increased it to the recommended adult dose of 150. After a few months, it did help me...then after a few [more] months I started to feel depressed and anxious. And so, the counsellor and psychiatrist I was seeing at the time increased it to 225. Which again, I felt a benefit from that, and I was seeing a counsellor at the same time, which was really good. And then about a year later, my doctor increased the dose to the maximum dose they can do, which is 300. And after two months I was still depressed [and] anxious...so, she recommended tapering off of it. And I was off it for about a year and a half. And [I] didn't really feel any different than when I was on it.

John reflected on a similar trial and error experience while his medical caregivers were finding the right medication for him:

I [had] to take a lot of pills in the morning. Especially on Effexor; it was, it was rough. I did attempt to try different drugs. Maybe six months in? Just as—you know, let's see what else is out there—this was working, but maybe this one's gonna work better. So we tried Wellbutrin. Put me completely in a sour mood, and I went backwards. It also gave me severe insomnia for about a week. So I definitely didn't like that one. I think I tried Celexa. Same thing. No effect. I think it was Celexa. That was it, and then I went straight back to Effexor.

In addition to tinkering with medication types and medication dosages, participants sometimes endured a lengthy process of managing the undesirable side effects of depression medications. Henry, for instance, eventually found one antidepressant that worked for him, but not before experiencing some grievous side effects from a previous medication:

I started taking the antidepressants, and the first ones that they gave me, I took it [the first antidepressant] for like a month, and I didn't feel any change (in my depression) at all. But they [that particular antidepressant] hit me hard. Like, the side effects were brutal and I went back to her [his doctor] and said "these suck." They don't work for me, or I don't respond to them or whatever. And I asked them [his doctor] to change it. Well I didn't ask them to change it [the dosage of his antidepressant medication], but they recommended I change to something different, and then I took those for about two weeks. ... Then after about three weeks, I started to notice the total difference. It [life] was pretty crazy. And then it [his life with the new medication] kept like that [remained crazy], and then we upped it [the dosage] a bit, and then I felt a lot better.

Rather tell people about the antidepressants than counselling. Most participants felt a stigma was associated with the use of antidepressants, counselling, or both, although the source of the stigma varied slightly for the two treatments. Additionally, even though the students felt stigma during their use of antidepressants they were more fearful that people might find out that they were

attending counselling. The stigmas that students felt while using an antidepressant and attending counselling are presented below.

The stigma of antidepressants. Participants felt the use of an antidepressant was “a sign of weakness” that caused them embarrassment and the feeling they were “not normal.” Ali, who used both these expressions, found herself “frustrated” and “uncomfortable” with having to “rely on an outside source to feel better.” In addition, Ali found she hid the fact she was taking an antidepressant from friends and even her boyfriend, for fear they would see her as weak or urge her to “just pull up her bootstraps.” Yet at the same time, Ali, found this stigma confusing, and referred to the common diabetes analogy to question why she felt so much shame about taking antidepressants:

And like the stigma of being on an antidepressant is just...[pause] there's no stigma attached for a diabetic to be taking insulin, but yet if [they are] off their insulin [if they forget to take insulin], yeah, they'll pretty much die if they're not careful. Same thing goes with being clinically depressed and antidepressants. If you really need them, and you're not careful, and you're taken off them, you're gonna self-assassinate.

Other participants also noted they had experienced the stigma associated with antidepressant medication and the perception of not being normal. As Taryn explains:

I think when it comes to antidepressants, there might be a little more of a stigma that I'm not used to. Like, if you're on antidepressants, oh you must not be normal; you must be crazy and not able to cope with things.

Henry was also fearful that if his friends found about his depression and his use of an antidepressant, they would begin to treat him differently and even be afraid of him:

And like, yeah I think that, there's no way I could talk about it [antidepressants] with my friends... Like, there's no way, there's absolutely no way I was telling anyone I was on the pills. Because they'd think I was crazy or like, because you get to know this guy and the all of a sudden he does this huge 180, and he's on antidepressants. Like whoa, whoa, whoa. And I was lucky enough to have a girlfriend, so I wasn't out there chasing girls and them finding them out like, whoa, what is this psycho? Is he going to hack me up?

Thus, the source of stigma for antidepressant medications was perceived to be from others more than from self. Also, although antidepressants are the most common treatment of postsecondary students with depression, these medications carry with them the risk of numerous side effects; include the potential for social stigma.

The stigma of counselling. Participants also acknowledged a stigma associated with counselling, the belief that counselling implies something is wrong with a person. One participant, Bella, thought the stigma associated with counselling originates from people's tendencies to draw presumptuous conclusions about this treatment:

I think people just think, oh you go to counselling? You probably want to kill yourself or something. People always think to the extremes. And they don't think that it's just a...something to help yourself emotionally, so that you can move on. They think that it's always just the most terrible thing. You have to go there because, if not [if you don't attend counselling], you're going to off [kill] yourself or something.

According to another participant Henry, much of the stigma associated with counselling is borne from antiquated views of counselling that even he used to hold. He recounts his perceptions of counselling before and after his own counselling experience:

But then, and then you see in the movies, like, what is this image of counselling: sit on one of those little chairs, and you just sit there and somebody takes notes and that kind of crap. And it's totally not like that.

And they ask questions about you, and it's not like the [typical movie scenario of a counselling session, in which the psychologist says,] "I want you to go to your happy place" crap. I don't think people get that. That's the image of counselling I had before I went there, and it was not like that at all, right?

Interestingly, participants indicated that counselling actually held greater stigma associated for them than antidepressants did. For example, Bella, found that people had a "who cares" reaction to her being on an antidepressant.

However, when people discovered she was also going to counselling, she described people's reaction: "Whoa! You're going to see somebody? What's wrong in your head?". Similarly, Marly mentioned the stigma of counselling and compared it to that of taking antidepressants:

I see that counselling is helpful, but [the common perception is that] people who get counselling are weird and out there. And you know, I don't see it as a problem; I see it [the stigma] as normal but definitely societal—who goes to therapy right? You're messed up if you need therapy. That's kinda what we believe, right? But, of course, if you take nine different pills in the morning to get through the day, you're normal. But if you get a little counselling...you're out to lunch. You can't be trusted as a human or whatever. Sometimes it [the greater stigma of taking counselling] gets pretty bad.

Henry mirrored this sentiment, and stated he "...would rather tell people about the pills than the counselling" even though he also believed that if people discovered he was on an antidepressant, they would see him as crazy or a "psycho."

Some students believed the stigma of counselling was greater than that of antidepressants because the use of medication is so widespread and common.

Sophie explained,

It's hard to say...because antidepressants, they're kinda common these days. Like a lot of people are on pills for various things. I don't think it's

quite as stigmatized anymore as perhaps it would have been before. Not as much as counselling is.

Marly, held a similar perspective and further surmised that the stigma associated with counselling would be difficult to change, but could persist for some time:

The stigma toward antidepressants drugs is gone, I would say. In that everyone's tried them at one point. And at the other end, the [stigma associated with having] therapy ha[s] never gone away. It's still...you need to go and talk to someone who is not a friend? Like you're paying for therapy? What is wrong with you? Why can't you deal with this yourself? And that's unfortunately a stigma that won't get removed for a while.

Participant responses indicate that the stigma for counselling could be externally or internally produced. The stigmas of antidepressants and counselling were described as real and unfortunate side effects of depression treatments.

The other side of side effects. This theme describes some of the side effects that participants experienced while using antidepressants, counselling, or both. Most participants acknowledged that although they experienced some benefit from either mono-therapy or combination therapy, these benefits always occurred with two consequences—a) the physical side effects and b) the fear of dependence.

Side effects of antidepressants. All participants experienced at least one side effect or adverse physical reaction to prescribed antidepressant medication. Some reported sleep disturbances, an upset stomach, or what they termed a “crazy dry mouth”; however, some students were willing to endure and adjust to these negative side effects to alleviate their depression. Other participants suffered far worse side effects that prompted them to either discontinue their medication or to have the dosage adjusted. For example, Cleo found she could not think clearly while on her medications:

...when I was taking the dosage of 20 [mg of her antidepressants], I had this overmedicated, stuffed up feeling. And actually [I] had this for a few days even when I was on 10 (mg). [I felt] like, my head [was] stuffed with stuffing or cotton or whatever you know...like a bit of...it [was] a weird feeling. But it's an overmedicated feeling that I don't like.

Similarly, Taryn experienced a “robotic” and “muted” feeling, which she likened to a previous concussion she had had. She said these side effects interfered with her ability to “feel”:

I think it [the medications] just kind of muted everything as opposed to manage just the negative emotions, if you know what I mean. Like, I felt really detached. I didn't even feel happy emotions so much. I just didn't feel any emotions. And I was just kinda robotic and slow. So it didn't feel like I was living, even though, you know, living sad is not fun. I'd prefer that to feeling like I'm not alive.

John, who had used numerous antidepressants to manage his depression, reported feeling feverish or having a sense of vertigo. However, the most notable side effect for John was the withdrawal symptoms he experience from Effexor [an antidepressant]. These symptoms were so extreme he became fearful he might lose his medication and miss his dose, and he became consumed with worry when he was near the bottom of his prescription:

The weirdest one was like brain shock. I don't know what—if there's a good term for it, but everyone describes it the same. It's just a—it's like an electrical discharge down your spine. Every two minutes. It's terrible. You just sit in a chair all day. It took me about 4 or 5 days to get out of it. That was just when I was weaned of Effexor; then, I went onto the Wellbutrin [an antidepressant], and I haven't been on the Effexor since then.

All participants who had used antidepressants experienced some degree of physical side effect.

Fear of dependence. In addition to the physical side effects of antidepressants, many participants experienced an uncertainty about whether or not they could ever

live without their antidepressant. Some students were fearful they would “never get off them” and said they were “sad to be dependent on a pill.” For example, Bella, whose sister and grandfather are also on antidepressants, could not perceive an end to her need for medication:

It kinda sucks just to know that like I’m going to have to take this pill every day probably for the rest of my life just to be happy. It doesn’t feel normal but...it’s going to be my normal, I guess. I look around at people and like it doesn’t seem like they would be depressed. It doesn’t seem like they have to be on a pill... It just feels like nobody else is on them, and has to depend on them to be happy.

Cleo, who was initially resistant to taking an antidepressant because she had heard stories of people “getting addicted to them,” admitted to occasionally imagining her life without medication:

Well I imagine [what] it would be like, how I was maybe 10 years ago. When I felt like I—I never even thought about needing an antidepressant medication. I don’t know if I’ll ever be like that again. Like one of my doctors says, “Yes, I will.” My psychiatrist [whom] I saw last week says, “No, you might as well get used to living like this.” So who knows...I don’t know.

While most of the students viewed the need for an antidepressant as a lifetime commitment with no end point due to the chronic nature of depression, Sophie was afraid to discontinue the use of her antidepressant even though she was no longer feeling depressed:

... I don’t think I am depressed anymore, but I wouldn’t want to make any bad change and screw everything up. Does that make sense? I’m kinda afraid to rock the boat...I don’t know if it is a mental thing that I need this as a security, or if it’s actually something that I actually have to have. I would probably experiment with it, but I am not really prepared to do that right now.

Side effects of counselling. Side effects from counselling were more mentally and emotionally taxing on the students than the physical side effects of the

antidepressants. The two side effects of counselling appeared to be (a) increased concerns or worries and (b) the measurability of the benefit of counselling.

Uncertainties of counselling. Participants were often uncertain about whether counselling would offer them confidentiality and whether they could be completely honest with their counsellor. For example, Ali was cautious; initially, she was not sure how much she could share about her suicidal ideation because she worried her counsellor would become deeply concerned for her safety and call someone to help. Ali disliked the suicidal ideation questionnaire she was given each counselling session:

They need to ask [about] it [suicide ideation], but [when they ask] point blank, “Fill out this questionnaire”—[that] really chafes me. I mean, I think it’s one of those [issues in which] you [the counsellor] just kind of have to listen to the person, and when it [the suggestion of suicidal ideation] starts to come up...ask some leading questions, and let them [the client] tell you rather than... [mocking tone], “So on a scale of one to ten, how likely are you to kill yourself right now”—because really, if you are honest and say ten, they’re going to be like [imitating the counsellor’s response], “Okay, off to the psych ward with you!”

Similarly, Henry was concerned about how confidential counselling would be; however, unlike Ali, his concern stemmed from the fact that he had believed that counselling at his university was provided by volunteer students. As he explained:

I honestly thought that the counsellors were students. So I was pretty fearful. I am sure they are great, but it’s a trust thing. Because you see another person in your class, and they know you have depression, and they have the power to out you [betray confidence]. They have this hold over you right? Like, obviously I’m pretty sure they wouldn’t, right? “They’ve got some sort of thing going on, but that’s a fearful thing...They shouldn’t have any power over you.

A few students revealed they were worried about the cost of counselling and uncertain about the amount of time it would take in their already busy schedule. Cleo

became severely discouraged when she felt she was receiving little help from counselling: “I don’t like to go to counselling when it seems like nothing comes out of it. I mean it takes up time. It takes time to go to these appointments. It takes time away from getting my work done.”

Ali was also cognizant of the time she spent in a counsellor’s office, but not because of lost time, but because “every hour I’m sitting with this person, it’s a hundred bucks going out of my parents’ pocket.” Henry echoed Ali’s feeling of guilt about spending his parents’ money on counselling and admitted this caused him to switch from counselling to antidepressants:

Another reason, too, was it was 250 dollars a session, and that was pretty pricey to be honest. I wasn’t paying for it, but I still felt guilty [about the money] my parents [had to spend]. They would have wanted me to keep going [in counselling], like they want you to do well, but the pills [are] working now, so I don’t know.

For many of the students their fears regarding the cost of counselling came out of their experiences with community counselling and not post-secondary mental health centres. While participants eventually developed the rapport with their counsellor which assured them of confidentiality uncertainties, the cost of counselling and subsequent guilt associated; lead some students to stop seeing their counsellor.

Measurability of counselling. A few of the students decided to discontinue counselling because of their inability to measure the benefit of counselling. Darryl found it “harder to measure the gain or positive aspects of [counselling]...whereas the antidepressants are more of quantitative value of medication that will get you to a certain level. It just seems more concrete.”

John, also found it difficult to measure the benefit of counselling, especially because he was engaged in discussions with his family and doctor regarding his depression. Although John admitted to finding “reassurance from a stranger telling you that you are going to get through this,” he also stated that counselling “felt like I was going over the same talks I have with my doctor and my family...it just felt like we were going down the same path.”

Discussion

Numerous quantitative studies have identified depression as a prominent issue affecting the student population in many countries. Further, many of these studies have identified the potential contributing factors of this rise in student depression and the effects that depression is having both on individuals and their academic outcomes. This study provided students who are living with depression while attending postsecondary education the opportunity to voice their experiences and perceptions. University and college student perspectives on depression have been given scant attention; thus, the perspectives in this study represent an excellent source of data on the dynamics between attitudes and beliefs towards depression as well as student responses to treatment options currently available.

This study has demonstrated that although student depression is complex, some similarities exist between the student experience with depression and that of the general population. For example, when this study is compared with Malpass et al.'s (2009) meta-ethnography which reviewed 16 qualitative research articles aimed at understanding people's experience of using an antidepressant for their depression, numerous similarities

arise. First, Malpass et al. (2009) describe a medication career. Malpass et al. (2009) imply that individuals in the studies were involved in a process by which they experience an evaluation process, a return to function, side effects, a latency period, and finally, the concordance of relationship. The students in this study identified periods in their use of antidepressants that would appear to fit with many of the aspects of the medication career as identified by Malpass et al.. The students noted that throughout their use of an antidepressant they were continually evaluating its effectiveness in improving their depressive symptoms. Whether it was during “horrible” physical side effects that caused them to discontinue usage, or during times when they questioned whether or not they still needed the medication, but were “afraid to rock the boat” and discontinue using an antidepressant; the students appeared to be constantly situating their need for antidepressant treatment. The students noted that the counsellors often helped them navigate the side effects and their decision making while weighing the pros and cons of the antidepressant treatment.

Additionally, Malpass et al. (2009) describe a moral career as the process in which an individual decides to seek help, accept treatment, continue treatment, and finally arrive at a decisive moral juncture. The students in this study described how they went through the process of identifying the need for an antidepressant, or were encouraged to seek out an antidepressant for their depressive symptoms; most notably for their lack of energy and motivation. Once the students had accepted their need for an antidepressant many of the students noted that they had difficulty coming to the realization that they need to “rely on an outside source to feel better”. The students felt that “could not talk to friends about the antidepressant” because people would think they

were “crazy”. The journey that the student embarked on after they were placed on an antidepressant left them wondering if this was “their new normal”, referring to an artificial self, similar to the one posited by Malpass et al. (2009).

When this study is compared to Kwintner’s (2005) study which investigated people’s experience of using an antidepressant while attending psychotherapy, a few comparisons can be made. First, the majority of the participants in Kwintner’s study identified the biological causes of depression to be the reason for their antidepressant use and that their physical need for an antidepressant is similar to a diabetic person’s biological need for insulin. In this study, many of the participants also used the analogy comparing their body’s need for an antidepressant to the diabetic individual’s life saving need for insulin. Interestingly, participants in both Kwintner’s study and this study used the diabetic analogy to not only explain their need for an antidepressant, but to also “side step social stigma” (p. 38). Second, all of the students in my study felt stigma associated with taking an antidepressant, while similarly ten of eleven participants in Kwintner’s found stigma associated with antidepressant use. The stigma felt by the participants often lead them to hide their antidepressant usage due to the fear of being labelled “crazy”. Finally, some participants in both studies noted how their antidepressants helped “facilitate” (Kwintner, p. 44, 2005) and give them the “energy” to attend counselling. For these participants the use of an antidepressant gave them the energy required to participate in the counselling work. However, another similarity could be found in the opposite, as participants in both studies also noted that the antidepressants left them “foggy” and unable to participate in counselling. Once these participants discontinued the medication they felt that they were then able to be engaged in the counselling process.

Overall, this study augments the understanding of perceived life stressors, perceived contributing factors, preferred treatment, and stigmas associated with depression and treatment, the lived experiences of depression and how these factors run concurrent with the experiences of being a student. Because few studies have explored the lived experiences of postsecondary students who use antidepressants, counselling, or both to manage their depression, the findings of this qualitative study offer new insights. Discussions with these students who used both antidepressants and counselling revealed some important implications for counsellors and students. These findings could help healthcare professionals better recognize depression within the postsecondary student population, and could lead to increased awareness of the needs of students.

Implications for counsellors

The most striking and surprising implication for counsellors from this study's data is that counsellors must work even more vigorously to overcome the stigmas attached to counselling. This study revealed that stigmas attached to counselling are greater than those attached to antidepressants. One student boldly asserted he would rather tell his friends about the antidepressant than the counselling, even though they might consider him "psycho" for being on them. Many participants postulated that counselling had a greater stigma because the stigmas attached to antidepressants had lessened due to "everybody being on something [medication] these days." Although counselling centres in postsecondary institutions have already worked hard to decrease the stigma of counselling, this study reveals that more work must be done. Once the majority of participants in this study were able to work up the courage to go to a counsellor, they discovered counselling was not like the stereotypes portrayed in the popular media.

Counselling must, therefore, take an increasingly prominent and unapologetic role within postsecondary institutions to demonstrate that counsellors have the skills to help individuals managing depression, and counselling personnel must demonstrate they are professionals who value confidentiality and can offer more than academic assistance alone.

A second potential implication for counsellors is borne out of the student's beliefs that antidepressants work on physical aspects of depression and counselling works on the mental aspects of their depression. Based on the experiences of the participants in this study, it would appear that whenever the student was requiring energy to "get out of bed" or motivation to be active in their life, they would be encouraged by a health professional to try an antidepressant. Although it is proven antidepressants can provide energy, does counselling not provide energy and motivation as well? There are numerous counselling theories which address the motivational needs of the client prior to therapy such as motivational interviewing, trans-theoretical model of change, and motivational enhancement therapy, and as such aim to provide energy (Ryan, Lynch, Vansteenkiste, & Deci, 2011). If depressed students on campus are seeking out assistance for their low energy and motivation, campus mental health centres would be wise to design their educational campaigns around promoting the benefits of counselling for these issues. These educational campaigns would encourage students to seek out the direction of a counsellor first for their low energy and lack of motivation rather than turning to an antidepressant as their initial treatment choice.

A third potential implication is that counsellors could benefit from an initial interview screening tool to better understand student perceptions of their depression and

to better promote treatment options. This tool could provide counsellors with immediate insight into client belief systems. The literature suggests that client adherence to a preferred treatment option increases when the client feels the counsellor understands his or her illness and are involved in the decision making process regarding treatment (Malpass et al., 2009). Furthermore, Van Voorhees et al. (2005) state that patient attitudes and beliefs regarding a treatment—including negative perceptions of treatment, preferences for treatment, and previous experience with treatment—alongside a depression etiology are internal factors that influence a client’s intention, not only to accept a diagnosis of depression but also to engage in treatment.

Impetus for this initial screening tool is bolstered by one of this study’s themes *tweaking and tinkering*, which describes student willingness to adjust counselling treatment until they find the right fit with a counsellor. Although some participants in this study described an initial counselling experience that caused them to be unwilling to return to counselling, other participants pushed beyond their initial, distressing counselling session and continued to search for someone who would better fit their individual needs. A screening tool could assist both students and counsellors during this often problematic *tweaking and tinkering* stage in the following ways: (a) the tool could help students determine their fit with a counsellor; that is, the tool would help students assess whether the counselling style and knowledge offered by that practitioner would work for them; (b) the tool could decrease the “wasted time” students speak of while searching for an appropriate counsellor; (c) if the tool indicated a poor fit, the counsellor could advise the student of alternatives and encourage the student to continue seeking counselling as a treatment choice. Determining a person’s attributes and needs prior to

beginning long sessions could lead to much quicker benefit for the client. Postsecondary students who are already pressed for time and need quick help could find this tool the difference between dropping out of/or continuing treatment.

A final implication from this study is that counsellors may require a better knowledge of antidepressants. All participants in this study had used an antidepressant and many had developed a sophisticated understanding of depression and antidepressants. However, some students had misinterpreted this information by concluding that because antidepressants could correct bio-chemical imbalances and supplement low energy levels, the primary treatment for depression should be medications rather than counselling. In other words, the dominance of information on antidepressants led some students to incorrectly believe that they required a physical solution for their physical problems rather than counselling for mental or mind problems.

Counsellors would gain much benefit from a solid foundation in psychopharmacology as students are increasingly coming to postsecondary studies already on an antidepressant and many may be inquiring about using one. This understanding would allow counsellors to better help clients who had studied depression medications, something most participants in this study had. Although counsellors would not want to spend the entire session discussing antidepressant medication, an initial discussion would demonstrate counsellor competence and provide an opportunity for the counsellor to discuss the equal benefits—including increased energy levels—that could result from counselling.

Chapter Four: Counsellor's Experience

Literature Review

Despite evidence indicating a high prevalence of depression in university and college students, affected students are not accessing available mental health services. The American College Health Association's National College Health Assessment II (ACHA-NCHA II, 2009) reports that of the more than 34,000 post-secondary students surveyed, 29.6% had "felt so depressed... it was difficult [for them] to function," but only 9.2% had been diagnosed or treated for depression during the previous year. Further, the American Foundation for Suicide Prevention Screening Project reported that 85% of students who had screened positive for moderate to severe depression were not being treated with either counselling or an antidepressant (Garlow et al., 2008). Also, the Health Minds Study found that only 36% of the students with symptoms of major depression had been treated the previous year (Eisenberg, Golberstein, & Gollust, 2007). This cluster of studies indicates that although a significant proportion of post-secondary students experience depression symptoms, most do not receive treatment.

Of the post-secondary students who do seek treatment for depression, antidepressants represent the most frequently used treatment option (Alshuler et al., 2008). ACHA-NCHA II (2011) reported that over 7000 students were currently using medication to manage depression, while less than 2000 were using therapy alone. Some counselling centres have estimated that 25% to 50% of students seen at student health centres were on antidepressant medication (Kadison, 2005). High percentages of antidepressant use, both surveyed and estimated, have provoked the question of whether these drugs are being given for depression or for the stressors of student life

(Frankenberger et al., 2004). Only more qualitative research will reveal the reason for increasing reliance on antidepressants by post-secondary students.

Although qualitative research on the perspectives of post-secondary students with depression is sparse, research on depression in the general public is increasing. Malpass et al. (2009) completed a meta-ethnography of 16 articles published between 1993 and 2007 on how people managed antidepressant use and how they decided to initiate or terminate use. Studies on the perceived effects of antidepressants on self-concept and perceptions of stigma were also included in this synthesis (Malpass et al., 2009). The authors concluded that antidepressant use seemingly caused people to encounter two processes: (a) the *decision making process*, also termed the *medication career*, in which people decipher how to assimilate the new practice of taking an antidepressant into their lifestyles and (b) the *meaning making process*, also termed the *moral career*, in which people apprehend the implications that the new medication will have on their lives and personhood. The authors posit that during the medication career people taking antidepressants negotiate their medication treatment, make decisions around medication use, and attempt to understand their new medicated self (Malpass et al., 2009). Alternatively, during their moral career phase, people ponder how taking an antidepressant may create a new self-identity. The authors note that during the moral career phase, self-identity shifts; thus, people taking an antidepressant experience identity conflicts as they journey through several phases: (a) the medication reveals a new self-identity, (b) it enhances an artificial self, and, once the medication has been discontinued, (c) the people reclaim their previous authentic self (Malpass et al., 2009). These findings have been neither proven nor refuted in the post-secondary student population.

Other studies in the general population have examined the efficacy of combining medications with counselling to treat depression. A unique qualitative study not included in the above meta-ethnography, but also aimed at understanding the experiences of individuals treating depression with both an antidepressant and counselling, is Kwintner's (2005) *Message in a Bottle: The Meanings of Antidepressant Medication for Psychotherapy Patients*. The majority (55%) of this study's eleven participants, all of whom had a post-secondary degree, viewed antidepressant medication as beneficial to therapy. These six individuals asserted that an antidepressant "facilitate[d] therapy" and allowed them to get "out of the ditch," so they could "travel down the road" (Kwintner, 2005, p. 43). Further, a majority (82%) of participants felt therapy complemented their medication because therapy gave them greater opportunity to discuss medication effectiveness, dose adjustments, and side effects than they would have with a doctor. Some participants stated counselling yielded additional support for antidepressant use when therapists expressed pleasure or relief towards their decision to start an antidepressant. Although some of the participants experienced benefits of the addition of an antidepressant, there were some who felt that the antidepressant hindered counselling. For example, one participant felt that the antidepressants "suppressed" her ability to discuss and "deal with her feelings" (Kwintner, 2005, p. 44). Additionally, another participant believed that she was more engaged in counselling once she discontinued the medication because she no longer experienced side effects.

Studies such as Kwintner's (2005) are significant to counsellors in post-secondary institutions for two reasons. First, such research indicates that as the frequency of people using counselling and antidepressants combined to manage depression are increasing,

antidepressants may in fact play a significant role in the counselling session. Second, such research challenges counsellors in post-secondary institutions to gain a more comprehensive knowledge of antidepressants, so they can better understand the medical model's explanation of how antidepressants work biochemically speaking, as well as, help the student identify potential side effects of antidepressant use. Indeed, because 95% of 283 campus counsellors surveyed in the United States reported an increase in the number of students taking psychotropic medication (Gallagher, 2009), studies such as Kwintner's provoke counsellors to understand how antidepressants can positively and negatively influence counselling outcomes. In summary, research has established the efficacy of a combined therapy-medications approach (Spencer, & Nashelsky, 2005), prompting counsellors to increase their understanding of depression medications.

Counsellors with knowledge of psychopharmacology can better help clients who could benefit from antidepressant medication. For example, Shipley (2011) identifies several types of analysis counsellors must employ when deciding when and how a student with depression symptoms should be referred. First, Shipley encourages counsellors to be aware of the "biological nature of depression" and understand that if individuals are not reporting "major-life stressors," then they may be initially "incapable of responding to typical psychological treatments" (2011, p. 148). Alternatively, if major stressors include recent life events, then psychological treatments could be beneficial; however, if biological and recent stressors appear to be evenly matched, then a combination of the two may be warranted (Shipley, 2011). Finally, Shipley notes that "satisfactory awareness and appropriate application of psychological and pharmacological therapies in tandem, where advised, is of greater urgency" (2011, p.

148). Although counsellors do not prescribe antidepressants or other pharmacological agents, increased knowledge of these treatments would benefit their practice, both when treating clients who begin therapy on an antidepressant and when treating those who do not.

Because college and university counsellors are seeing more clients with depression symptoms, counsellors must understand not only how to counsel clients currently on an antidepressant, but they must also understand how to assist clients who would benefit from adding an antidepressant to their treatment regimen. Thus, this paper presents the perceptions of university and college counsellors on (a) antidepressant use in post-secondary students and (b) the advantages and disadvantages of augmenting counselling therapy with antidepressants (or vice versa).

Method

Max van Manen's hermeneutic phenomenology philosophies (1990) guided the methodology of this study. Van Manen's approach is both descriptive and interpretive, allowing participants in this study to speak about their experiences themselves; it also allowed me to represent participant experiences in language that is "inevitably an interpretive process" (van Manen, 1990, p. 181). Another reason this approach suited my study was "the aim of phenomenology is to transform lived experience into a textual expression of its essence—in such a way that the effect of the text is at once reflexive re-living and a reflective appropriation of something meaningful..." (van Manen, 1990, p. 36). Thus, I chose van Manen's approach because it allowed me to present counsellor

experiences in the most immediate and non-filtered way, while still allowing me to make helpful analytical conclusions.

Qualitative inquiry, as employed in hermeneutic phenomenology, is common in health professional studies; therefore, this approach is a suitable tool for inquiry as “nursing practice is enmeshed in the life experiences of people” (Streubert, & Carpenter as cited in Nieswiadomy, 2002). Munhall (2007) agreed that phenomenological studies are an appropriate instrument to provide understanding of the meaning of an experience and an important means of applying the resultant understandings in the form of newly designed interventions. Inquiry for this study began by identifying and interpreting van Manen’s six research activities (van Manen, 1990, p.30), as follows:

(1) Turning to a phenomenon which provokes serious interest in researchers and links researchers to their world (I studied depression in post-secondary students, whom I teach and of whom I am a member, through the experiences of post-secondary counsellors.);

(2) Investigating experience as we live it rather than as we conceptualize it (I investigated counsellor experiences as they experienced them);

(3) Reflecting on the essential themes which characterize the phenomenon (After analyzing counsellor accounts, I identified primary themes of these experiences.);

(4) Describing the phenomenon through the art of writing and re-writing (I fulfilled this step by transcribing my interviews with study participants, re-reading the texts multiple times, and eliciting dominant themes in my text.);

(5) Maintaining a strong orientation to the phenomenon (I maintained a robust relationship with my subject through continued reading, ongoing engagement with counsellors, and regular consultations with my supervisor and committee.); and

(6) Balancing the research context by considering parts and whole (I evaluated both the comments of individual counsellors and the themes articulated by the entire participant group.).

Participants

Counsellors who participated in this study were recruited from a small southwestern Canadian city, home to both a university and college. Counsellors were recruited via an email sent to counselling offices at both institutions, attached was an invitation to participate letter (Appendix E). Inclusion criteria required participant counsellors to have treated at least three students who—to the counsellors’ best knowledge—had previously taken or were currently taking an antidepressant to manage depression.

Procedure

The Invitation to Participate letter outlined the purpose of the study as well as potential benefits gained by participation. This letter also informed counsellors that their participation would be voluntary and their personal information and interview data would be kept confidential. Counsellors who wished to participate were invited to voluntarily contact me by phone or email for more information or to make an appointment at their convenience for an interview.

In all, six counsellors participated: four from the university setting and two from the college setting. Data were collected in face-to-face, audio-taped interviews. The researcher obtained written consent from all participants prior to interviews. Interviews

lasted between 30 and 60 minutes. The researcher used an interview guide (Appendix F) to focus the narrative on counsellor experiences because “the interview process needs to be disciplined by the fundamental question that prompted the need for the interview in the first place” (van Manen, 1990, p.66). All interview audio-tapes were sent to a professional transcriptionist for transcription.

Participant identities remained anonymous through the process. The participants self-chose a pseudonym to ensure anonymity during the referencing and dissemination of findings. Data from each participant were assigned identification numbers known only to my supervisor and me. Consent forms and lists of participants were kept separate from the transcripts. Additional participant demographic information was gathered to enrich the findings and facilitate data analysis. Demographic information (Appendix G) included (a) participant age and gender, (b) the years each participant had been a counsellor, and (c) each participant’s professional designation.

Analysis

Themes were elicited using the three approaches offered by van Manen (1990). First, the transcripts were read in their entirety and the essence of each participant’s transcript was captured in a single phrase; van Manen identifies this step as the holistic reading or the sententious approach. Second, each transcript was re-read using van Manen’s selective reading step, in which researchers give the texts several readings to elicit particularly revealing statements or phrases. Then the transcripts were read again employing van Manen’s detailed line-by-line approach to reveal significance in individual sentences or paragraphs. Significant segments of text were assigned a theme

name. Finally, groups of text with identical themes were grouped for further analysis using NVIVO 9 qualitative analysis software.

Rigour

The rigour of this study was assessed using some of Lincoln and Guba's tenets of trustworthiness: credibility, confirmability, and transferability. Credibility refers to "confidence in the truth of the data" (Loiselle, & Profetto-McGrath, 2004, p. 317). I addressed credibility by completing interviews until an understanding of the phenomenon was attained. I addressed dependability, "data stability over time and over conditions" (Loiselle, & Profetto-McGrath, 2004, p. 317), and confirmability, by developing a thorough audit trail that could be reviewed by an external reviewer. Transferability refers to "the extent to which the finding from the data can be transferred to other settings or groups" (Loiselle, & Profetto-McGrath, 2004, p. 318). Although hermeneutic phenomenology is not meant to be generalizable, a purposeful sample that represented the phenomenon of depression in postsecondary students was obtained in hopes that their stories would resonate with other students managing depression.

Additionally, subjectivity, as described by Young and Collin (1988), was fulfilled as I identify myself as being an implicated researcher who is both a student in a university and an individual who works in a mental health facility and has previous experience with personal stories of antidepressant and counselling use. Further, validity, as seen as being conferred by the reader (Young, & Collin, 1988), will hopefully be found as the themes of the studies resonate with those individuals who read this thesis.

Results

The Three Types of Students

When discussing their experiences of treating students with depression or symptoms of depression, counsellors often found it useful to classify clients into three groups. The first group was composed of students who enter counselling with either current or previous antidepressant experience. Members of the second group come solely for counselling; these students resist antidepressant use under any circumstances. The final group consists of students who have chosen counselling as the sole intervention for depression, but after a time, the counsellors actually encourage the student into getting on a prescription for antidepressants. Each of the three groups will now be discussed in turn.

Students with previous antidepressant experience: “Show me what you’ve got.”

Counsellors described students who had current or previous experience with antidepressants as holding a different perspective than students with no experience with depression medications. For example, Joan observed that students who came to counselling already on an antidepressant needed to be convinced that counselling would benefit them, because most of her clients in this category doubted whether counselling could provide an answer for them. As Joan notes:

With these individuals [students on antidepressants] I need to let them tell a little bit more of their story...because they need to see something different. You need to prove it to them that this [counselling] is a useful thing for them to engage in.

In addition, Joan noted that students who came into counselling with previous antidepressant experience often knew “an awful lot about meds” and an “awful lot about depression.” She noted that she believed this knowledge often originates from a family history of antidepressant medication use where the student’s attitude is “My mother’s on

meds; my father's on meds; someone is [always] on meds." Joan further explained she felt this group of students often challenged her to "fix" them and wanted her to "show [them] what you got." As she described,

When they [students] come in and have been on meds, they can fly around the pharmaceutical jargon very well. They almost try to intimidate me with that. They almost sit back and say, "Show me your stuff." I see that quite a bit, almost more so with males than females.

Furthermore, Jay, a college counsellor, noted that many individuals who came to counselling with current antidepressant use were there because "my psychiatrist tells me I have to be connected to somebody." She stated that such students often had the mindset "[The] medication is doing what it needs to be doing, [and] counselling hasn't been helpful," so Jay surmises that these students do not want to be in the counselling office. Betty, a university counsellor, also found this type of client had an "unmotivated" mindset and held the attitude, "I don't want to talk about this; I just want to take the pill. Thus, students who enter counselling with current or previous experience with an antidepressant hold attitudes that seem to diminish the efficacy of counselling, at least the efficacy of the initial stages of counselling.

Students with resistance to medications: "Medications show weakness."

Data revealed that clients in this group represent the "overwhelming" majority of clients counsellors see. Betty observed,

I think ...most of my clients would want to do counselling alone [without an antidepressant]. I find the ones that come in here don't want to do medication; they'd rather try counselling first and see how we do with counselling first. Typically that's sort of the projection. Most often they come in and say, "You know, I really don't want to go on medication." I don't have a lot of students who are like, "Yeah; I think I need the medication."

Joan echoed this observation:

You know, when a client is coming to us with anxiety or depression, I outline all of the options...available to them. But as I say, the folks that are coming to us that aren't on meds to begin with. [I sometimes have to say] that's [treatment with an antidepressant] something that we are going to explore, [but students in this group] ...usually are not ready to hear it.

Cindy, a counsellor, who worked in the community for years before taking a job at the university noted that student clients tended to be more “educated around what some of their options are [to manage their depression]” than previous populations she counselled. Many of the other counsellor participants also noted that because students are more educated and “high functioning,” they tend to have more “self-efficacy in terms of helping themselves and being able learn from counselling”. Joan thought this particular group believed they could manage their depression with counselling alone, so much so that they would view antidepressant use as an admission of weakness. In her words:

They're [the students] much more attendant. The tendency is much more to be in touch with their immediate emotions—and maybe overly in touch with that—maybe to the point of navel gazing stuff. And, fairly, you know, they can do it themselves. That would be some of their characteristics that ...[show me that these students view] taking a medication ...[as] a weakness. And almost having to do that [take an antidepressant] would be succumbing to the weakness.

Students who could benefit from an antidepressant: “You need more than I can offer.”

All counsellor participants were able to identify situations where they had found themselves trying to “persuade,” “convince,” or “cajole” a student to talk to a physician or psychiatrist about adding an antidepressant to the treatment plan. The counsellors described situations in which students “needed more than what I could offer them” as the rationale for encouraging them to seek the assistance of another health professional. For

example, Sarah described when she would consider referring a student to another health professional:

I guess, I think [when]...this person needs more than what I can offer them possibly.... if I bring somebody in, ...another medical professional or somebody in the helping profession, and they can offer this individual something that I am not able to, then it is kind of a win-win situation usually.

However, the students often needed reassurance that seeing another health professional was in their best interest. Joan recalled that she often needed to give what she termed “halos,” or high praise, to the health professionals to whom she was referring the student because of the student’s hesitation to seek further help for depression. Joan notes:

I usually have to convince them [the students]... to give my health people halos almost, to identify that I trust them and that they wouldn’t put them [the students] on something that would be detrimental to addictions or substance use. And they [the students] respond very well to that, and I do see an improvement in them, and we are able to move forward with their counselling. But that’s been the usual hesitation [on the part of the students] to go and do that.

The counsellors were quick to note that although they could encourage clients to see another medical professional, counsellors also needed to encourage students to be proactive in deciding whether or not to begin antidepressant therapy. Jane describes how she would coach a student who had decided to see a psychiatrist:

[Jane addresses an imaginary client], We know you are going to see a psychiatrist. Don’t forget you still have your choice at that point when you talk to him, to decide whether or not you want to take the medication. And even if you decide then [to use an antidepressant] and you go and fill it [the prescription], you still have that choice then, to decide whether or not you want to take that medication. [Now talking to the Researcher], And then I talk about the process...and remind them this isn’t a lifetime commitment.

Advantages of Antidepressant Use by Students: Providing Energy to a Body that has its' own Agenda

Regardless of counsellor demographics—where they worked, their age, their counselling style, or their years of practice—all counsellors agreed that antidepressants had a place in managing student depression. While the counsellors noted that adding an antidepressant is never the first option, they found that adding an antidepressant is necessary for some individuals. An antidepressant was seen as necessary or helpful for two reasons: (a) to provide “energy” or an “extra something” to do the counselling work, and (b) to overcome physiological factors such as neurochemical imbalances that “have their own agenda.” Both advantages are discussed.

No motivation: They can't even get out of bed.

Counsellors favoured antidepressants because of the physical boost they can provide, a boost that can better facilitate the counselling processes. The counsellors agreed that they found it difficult to engage students in the “counselling work” or to make “progress” because the students were so “unmotivated,” some students to the point that they could not attend counselling sessions on a consistent basis. For example, Jay described students she believed would benefit from an antidepressant:

The students that I have are really unmotivated, even though they want to be in counselling. If they're having trouble getting their homework done or they're just—even having trouble getting out of bed—typically those students are more...open to taking medication because they are not getting anything done. They're not going anywhere and they're not doing anything, so you can get them on the medication. And I can present that a little more strongly to them also. [I say to them,] “You're not going to be able to do this unless you can get your motivation up. Unless you can get out of bed and com[e] to counselling, right?...You can't wake up in the morning, you can't get yourself here, we're not going to make any progress.” And so, at that point, I think they are more open to taking the medication. And then we have success.

Betty spoke of a similar rationale for encouraging student clients to seek antidepressant medication:

Typically the ones that do both [an antidepressant and counselling] are the clients that are very unmotivated. And I'm thankful that I can get them to go on a medication and try out medication when that [the lack of motivation] is the strongest symptom...because the clients that go on medication at that point, I can actually do counselling with.

Joan noted that students who were unwilling to get out of bed to attend counselling required the addition of an antidepressant, so she could continue counselling them. Joan states:

Because they were then able to do the things that we wanted them do in homework, and do the work that needed to be done [after the addition of an antidepressant]. Rather than sort of ... go home, roll back into bed and wait for the next week, which is what was happening. And that can't happen. Because I can't continue to counsel somebody like that.

Jay, who previous to working at the college had opposed recommending antidepressants to clients, had seen the benefits of antidepressant use by her students. These experiences challenged her previous views on antidepressant use, making her willing to try anything "that's going to help them," as follows:

I hear from people [who have used an antidepressant] like, "Wow, I can't believe that I ever lived like that, that I couldn't get out of bed. Whereas now I can get out of bed and go to work—like, do my things that I would normally do." So, [chuckles] it's [antidepressants] not for everybody, but for those people that it works for, those people who maybe there's the piece of feeling like they can't out of bed, its debilitating. I like finding something that is going to work for them.

Spinning their wheels: "The body has its own agenda"

In addition to providing the benefits of energy and motivation, counsellor participants viewed antidepressants as necessary in the treatment of depression when the biological systems of a body had "their own agenda," that is, when physiological factors

played a dominant role in the depression. In these cases, some counsellors felt they “were spinning their wheels” and that it “didn’t matter what we do in counselling...if the medication is what’s needed.” As Jay described:

If it’s going to help, let’s get everybody on board. If it’s medication, great! And if it’s seeing you every week [counselling], great! Let’s just do all of these things. But then there’s the students who are like, “I am not going to do medication because I have seen what it does and I don’t want that...” [but] why swim upstream? When your chemicals in your body have [their] own agenda. Because we can only do so much with counselling, and if you keep bumping up into what the body is doing, right?

Many of the counsellors used medical analogies to explain a body’s need for antidepressants and how this need is similar to other medical illnesses requiring pharmaceutical intervention. For example, Joan compared the need of an individual with depression to the need of someone with diabetes for insulin. As Joan explained:

I always use the diabetic analogy. You know, a diabetic without insulin is in big trouble, and yet they need to have, their diet, they need to have control over their own responsibility and what they are taking in and how they are caring for themselves, their sleep, their stress levels, and yet without insulin, they’re in big trouble. So this starts to make sense to them...they’re [clients] more acceptant of it [the need for an antidepressant] at that point.

Betty employed the same medical model to explain how “brain chemicals” work and how these chemicals have affected the student’s moods: “If you were a diabetic and you needed medication, [you would take insulin]. Why is this [depression] any different?”

Sarah felt the medical model provided two advantages: (a) it aptly explained how brain chemicals cause depression and (b) it provided both students and the general population with the “reassurance” that depression “is not [their] fault.” In her words:

I think that if you are diagnosed with an illness that has a medical etiology, and it’s being treated medically, then I think that... a lot of clients...[can then know they are] not responsible for it. And I think that that can be a very positive thing...quite an empowering thing. And sort of like, here I go to the doctor, and

I've got the flu, and I get some medications, and [the client then] think[s], "Okay, probably by tomorrow I'll feel a lot better." While antidepressants traditionally don't work by morning, but I think the notion that you're doing something about it is good.

Disadvantages of Antidepressant use: Lots of problems but quicker to the draw

Counsellors identified disadvantages of using antidepressants to treat depression in students. Counsellors noticed that these disadvantages affected both student wellness as well as the counselor's ability to effectively counsel. The analysis process elicited three disadvantages in using antidepressants to treat students with depression symptoms: (a) negative side effects, (b) the "magic bullet", and (c) session time can become focused on antidepressants. Each of these themes is briefly discussed.

Side effects: Both getting on and getting off antidepressants can be tricky.

All counsellors identified side effects as a negative outcome of antidepressants. Several counsellors' recounted similar lists of negative side effects their clients had experienced, including weight gain, "zombie-ism," "foggy head," and sex drive issues. While some counsellors noted how these side effects made it difficult to ascertain whether the client was improving or how the counsellor was helping the client, other counsellors were more troubled by the apparent lack of information provided to students by doctors or psychiatrists about how to properly wean themselves from the medication. Betty explained:

Just going off cold turkey has got to affect you adversely...I have had students say, "Yeah, I just decided to stop taking it [antidepressant] and then, I couldn't make it for an exam because I felt so terrible. Then I did some things I normally wouldn't do because I wasn't coping well at the time." And so ...that is a disadvantage. When they don't have proper follow-up time with their doctors, and they're [the clients] not patient enough to let the medication work. And they're not responsible enough...to go in and to talk to the doctor when it is not working if when they are feeling funny and they're scared.

Joan recalled having clients who had begun antidepressant therapy, but in counselling sessions had revealed their ignorance of how to terminate the medication slowly to avoid side effects. In such cases, Joan had to quickly shift the focus of the session, so she could explain this important information to the client.

Joan also noted that some clients wanted to quit shortly after beginning a depression medication because of their aversion to the side effects:

And they want off as quickly [and] as fast as they're getting on it...so that's more difficult to explain about coming off it and get the supervision of the doctor, etc. So, both going on and getting off is tricky. Because they do want off of it, and they don't want the side effects. They don't like the side effects, and they're very negative about them— weight gain, zombie-ism, sleeping all of the time, foggy head, dry throat, all that stuff, sex drive—...that is all completely foreign to these individuals, and they do not like it. So then it makes counselling more challenging.

Cindy was similarly bothered by students “not being informed about the effects of stopping cold turkey”; however, she also felt students were being “over-medicated,” and she often struggled with understanding “why they [were] on so many medications”. As she explained:

Over-prescription. Being over prescribed. Giving medications when they [students] don't understand why or when...not being informed about the consequences of stopping cold turkey or not being told about the side effects and things like that. Just expecting the medication to work without doing the counselling work.

Counsellors must often participate in the adjustment and maintenance process when students add an antidepressant to their treatment plan.

The magic bullet: Just sit back and feel better.

Another disadvantage of antidepressants was wrong perceptions students had towards the role of a medication in their process of regaining health. All counsellors

identified this attitude as a problem; that is, the counselling process was encumbered when student clients viewed antidepressants as a “magic solution,” a “magic pill,” or a “magic bullet.” The counsellors felt that students with this view of depression medications often had the attitude “I don’t need to do anything except sit back and feel better.” As Joan explained:

The folks that come to me already on medication...I am not sure that they really think that counselling is going to be the answer. I think that they look at their medication as the magic bullet. And if they just stay on their medication then this will all go away.

Sarah believed that students who viewed their antidepressant as a magic bullet became passive in the counselling process and reticent to pursue their journey to wellness, as follows:

I think that one of the disadvantages is the notion that the pill will work, and you’ll just sit back and you’ll get better. And you don’t have to do anything to facilitate that process, because—after all—it’s all biochemical, and the pill will balance this all out, and so you’re not an active part in that process. I think that is a negative thing.

All counsellors concurred those individuals who viewed antidepressant medication as an instant remedy became less engaged in the counselling process and did not “do the counselling work.” The counsellors felt these individuals became overly reliant on the medication and therefore less willing to do the rigorous personal work required to resolve the issues that first prompted counselling. As Jane described:

What I’ve found is that because they’re taking a pill, then the pill is going to solve things for them. They’re not as connected or invested in the counselling process. So they might be less likely to do their homework. Or they might actually just discontinue counselling all together because the pills have fixed whatever they thought the issue was.

Jay had also experienced students who “cut ties [stopped going to counselling] when things are going well”; in other words, these students disengaged in the counselling process after they began to take an antidepressant. Jay identified the cause of this behaviour as the belief that the medications were going to do all the work:

I know a lot of times people feel like [because] I am taking the medication I don't need to do homework. I don't need to do counselling homework. Because the medication is going to do what it's doing, and I don't have to do anything. Because this is going to change all of the chemicals, and I am going to be great, and then [they] come back the next week and say, “I still don't feel 100%, and how come I don't feel 100%?”

The counsellors noted that students who firmly believed their antidepressant was going to be an instant remedy often expressed “frustration” and “disillusion[ment]” when it did not perform for them as had been advertised. Cindy described her experience:

I've also had it where they thought it was a magic pill, and they just tried doing that, and it hasn't worked, and then they've come to counselling kind of frustrated... feeling a bit more hopeless because they tried the magic pill, and the magic pill didn't work, so they must be really screwed up, which is not a good place for them to start from.

All counsellors noted that students who had tried both antidepressants and counselling but had achieved little or no success felt increasingly helpless and hopeless; this only intensified their search for answers. As Jay described:

Students who are taking medications and they are not working are feeling ..., “I am taking this medications and it's not helping, and I don't feel good.” And so for the student trying to figure out, “So how do I feel better? What is it that I need to do, because I want to feel better now? ...And counselling is not helping; you're [the counsellor] not helping, my instructors are not helping, nobody's helping and, the medication isn't helping.”

Session time can be focused on antidepressant issues.

Some counsellors explained that if students on antidepressants were experiencing difficult side effects or if they were considering stopping their medications cold turkey,

the focus of a counselling session time could shift suddenly from the issues at hand to problems with the medication. Most of the counsellors responded by encouraging the students to see their doctor and gain information on how to safely wean themselves off the medication. In this situation, the counsellor's role then shifted to helping the student manage the antidepressant: deciding to get additional help from their doctor, creating a list of questions to ask their doctor, and other antidepressant issues. When this situation happened to Jane, she felt constrained to immediately shift the focus of the session and to help the student deal with the antidepressant issue:

Well you have to, or at least I feel I have to talk to them about the medication. So you can spend the entire session just talking about whatever it is that needs to get worked through, or how they are doing. Part of the check-in at the beginning has to be about the medication. It has to be. Because it is either going to come up or it's going to interfere, and you need to know what's going on around that...I take that role too of reminding them if things are not going well, ...[they] need to check in with [their] doctor about it. So, I mean it does shift it a little bit...focusing on the negative side effects.

Although the research indicates counselling and antidepressants can work effectively in tandem, counsellors must often participate in helping students manage negative outcomes from antidepressants. Negative outcomes from the counsellor's perspective include bothersome side effects, incorrect attitudes, and distraction from the core counselling process.

Counsellor Perceptions of Factors Contributing to Student Depression

Although all the counsellors were currently positioned at a post-secondary institution, all had different backgrounds and fields of expertise. This created a breadth of responses to the question about the cause of the depression. Four themes emerged: (a)

life transitions with developmental stress and (b) isolation with relationship trauma, (c) academic pressure, and (d) perfectionistic tendencies.

Life transitions, developmental stress: From being cared for to caring for self.

Many of the counsellors identified the transition from dependent adult, monitored to some degree by parents, to independent adult, in charge of personal decisions and responsible to cope by themselves, as a contributing factor to student depression. Cindy noted that parents may act as buffers which prevent students from learning the skills to cope with their struggles:

There's sort of the disillusioned kind of group. So, they've maybe been taught that they should just get good things and not necessarily have to struggle sometimes or maybe haven't been taught that part of life is to struggle sometimes, and [pretending to be a parent who is speaking], "You know you can learn from that." [Shifting back to her counsellor's perspective], So I think what happens is sometimes they come to school and they don't have people to act like a buffer, like parents or who[m]ever, and they have to deal with stuff themselves, and they find maybe they aren't equipped. ..And then they are shocked, and they are not coping well. Because they haven't learned the skills, and then they are not doing well in school, and they just kind of expected to do well.

Betty echoed Cindy's thoughts and further noted that she felt that the current generation has difficulty making the transition from "being cared for to having to care for myself," which makes the transition to university life particularly difficult. As she described:

I think transitions and making the change from being cared for to now having to care for myself. I think particularly for the generation that's coming in its really big. Because they have...parents who just tried to do everything for them and have really meant well, but when they [the students get here], then they don't know how to take care of themselves, and they don't know how to cope and be able to take risks and manage the change that is going on.

Joan noted that university living is a “whole new world” for students, a world where they are “pulling away from their family, getting used to a new place, a new culture, and new expectations. This isn’t high school. They have to think for themselves.” Because students often move away from their family and friends to attend post-secondary education, they experience a second and concurrent factor contributing to depression: isolation.

Isolated and alone: Experiencing Relationship Trauma.

Joan identified transition and isolation as the two most prominent factors contributing to student depression. Sarah also viewed the loss of relationships as a major contributor to cases of student depression that she sees in her office:

I think for a lot of the students that I see, loss is a big one [a contributing factor to depression]. You know, whether that’s loss of a significant person in the family or a break-up of a relationship, or a whole bunch of change where you feel a bit disconnected from who you are. I think that students don’t recognize that all these changes are going to contribute to how they are feeling. They might think..., “Can you suggest a pill that I can take that will make me feel better.”

Sarah observed that some students do not “recognize that all these changes are going to contribute to how they are feeling.” Difficulties in navigating relationship changes at college or university are exacerbated when trauma occurs within relationships.

Counsellors identified common types of trauma that affects students, including “relationship break-up,” “isolation”, and “relationship violence.” Cindy noted that students may not associate current or previous relationship distress such as having been in a “horrible relationship” or been “victimized” with the depression they are experiencing. Cindy remarked that counselling can help such students identify relationship trauma as a contributing factor to their depression.

The lack of relationships or loneliness contributes significantly to depression in post-secondary students. Cindy acknowledged that many students whom she counsels are “really lonely,” a factor that makes other relationship issues such as “relationship break-up,” “sexual assaults,” and “witnessing or experiencing domestic violence” more traumatic. Cindy surmises that trauma in university life also provokes students to “start to process” traumatic events they experienced before they entered university. That is, the momentous changes students face prompt students to examine their lives, their values, and their past experiences. In her words:

Well, for me, just because of my own clinical interests, it’s a lot of sexual abuse, sexual assaults, and childhood abuse type issues. So, it may be that now they are safe enough, being in the situations that they were they are safe enough now that they can start processing it. Or they get exposed to things in their classes, which makes them go, ohhh, okay, maybe that wasn’t quite right. And then they have to reintegrate that into who they are.

Stressors such as developmental issues, isolation, and trauma compound to prompt some students to ask the big questions of life such as “Who am I?”, “What is the purpose of my life?”, and “Where am I heading in life?” This process can contribute to depression, especially when a number of issues occur concurrently in a student’s life.

Relationship trauma can compound with other factors to compound depression in students. Betty noted that in addition to the “pressures to do well in school,” the relationships that students are forming and “managing” often contribute to depression in students. Betty described “disillusioned” students who had “hoped that university would be different.” Some students Betty counselled viewed the university environment as a place where they were “not able form close friend groups” or even “form relationships.” Because of the many types of relationship stressors that can occur in post-secondary

student life, counsellors identified relationship trauma as a major contributing factor to student depression.

Academic Pressure, Great Expectations: “I should be able to do this.”

All counsellors identified academic expectations as a contributing factor to student depression. They noted that this stress is not only felt by the “high functioning kids” but especially by individuals who had experienced “longstanding” depression. Betty stated that students experience depression because coping with all the demands of university “is just even a greater challenge than what they’ve experienced before.”

Jay described a “weird pressure,” a false expectation idea that students had: “You can be anything, and you can do anything.” She noted that this pressure negatively affected students because often, students were still getting accustomed to post-secondary life and did not “know what they should be doing” or had “zero direction.” Counsellors noted that this pressure was further accentuated by friends who appeared to know what they wanted and what classes they should be taking and other family members who had been previously successful in post-secondary study. Jay described the pressure students experience from a student’s perspective:

And so I’m taking welding because everyone in my family are welders, but I don’t like welding, and I’m trying to make it fit, and it doesn’t fit, and it doesn’t feel good...And all of my friends are now in 3rd year, and I’m stuck taking 2 classes and taking all of these accommodations, and now I don’t fit in with anybody, and [other people are saying] I can’t do this, who do I think I am, I am not a student. When...my mom’s a lawyer and my dad’s a physician, and here I am struggling through two classes a semester.

Likewise, Joan described students who had experienced depression, partially due to “great expectations upon themselves, either by themselves or [by] their family, and they should know exactly what it is they’re going to do.” Students can view post-

secondary school as their first chance to prove themselves, both to themselves and those they know. However, living under such pressure can contribute to depression in students.

Joan noted that in addition to the pressure these students experience from academics, relationship trauma, and unrealistic expectations, many students whom she counsels have perfectionism and self-esteem” issues, as follows:

Almost always perfectionism. They just have very low self-esteem, and they are never good enough. I see that an awful lot. There’s something inherently wrong in them, and they need to figure it out. They need to figure out why they are feeling this way. They are looking for answers within themselves because they’ve been able to solve almost everything else; they’re high functioning kids here. So, they’ve been able to get his far on their own strategies, right? [They say to themselves], “So, what other things can I be doing? What else can I be exploring? Why am I feeling this way, because I shouldn’t be?” [Joan observes] They *should* themselves all over the place.

Discussion

General Discussion

Counsellor observations in this study display some interesting similarities to those in Kwintner (2005), who also studied combining antidepressants with therapy to treat depression. For example, many participants in Kwintner’s study reported that an antidepressant “facilitated therapy” and an antidepressant enabled them “travel down the road until [they were] out of the ditch” (p.44). Although, Kwintner does not directly discuss the benefits of energy or motivation that antidepressants yield, Kwintner’s study does infer these benefits by stating that antidepressants help individuals with depression get out of bed each day to attend counselling. Participants in both studies identified that their antidepressants changed their “chemical deficiencies” to promote increases in energy and motivation. Thus, both studies affirm that it is a common belief, for students

and counsellors alike, that antidepressants can work to facilitate counselling by augmenting people's energy levels.

A second similarity exists between the two studies. Similar to this study, Kwintner's participants affirmed their counsellors as "very supportive" and willing to discuss the "technical aspects" of their antidepressant use, such as dose adjustments, effectiveness, and side effects. In this way, both studies also affirmed that counsellors must sometimes facilitate antidepressant therapy by using session time to address medication issues. However, in contrast to counsellors in Kwintner (2009), counsellors in this study viewed the need to refocus a counselling session to help students resolve medications issues as a disadvantage.

A final similarity of note was counsellors in both studies relied on what Kwintner termed the "diabetes analogy" to explain some individuals' need for an antidepressant. Participants in the Kwintner study would more readily accept a "biological diagnosis" for their depression and experience "reduced feelings of blame, shame, and responsibility" (p. 47). In this study, the "Spinning their wheels: The chemicals have their own agenda" theme closely mirrored Kwintner's findings as the counsellors were also quick to use the "diabetic analogy" to get students to accept a biological theory for their depression. The counsellors in this study further noted that the student acceptance of the belief that brain chemicals were causing their depression not only convinced students to use an antidepressant, but it also allowed students to feel the depression was "not [their] fault," which was "empowering."

When this study is compared to Malpass et al. (2009), a few interesting similarities emerge. First, Malpass et al. (2009) describe a medication career. Malpass et

al. (2009) imply that individuals in the studies investigated were involved in a process in which they experience an evaluation process, a return to function, a side effects, a latency period, and finally, the concordance of relationship. All counsellors in this study noted experiences where they helped students evaluate the risks and benefits of beginning an antidepressant. Further, they counselled students on the importance of not stopping medication abruptly to prevent side effects, they perceived return to function, they monitored for the effectiveness of the antidepressant, and they encouraged students to build a relationship with their practitioner when questions arise. Thus, counsellors who work with individuals that are using an antidepressant are indirectly involved in the “medication career” of their clients.

Further, it could be argued that counsellors who are counselling students on an antidepressant could be involved in all aspects of their moral career, as delineated by Malpass et al. (2009). Malpass et al. (2009) describe a moral career as the process in which an individual decides to seek help, accept treatment, continue treatment, and finally arrive at a decisive moral juncture. The counsellors in my study reported the same range of experiences: they facilitated student decisions to seek additional help from another health professional, they helped students accept the medical model of depression with the belief that they may suffer from a chemical imbalance, they discussed student feelings regarding continuing and stopping treatment, and they helped students alleviate fears that antidepressant use was a sign of weakness.

In kind, it would appear that post-secondary counsellors may play an important role in assisting the students they see in both their moral and medication careers. This is of importance as the amount of time that general practitioners and psychiatrists appear to

have for understanding and exploring patient preferences or concerns appears to be limited. Counsellors who gain an understanding of the two distinctive careers that antidepressant use may trigger in students would be more apt to recognize the impacts that the antidepressants are having on the students and their ability to engage in the counselling process. As Kwintner (2005) has suggested, “Psychotherapy is a place where patients who have recently begun taking antidepressant medication can integrate this new experience and explore its meaning” (p. 49). This need to understand counsellor perspectives of antidepressants and their effect on students as well as the influence antidepressants have on the counsellor’s ability to counsel students with depression underpinned this study.

Implications and Future Research

Numerous potential implications for practice arise from this study. First, it is important to note that the counsellors distinguished three groups of students who come to counselling with depression. These groups are important because they represent individuals who are entering counselling with differing beliefs regarding their depression etiology and the therapies they are willing to explore; some of these ideals may require discussion during therapy. Counsellors would be wise to gain an understanding of which group a student falls into as the knowledge may help the counsellor to understand whether or not the counselling session may be impacted by the student’s potential navigation of the individual’s medication or moral career as proposed by Malpass et al. (2009). Furthermore, this early identification may allow counsellors to more quickly recognize strategies that maybe more appropriate and ultimately more effective in

addressing a student's current or previous experiences with an antidepressant as well as the role that the antidepressant may play in that client's therapy.

In addition, a stronger understanding of both the perceived advantages and disadvantages that antidepressants have for students in counselling may better assist counsellors in aptly encompassing other health professionals when clients require either "more than [the counsellor] can offer," when students have unknown biological causes, when students are experiencing difficult side effects, or when students are considering quitting their medication. An enhanced understanding by counsellors of the advantages and disadvantages that each antidepressant may have for individual students and their time in counselling would allow counsellors to be ready for the potential impacts the antidepressant may illicit once prescribed. Furthermore, counsellors would be wise to identify their own perceptions and beliefs on antidepressant use by students in therapy, as counsellors may play an important role in assisting students with depression to navigate their post-secondary career.

Chapter 5: Discussion

Summary of Findings

The aim of this research was to increase understanding of the student experience of using antidepressants with counselling to manage depression. In an effort to gain a richer understanding of student depression in universities and colleges, the researcher explored the experiences of students with depression as well as the experiences of counsellors who work with students to manage depression. Using thematic analysis, guided by van Manens' hermeneutic phenomenology (1990), themes were identified from student interviews (Chapter 3) and counsellor interviews (Chapter 4).

Chapter 3

Themes identified from the student interviews are identified in Table 1 and discussed below.

Table 1. Student Themes Identified in Chapter 3

Major Themes	Themes
1. Split between antidepressants and counselling	Antidepressant-body component of the split
	Counselling-mind component of the split
2. Challenges along the way	Tweaking and Tinkering
	Rather tell people about the antidepressant than counselling
	The other side of side effects

Analysis of the student interviews (Chapter 3) elicited two major themes: 1) a *split between antidepressant and counselling* and, 2) *challenges along the way*. The first major theme, *a split between antidepressants and counselling*, highlighted how students

view the effects of counselling and antidepressants in a compartmentalized way; it also described how students distinguished the effects of each treatment on their body and mind. Therefore, to best describe this Cartesian split between body and mind, two subthemes were developed. The first subtheme, *the antidepressant-body component of the split*, expressed the understanding that, as one student eloquently stated, “For a physical problem, you use a physical solution”. Within this subtheme, students linked their genetic or biochemical selves with their need for an antidepressant. Also, students identified their need for an antidepressant with their need to manage physical difficulties, such as sleep difficulties and low energy. The second subtheme, entitled *the counselling-mind component of the split*, was developed to explain how students experienced counselling as helpful in the situations they were currently or had previously faced. For many students, these contextual or situational factors related directly to the school experience and included factors such as leaving home, facing coursework stresses, encountering social pressures, and battling perfectionist tendencies, to name a few. Although the majority of students admitted that school life accentuated the challenges of managing depression, many also acknowledged that depression symptoms had existed prior to entering academia.

The second major theme, *challenges along the way*, yielded three subthemes: *tweaking and tinkering*, *rather tell people about the antidepressant than counselling*, and *the other side of side effects*. The challenges represented by each subtheme are discussed separately. The first subtheme, *tweaking and tinkering*, described the numerous adjustments students or their health professional had to make to bring students some relief from depression. Often this experience was described as a frustratingly lengthy

process characterized by trial and error. The second subtheme, *struggling with stigma*, explored the stigmas students associated with an antidepressant or counselling. Interestingly, while students identified the stigmas of antidepressants as “weak[ness],” “craz[iness],” or “psycho[sis],” students described counselling as an indicator of an intrinsic flaw, that something was innately wrong with them and that people with depression “can’t be trusted”. The students acknowledged they would rather tell people they were on an antidepressant than attending counselling, explaining they felt less stigmatized because antidepressants were more pervasive, more visible, and therefore, more accepted within society. The final subtheme, *the other side of side effects*, proposed that along with the numerous physical side effects that came with an antidepressant, such as an “overmedicated stuffed up feeling” and “brain shock,” counselling also had its share of side effects. Although these side effects were not physical in nature, they evidenced as increased concern or worry as well as difficulty when students attempted to evaluate the merit of counselling. These concerns included increased worry about whether counselling would be truly confidential and whether it would be done professionally. Further, some students discontinued therapy because of (a) their inability to ascertain benefits from counselling or because of (b) their perception that the commitment required by counselling was not worth the effort to fit counselling into a busy schedule.

Chapter 4

Themes presented in Chapter 4 are identified in Table 2 and subsequently discussed below.

Table 2. Counsellor Themes Identified in Chapter 4

Major Themes	Themes
1. Advantages of student antidepressant use	No motivation: they can't get out of bed Spinning their wheels: the body has its own agenda
2. Disadvantages of student antidepressant use	Side effects: both getting on and getting off can be tricky The magic bullet: just sit back and feel better Session time can be focused on antidepressants

Analysis of data from the second research question focussing on the counsellor experience revealed that, although not a theme, counsellors often found it useful to base their approach on the type of student they were counselling, that is, according to one of the following three types: (a) students who had previous antidepressant experience, (b) students with emotional resistance to taking a depression medication, or (c) students who could benefit from an antidepressant but needed to be persuaded to use one. Counsellors often compared and contrasted amongst these groups to help them more clearly identify the effects that antidepressant use had on counselling.

Thematic analysis of counsellor experiences revealed three major themes:
advantages of antidepressant use by students: providing energy to a body that has its own agenda; disadvantages of antidepressant use by students: lots of problems but quicker to

the draw; and *multiple factors contributing to student depression*. The first major theme highlighted the counsellor-perceived advantage that students gain from combining counselling with an antidepressant. Two subthemes emerged regarding the advantages antidepressants offered to students. The first subtheme was *provides motivation: they can't even get out of bed*. Counsellors explained how an antidepressant provided “energy” and “motivation” to students who were having “difficulty getting out of bed” or for those “not able to complete the homework.” The second subtheme, *spinning their wheels: the chemicals have their own agenda*, emphasized the counsellor belief in the bio-medical model of depression, and that sometimes “it doesn’t matter what we do in counselling...if the medication is what is needed.” Counsellors often needed to explain the workings of brain chemicals to students and to describe how disruptions or changes could lead to depression. Subsequently, most counsellors in this study used medical analogies to explain how depression was similar to other medical illnesses requiring pharmaceutical intervention, such as diabetes, which requires insulin.

The second major theme, *disadvantages of antidepressant use: lots of problems but quicker to the draw*, revealed three negative effects of antidepressants on students trying to regain wellbeing and on the counsellors trying to effectively counsel them: (a) *side effects: getting on and getting off is tricky*; (b) *the magic bullet: just sit back and feel better*; and (c) *session time can shift to antidepressant issues*. The first subtheme highlighted undesirable side effects reported by students such as “weight gain,” “zombie-ism,” “foggy head,” and sex drive issues. Within this theme, counsellors noted how side effects impeded students from determining whether or not they were improving; also, the side effects often motivated students to quit their medication “cold turkey,” instigating

even greater challenges, including increased side effects and decreased ability to cope. The second subtheme highlighted how students often became “passive” in counselling and did “not do the counselling work” because they saw the antidepressant as a “magic bullet,” an instant and easy remedy. This subtheme emphasized the student belief that the antidepressant alone would heal their depression, an attitude that counsellors observed would prompt students to quit counselling altogether or to become increasingly frustrated or disappointed when the medication did not help them improve as advertised. The final subtheme affirmed that when counsellors had to convey information about the side effects, dosages and other antidepressant-related facts, the focus of counselling sessions “shifted” from the counselling process to antidepressant management. Counsellors viewed this as a disadvantage because counselling time was often limited; however, counsellors also noted that discussing antidepressant use was necessary to ensuring the health and safety of students.

The final major theme, *multiple factors contributing to student depression*, elicited three subthemes: *a developmental transition: from being cared for to caring for self*; *isolated and alone: experiencing relationship trauma*; and *great expectations: “I should be able to do this.”* The first theme described the counsellor experiences of working with students who were having difficulty navigating the “whole new world” associated with post-secondary studies and students who were being required to “think for themselves” for the first time without the assistance of family or close friends. Counsellors noted that many new challenges confronted students entering post-secondary studies. Some challenges included being independent, handling personal decisions alone, encountering new social situations, and managing finances. In the post-secondary

context, parents no longer acted as buffers between the students and these life stressors. The second theme identifies isolation and relationship issues as major contributors to student depression. Specifically, counsellors named “relationship break-up,” “isolation,” and “relationship violence” as factors in the increased incidence of student depression on campus. The final theme explored counsellor experiences of treating “high functioning” students who had “perfectionist tendencies,” those who become depressed because they perceived they “should” be able to manage academic stresses but could not. Additionally, this theme revealed the “weird pressure” students often described when exploring feelings of having “zero direction” and difficulty when identifying a career choice that would make both them and their families happy.

Implications: Comparing Student Experiences with Counsellor Experiences

Evaluating the ability of these studies to help postsecondary students manage depression and eliciting truth from these studies to guide the counsellors who meet with students includes comparing the themes from the student and counsellor interviews and understanding the similarities and differences of the two perceptions. The first similarity is both students and counsellors share the belief that students who are attempting to decrease the physical challenges of depression, in particular, lower energy levels, need an antidepressant. Student participants appeared to clearly understand that if their body or biochemical imbalances were causing depression, medication would help to manage depression. The counsellors also appeared to hold the same belief, as they observed, clients “can’t swim upstream” against the body. In such situations, counsellors would use a medical model to encourage students to seek an antidepressant to heighten their motivation and energy.

Second, students and counsellors viewed the role of time in similar ways. The students indicated that adding counselling onto an already heavy academic load was more than they could handle. Time pressures students faced when trying to incorporating counselling into their treatment included (a) finding the “right fit” between a counsellor and their needs or expectations, (b) clearing enough time to attend each counselling session, and (c) perceiving counselling as a “waste of time.” The only difficulty students noted for antidepressants in regards to time was the tedious process of starting, adjusting to possible side effects, discontinuing, and restarting a medication, a “trial and error” process. Conversely, counsellors saw antidepressants as improving students’ use of time by improving their motivation and energy to complete counselling homework and to use counselling time most effectively. However, when students did begin using an antidepressant, counsellors also noted that session times were diverted by the need to discuss medication side effects and processes. Additionally, counsellors noted that once started on an antidepressant, students often viewed it as their “magic bullet,” which decreased student commitment to the overall counselling process.

Students and counsellors held divergent perspectives on the stigmas associated with antidepressants. Many of the counsellors noted that most students did not want an antidepressant and had to be “convinced” to use one. However, the students appeared to associate greater stigmas with counselling than with antidepressants. Further, students noted that although they would not want others to know they were on an antidepressant, if people were to know anything, students would prefer others know about their antidepressant but not about their counselling. As one participant noted, “If you take nine different pills in the morning to get through the day, you’re normal. But if you get a little

counselling...you're out to lunch.” This difference is especially interesting as it evokes the question of whether the students whom counsellors see accurately represent the overall student population who are experiencing depression.

The above similarities and differences reveal a number of potential implications for counselling practices in post-secondary institutions. First, to increase the numbers of students participating in counselling, counsellors would be wise to educate the general student population on the benefits that counselling can have on a person's motivation and energy. Time pressures have serious consequences on students, who may begin to struggle with decreased energy and motivation. If education campaigns emphasized the ability of counselling to increase personal motivation and energy, more students may be willing to receive counselling. Second, time pressures prevent some students who are struggling with depression from initiating the counselling process. However, a streamlined, Internet-accessed assessment tool, similar to the one used by Hass et al., (2008), may be helpful in decreasing the need for initial face-to-face contact for non-crisis situations, attracting a higher student involvement in the process, and improving the ability of students find the “right fit” with a counsellor possessing the type of expertise they want. Finally, it appears that the students whom counsellors currently see in their offices may not fully represent all the students with depression. Campus counsellors may need to use quantitative assessment tools to more accurately identify the number of depressed students and the percentages of them who have used an antidepressant. Following this, a qualitative study would allow counsellors to better understand the experiences of students who are depressed, to understand why some choose

antidepressants, why some avoid counselling, and ultimately, how to develop effective intervention. With this in mind, a mixed method study may be useful.

Limitations

While phenomenological research does not endeavour to be generalizable, it does intend to present the lived experiences of the participants (Osborne, 1990). However, some limitations to phenomenological study must be identified. While addressing student experiences (Chapter 3), three potential limitations are evident. The first is the small sample size; a larger sample size would have enriched the findings and may have produced slightly different results. The second limitation is that the students were able to self-identify as depressed. Students with a diagnosis of depression, who had taken both an antidepressant and counselling, may have experienced more success in managing major depression than students who took antidepressants alone (CPA, 2001). The final potential limitation is the student understanding of their antidepressant could be increased or decreased by the student's area of study. For example, students in a neuroscience program could have a different perspective about the effectiveness of an antidepressant than non-science students. The background information of participants could, thus, have altered their acceptance or perspectives of antidepressants or counselling.

In the counsellor-focused study, three potential limitations also arise. The first limitation is that if counselling has more stigmas than antidepressants, then post-secondary counsellor accounts may not truly represent the experiences of students who are currently using an antidepressant. Second, the fact that counsellors did not have identical credentials could be seen as a limitation. The various types of expertise (social work, addictions) could induce counsellors to specialize in counselling students with

specified situational or contextual factors (i.e. eating disorders versus relationship violence); thus, varying types of expertise could alter counsellor perceptions. Finally, as with the student-focused study, a larger sample size would produce a richer data source.

The researcher's bias should also be noted when determining limitations of this study. The researcher is a nursing clinical instructor who worked on acute and rehab psychiatric units and provided education to individuals on the benefits of both antidepressants and counselling. Additionally, the researcher is currently a student, and my experiences of witnessing depression in my classmates and listening to their accounts of using antidepressants may have skewed my perceptions of the interviews.



APPENDIX A

ARE YOU CURRENTLY USING ANTIDEPRESSANTS **AND** COUNSELLING TO MANAGE YOUR DEPRESSION?

Volunteers are needed for a Master's thesis study of post-secondary education students lived experiences of using both antidepressants and counselling to treat depression.

You will be required to participate in a one-hour long interview at a time and location of your convenience. A token payment will be given as compensation for your time and trouble.

If you would like to tell your story regarding the management of your depression, please contact Bill McKay for more information. Ph: 403-382-7165 or email: billy.mckay@uleth.ca

APPENDIX B

Interview Guide (Student)

The questions in this guide are intended to be used as prompts to keep the interview flowing and progressing.

1. Please tell me about the process of how you decided to take antidepressants for your depression.
2. Please tell me about the process of how you decided to seek counselling for your depression.
3. What made you decide to try both antidepressants and counselling, as opposed to just one of them (i.e., just antidepressants, or just counselling)?
4. How do you think the antidepressants have helped your depression?
5. How do you think the counselling has helped your depression? What's different about the way counselling has helped than the way the antidepressants have helped?
6. What was your experience of being on antidepressants for depression like? What did/do you like and/or not like about being on antidepressants?
7. What was your experience of being in counselling for depression like? What did/do you like and/or not like about going to counselling?
8. What do you think caused your depression, and how did your beliefs influence your decision about how to manage your depression?
9. How do you think depression has affected your academic career?
10. How do you think being a student has affected your depression?
11. What advice would you give to other students who might have depression?
12. What advice would you give universities to help them understand depression and implement effective interventions aimed at student depression?
13. If you were to experience depression again in the future, what would you do differently, based on the experiences you've had with antidepressants and counselling?

APPENDIX C

Invitation to Participate/ Letter of Consent

What are post-secondary education students lived experiences of using antidepressants and counselling for the treatment of depression?

Dear Participant:

The study that you have been asked to participate in is being conducted by Bill McKay, a graduate student at University of Lethbridge working under the supervision of Dr. Brad Hagen who is a Faculty member in the School of Health Sciences at the University of Lethbridge. The purpose of this study is to provide a deeper understanding of the phenomenon of post-secondary education students' use of antidepressants *and* counselling combined to manage their depression.

A one-hour long interview will be conducted at a place and time of your convenience. You will be interviewed about your experiences of managing your depression with both antidepressants and counselling. During this time, the interviews will be digitally recorded and later typed-up.

There are few, if any anticipated risks associated with your participation in this study. However, talking about depression and your involvement in counselling and medication treatment could generate strong emotions. If you feel that you would like support to deal with these emotions, the researcher would be happy to provide you with names and contact information for counselling and/or mental health services.

Although you may not directly benefit from participation in this study, the information you provide may help current and future students seek out, and receive the necessary and appropriate treatment they need for their depression. Further, the interview will be conducted by a skilled and compassionate mental health professional, and many people can find it a positive and healing experience to talk about their experiences with a skilled and experienced listener.

Your identity will remain anonymous and all information you provide will remain confidential. You will be asked at the beginning of the interview to choose a pseudonym that you would like to represent you in the research, and all identifying information will be removed from the typed-up transcripts. Your name will not appear in any use of the research in publications or presentations of the findings. If for any reason that you do not want to answer a particular question or you want to terminate the interview, you are free to do so without consequences. The digital recordings will be coded and kept separate from the participant list, both of which will be kept in a locked cabinet available only to

the researcher and his academic supervisor as to ensure confidentiality. The information provided will be destroyed appropriately five years after the completion of the study.

Participation in this research study is completely voluntary. Should you choose to participate, you will receive a \$20 dollar Tim Horton's gift card as compensation for your time and trouble.

The results of this study will be written as a Master's thesis and presented to the researcher's committee, again with all identifying information removed to ensure confidentiality. In addition, results may further be published in academic journals and post-secondary education newspapers to help professionals and students alike better understand the use of antidepressants and counselling within post-secondary education institutions. Should you wish to have a summary of the results mailed to you, you may contact the researcher by the telephone number or email address listed below.

If you have any questions regarding this study please feel free to contact the principal researcher by Phone: 403-381-2710; email billy.mckay@uleth.ca; or direct your questions to academic supervisor Dr. Brad Hagen by Phone: 403-329-299 or email brad.hagen@uleth.ca. **Questions regarding your rights as a participant in this research may be addressed to the Office of Research Services, University of Lethbridge (phone: 403-329-2747).**

Your signature below indicates that you have read the above information, have had the opportunity to ask questions, and consent to participate in this study. Further, your signature indicates that you understand that you can withdraw your participation from this study without consequence at anytime.

Printed Name and Signature

Date

Witness

Date

Please sign both copies. One copy will be for your records and the other copy will be for the researcher's records.

APPENDIX D

Student Demographics Sheet

	Pseudonym	Gender	Age	Year	Program
1	Bella	F	21	3	Nursing
2	Taryn	F	21	2	Kinesiology
3	Sophie	F	24	5	Human Resources
4	Darryl	M	20	2	Psychology
5	Ali	F	19	2	Psychology/ Kinesiology
6	Henry	M	26	5	Neuroscience
7	Marly	M	24	6	Kinesiology
8	Cleo	F	38	4 previous 3 months current	Open studies/fine arts
9	John	M	22	3	Psychology/ Economics
10	Erin	F	18	1	Biology in Education
	How long on anti- depressants	Counselling Sessions	How long counsel	Who recommended anti- depressants	Recommended counselling
1	3 years	4	4 months	Mom/GP	Mom/GP
2	6 weeks	15	4 years	GP/mom	Previous experience
3	6-7 years	Unsure	5 years	GP	Self
4	5 months	Unsure	½ years	Psychiatrist	parents
5	3 years	A lot-since 15	4 years	Psychologist	Youth leader/minister/ parents
6	3 years	7	6 months	GP/counsellor	GP
7	1 ½ years total	>10	1 ½ years	Mom	Mom
8	2yrs/ 1 ½ months current	4 @ university/2 4 others	6 years	GP	Psychologist
9	4 years	2-3	1 ½ -2 years	GP	Mom
10	6 years	36 approx.	1 ½ years	Family GP/mom	Mom

APPENDIX E



4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4

Phone 403.329.2699
Fax 403.329.2668

<http://www.uleth.ca/hlsc>

Invitation to Participate/ Letter of Consent

What are college and university counsellors' lived experiences of treating students who use antidepressants and counselling for the treatment of depression?

Dear Participant:

The study that you have been asked to participate in is being conducted by Bill McKay, a graduate student at University of Lethbridge working under the supervision of Dr. Brad Hagen who is a Faculty member in the School of Health Sciences at the University of Lethbridge. The purpose of this study is to provide a deeper understanding of the phenomenon of college and university students' use of antidepressants *and* counselling combined to manage their depression.

A one-hour long interview will be conducted at a place and time of your convenience. You will be interviewed about your experiences of providing counselling to students who are managing their depression with both counselling and antidepressants. During this time, the interviews will be digitally recorded and later typed-up.

There are no anticipated risks associated with your participation in this study.

Although you will not directly benefit from participation in this study, your colleagues, mental health professionals, and post-secondary students may benefit from you sharing your current understanding of students who use combination antidepressants and counselling to treat their depression. Sharing your knowledge may assist future students receive the necessary and appropriate treatment they need for their depression, as well as, benefit your future counselling practice or the practice of other counsellors who may read the results.

Your identity will remain anonymous and all information you provide will remain confidential. You will be asked at the beginning of the interview to choose a pseudonym that you would like to represent you in the research, and all identifying information will be removed from the typed-up transcripts. Your name will not appear in any use of the research in publications or presentations of the findings. If for any reason that you do not

want to answer a particular question or you want to terminate the interview, you are free to do so without consequences. The digital recordings will be coded and kept separate from the participant list, both of which will be kept in a locked cabinet available only to the researcher and his academic supervisor as to ensure confidentiality. The information provided will be destroyed appropriately five years after the completion of the study.

Participation in this research study is completely voluntary. Should you choose to participate, you will receive a \$5 dollar Tim Horton's gift card as compensation for your time and trouble.

The results of this study will be written as a Master's thesis and presented to the researcher's committee, again with all identifying information removed to ensure confidentiality. In addition, results may further be published in academic journals and post-secondary education newspapers to help professionals and students alike better understand the use of antidepressants and counselling within post-secondary education institutions. Should you wish to have a summary of the results mailed to you, you may contact the researcher by the telephone number or email address listed below.

If you have any questions regarding this study please feel free to contact the principal researcher by Phone: 403-381-2710; email billy.mckay@uleth.ca; or direct your questions to academic supervisor Dr. Brad Hagen by Phone: 403-329-299 or email brad.hagen@uleth.ca. **Questions regarding your rights as a participant in this research may be addressed to the Office of Research Services, University of Lethbridge (phone: 403-329-2747).**

Your signature below indicates that you have read the above information, have had the opportunity to ask questions, and consent to participate in this study. Further, your signature indicates that you understand that you can withdraw your participation from this study without consequence at anytime.

Printed Name and Signature

Date

Witness

Date

Please sign both copies. One copy will be for your records and the other copy will be for the researcher's records.

APPENDIX F

Counsellor Interview Guide

The questions in this guide are intended to be used as prompts to keep the interview flowing and progressing.

1. Could you please describe for me your experience of working with individuals who are using both antidepressants and counselling for the treatment of their depression?
2. As a counsellor, how do you determine whether a student with depression requires just counselling, just antidepressants, or both? What kinds of information/evidence do you base your decisions on?
3. Please tell me your beliefs around what are some of the more significant causes of depression in students, and how that influences your attitudes towards the use of antidepressants and/or counselling for students with depression.
4. In your mind, what are some of the advantages and disadvantages of antidepressants for treating student depression, and some of the advantages and disadvantages of counselling for treating student depression?
5. What are some of the dilemmas or difficulties you may encounter when offering counselling services for a student with depression who is also taking antidepressant medications?

APPENDIX G

Counsellor Demographic Information

Pseudonym	Institution	Age	Gender	Years as Counsellor	Professional Designation
Jane	College	34	Female	6.5	Registered Psychologist
Jay	College	38	Female	10	Registered Social Worker
Cindy	University	30	Female	10	Masters of Social Work
Joan	University	58	Female	12	Certified Canadian Counsellor
Betty	University	34	Female	5	Canadian Certified Counsellor
Sarah	University	60	Female	22	Registered Social Worker

References

- Adalf, E. M., Gliksman, L., Demers, A., & Newton-Taylor, B. (2001). The prevalence of elevated psychological distress among Canadian undergraduates: Findings from the 1998 Canadian Campus survey. *Journal of American College Health, 50*(2), 67-72.
- Adams, T. B., Wharton, C. M., Quilter, L., & Hirsch, T. (2008). The association between mental health and acute illness among a national sample of 18-24 year old college students. *Journal of American College Health, 56*(6), 657-663.
- Alschuler, K., Hoodin, F., & Byrd, M. (2008). The need for integrating behavioural care in a college health centre. *Health Psychology, 27*(3), 388-393.
- American College Health Association. (2000). National college health assessment: Reference group data. Report spring 2000. Baltimore, MD: American College Health Association.
- American College Health Association. (2009). American College Health Association - National College health assessment II: Reference group executive summary, Fall 2009. Linthicum, MD.
- American College Health Association. (2009). American College Health Association - National College health assessment, Spring 2008, Reference group data report (abridged). *Journal of American College Health, 57*(5), 477-488.
- American College Health Association. (2011). American College Health Association - National College Health Assessment II, Reference group executive summary, Spring 2011. Hanover, MD.
- Andrews, B., & Wilding, J. M. (2004). The relation of depression and anxiety to life-stress and achievement in students. *British Journal of Psychology, 95*, 509-521.
- Antonuccio, D. O., Danton, W. G., DeNestsky, G. Y., Greenbert, R. P., & Gordon, J. S. (1999). Raising questions about antidepressants. *Psychotherapy and Psychosomatics, 68*, 3-14.
- Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist, 55*(5), 469-480.
- Bitsika, V., Sharpley, C., & Bell, R. (2009). The contribution of anxiety and depression to fatigue among a sample of Australian university students: Suggestions for university counselors. *Psychology Counselling Quarterly, 22*(2), 243-255.

- Bitsika, V., Sharpley, C. F., & Rubenstein, V. (2010). What stresses university students: An interview investigation of the demands of tertiary studies. *Australian Journal of Guidance and Counselling*, 20(1), 41-54.
- Blanco, C., Okuda, M., Wright, C., Hasin, D. S., Grant, B. F., Liu, S., & Olfson, M. (2008). Mental health of college students and their non-college attending peers: Results from the national epidemiologic study on alcohol and related conditions. *Archives of General Psychiatry*, 65(12), 1429-1437.
- Boggiano, A., & Barrett, M. (1991). Gender differences in depression in college students. *Sex Roles*, 25(11/12), 595-605.
- Bollinger, L. C., Bush, C., Califano, J. A., Jr., Chenault, K. I., Curtis, J. L., Dimon, J., ... Wiener, M. A. (2003, November). Depression, substance abuse and college student engagement: A review of the literature. Report to the Charles Engelhard Foundation and the Bringing Theory to Practice Planning Group. The National Center on Addiction and Substance Abuse at Columbia University. Retrieved from <http://www.bringingtheorytopractice.org/pdfs/LitReviewDec03.pdf>
- Bostanci, M., Ozdel, O., Oguzhanoglu, N. K., Ozdel, L., Ergin, A., Ergin, N., ... Karadag, F. (2005). Depressive symptomatology among university students in Denizli, Turkey: Prevalence and socio-demographic correlates. *Croatian Medical Journal*, 46(1), 96-100.
- Bouteyre, E., Maurel, M., & Bernaud, J.L. (2007). Daily hassles and depressive symptoms among first year psychology students in France: The role of coping and social support. *Stress and Health*, 23, 93-99.
- Brener, N. D., Barrios, L.C., & Hassan, S. S. (1999). Suicidal ideation among college students in the United States. *Journal of Consulting and Clinical Psychology*, 67(6), 1004-1008.
- Camatta, C. D., & Nagoshi, C. T. (1995). Stress, depression, irrational beliefs, and alcohol use and problems in a college student sample. *Alcoholism, Clinical and Experimental Research*, 19(1), 142-146.
- Canadian Psychiatric Association (2005). Prescribing antidepressants for depression in 2005: Recent concerns and recommendations. *The Canadian Journal of Psychiatry*, 49(12), 1-6.
- Christensen, H., Griffiths, K., & Jorm, A. (2004). Delivering interventions for depression using the internet: Randomized controlled trial. *British Medical Journal*, 328, 265-268.

- Collin, A., & Young, R. A. (1988). Career development and hermeneutic inquiry part II: Undertaking hermeneutic research. *Canadian Journal of Counselling, 22*(4), 191-201.
- Cook, L. J. (2007). Striving to help college students with mental health issues. *Journal of Psychosocial Nursing, 45*(4), 40-44.
- Cooke, R., Beewick, B. M., Barkham, M., Bradley, M., & Audin, K. (2006). Measuring, monitoring, and managing the psychological well-being of the first year university students. *British Journal of Guidance & Counselling, 34*(4), 505-517.
- Cooper-Patrick, L., Powe, N., Jenckes, M., Gonzales, J., Levine, D., & Ford, D. (2002). Identification of patient attitudes and preferences regarding treatment of depression. *Journal of General Internal Medicine, 12*(7), 431-438.
- Copeland, J., & Martin, G. (2004). Web-based interventions for substance use: A qualitative review. *Journal of Substance Abuse Treatment, 26*(2), 109-116.
- Cornford, C. S., Hill, A., & Reilly, J. (2007). How patients with depressive symptoms view their conditions: A qualitative study. *Family Practice, 24*(4), 358-364.
- Cox-Dzurec, L., Allchin, L., & Engler, A. (2007). First year nursing student's account of reasons for student depression. *Journal of Nursing Education, 46*(12), 545-551.
- Crozier, S., & Willihnganz, N. (2005). *Canadian counselling centre survey* (Funded Research Report). Canadian University and College Association. Retrieved from <https://cacuss.ca/content/documents/fileItemController/SurveyResultsFeb051.pdf>
- Daughtry, D., & Kunkel, M. A. (1993). Experience of depression in college students: A concept map. *Journal of Counseling Psychology, 40*(3), 316-323.
- De Jonghe, F., Hendricksen, M., Van Allst, G., Kool, S., Peen, J., Van, R., et al. (2004). Psychotherapy alone and in combination with pharmacotherapy in the treatment of depression. *British Journal of Psychiatry, 185*, 37-45.
- Delisle, M., & Holden, M. (2009). Differentiating between depression, hopelessness, and psychache in university undergraduates. *Measurement and Evaluation in Counseling and Development, 42*(1), 46-63.
- Deroma, V. M., Leach, J. B., & Leverett, J. P. (2009). The relationship between depression and college academic performance. *College Student Journal, 43*(2), 325-334.

- Dion, K. L., & Giordano, C. (1990). Ethnicity and sex correlates of depressed symptoms in a Canadian university sample. *International Journal of Social Psychiatry*, 36(1), 30-41.
- Dixon, S. K., & Robinson Kurpius, S. E. (2008). Depression and college stress among university undergraduates: Do mattering and self-esteem make a difference? *Journal of College Student Development*, 49(5), 412-424.
- Dusselier, L., Dunn, B., Wang, Y., Shelley, M., & Whalen, D.F. (2005). Personal, health academic and environmental predictors of stress for residence hall students. *Journal of American College Health*, 54(1), 15-24.
- Eby, I., & Brown, N. J. (2009). *Mental health: Nursing care* (2nd ed.). Upper Saddle River, NJ: Person Education Inc.
- Eisenberg, D., Golberstein, E., & Gollust, S. (2007). Help-seeking and access to mental health care in a university population. *Medical care*, 45(7), 594-601.
- Eisenberg, D., Gollust, S. E., Golberstein, E., & Hefner, J. L. (2007). Prevalence and correlates of depression, anxiety, and suicidality among university students. *American Journal of Orthopsychiatry*, 77(4), 534-542.
- Eisenberg, D., Golberstein, E., & Hunt, J. (2009). Mental health and academic success. *B.E Journal of Economic Analysis and Policy*, 9(1), article 40.
- Field, L. D., Elliot, M. S., & Korn, P. R. (2006). A successful community-based intervention form addressing college student depression. *Journal of College Student Development*, 47(1), 105-109.
- Flynn, H. A. (2000). Comparison of cross-sectional and daily reports on studying the relationship between depression and use of alcohol in response to stress in college students. *Alcoholism: Clinical and Experimental Research*, 24(1), 48-52.
- Frankenberger, K. A., Frankenberger, W. R., Peden, B. F., Hunt, H. L., Raschick, C. M., Steller, E. G., & Peterson, J. A. (2004). Effects of information on college student's perception of antidepressant medication. *Journal of American College Health*, 53(1), 35-40.
- Furr, S. R., Westefeld, J. S., McConnell, G. N., & Jenkins, J. M. (2001). Suicide and depression among college students: A decade later. *Professional Psychology: Research and Practice*, 32(1), 97-100.

- Gallagher, R.P. (2009). Campus suicide prevention and intervention: Putting best practice policy into action. *National survey of counselling centre directors*. Arlington, VA: International Association of Counselling Services Inc.
- Garlow, S. J., Rosenberg, J., Moore, D., Hass, A. P., Koestner, B., Hendin, H., & Nemeroff, C. B. (2008). Depression, desperation, and suicidal ideation in college students: Results from the American Foundation For Suicide Prevention Screening Project at Emory University. *Depression and Anxiety, 25*, 482-488.
- Gallegos, N. (2005). Client perspectives on what contributes to symptom relief in psychotherapy: A qualitative outcome study. *Journal of Humanistic Psychology, 45*(3), 355-382.
- Gawrysiak, M., Nicholas, C., & Hopko, D. R. (2009). Behavioural activation for moderately depressed university students: Randomized controlled trial. *Journal of Counselling Psychology, 56*(3), 468-475.
- Givens, J. L., Datto, C. J., Ruckdeschel, K., Knott, K., Zubritsky, C., Oslin, D. W., Nyshadham, S., Vanguri, P., & Barg, F. K. (2005). Older patient's aversion to antidepressants: A qualitative study. *Journal of General Internal Medicine, 21*, 146-151.
- Gonzalez, V.M., Reynolds, B., & Skewes, M.C. (2011). Role of impulsivity in the relationship between depression and alcohol problems among emerging adult college drinkers. *Experimental & Clinical Psychopharmacology, 19*(4), 303-313.
- Grant, K., Marsh, P., Syniar, G., Williams, M., Addlesperger, E., Kinzler, M. H., & Cowman, S. (2002). Gender differences in rates of depression among undergraduates: measurement matters. *Journal of Adolescence, 25*, 613-617.
- Grime, J., & Pollack, K. (2003). Patients' ambivalence about taking antidepressants: A qualitative study. *The Pharmaceutical Journal, 271*, 516-519.
- Haines, M. E., Norris, M. P., & Kashy, D. A. (1996). The effects of depressed mood on academic performance in college students. *Journal of College Student Development, 37*(5), 519-526.
- Hass, A., Koestner, B., Rosenberg, J., Moore, D., Garlow, S.J., Sedway, J., ... Nemeroff, C.B. (2008). An interactive web-based method of outreach to college students at risk for suicide. *Journal of American College Health, 57*(1), 15-22.
- Heiligenstein, E., Guenther, G., Hsu, K., & Herman, K. (1996). Depression and academic impairment in college students. *Journal of American College Health, 45*(2), 59-64.

- Hojat, M., Gonnella, J.S., Erdmann, J. B., & Vogel, W. H. (2003). Medical students' cognitive appraisal of stressful life events as related to personality, physical well-being, and academic performance: a longitudinal study. *Personality and Individual Differences, 35*, 219-235.
- Horgan, A., & Sweeney J. (2010). Young students' use of the internet for mental health information and support. *Journal of Psychiatric and Mental Health Nursing, 17*, 117-123.
- Horton, G. E., Diaz, N. D., & Green, D. G. (2009). Mental Health characteristics of social work students: Implications for social work education. *Social Work in Mental Health, 7*(5), 458-475.
- Hunt, J., & Eisenburg, D. (2010). Mental Health Problems and Help-seeking behavior among college students: A narrative review. *Journal of Adolescent Health, 46*(1), 3-10.
- Hurtado, S., Sax, L. J., Saenz, V., Harper, C. E., Oseguera, L., Curley, J., & Lopez, L., ...Arellano, L. (2007, February). Findings from the 2005 administration of your first college year (YFCY): National aggregates. Higher Education Research Institute: University of California, Los Angeles. Retrieved from http://www.heri.ucla.edu/PDFs/2005_YFCY_REPORT_FINAL.pdf
- Hysenbegasi, A., Hass, S. L., & Rowland, C. R. (2005). The impact of depression on the academic productivity of university students. *The Journal of Mental Health Policy and Economics, 8*, 145-151.
- Joyce, A. W., Ross, M. J., Vander Wal, J. S., & Austin, C. C. (2009). College students' preference for psychotherapy across depression, anxiety, relationship, and academic problems. *Journal of College Student Psychotherapy, 23*, 212-226.
- Kadison, R. (2005). Getting an edge—use of stimulants and antidepressants in college. *New England Journal of Medicine, 353*(11), 1089-1091.
- Karp, D. (1994). Living with depression: Illness and identity turning points. *Qualitative Health Research, 4*(1), 6-30.
- Kelly, W. E., Kelly, K. E., Brown, F. C., & Kelly, H. B. (1999). Gender differences in depression among college students: A multicultural perspective. *College Student Journal, 33*(1).
- Keller, M., McCullough, J., Klein, D., Arnow, B., Dunner, D., Gelenberg, A., et al. (2000). A comparison of nefazodone, the cognitive behavioural-analysis system of psychotherapy, and their combination for the treatment of chronic depression. *The New England Journal of Medicine, 342* (20), 1462-1470.

- Kenney, B. A., & Holahan, C. J. (2008). Depressive symptoms and cigarette smoking in a college sample. *Journal of American College Health, 56*(4), 409-414.
- Kessler, R. C., & Walters, E. E. (1998). Epidemiology of DSM-III-R major depression and minor depression among adolescents and young adults in the national comorbidity survey. *Depression and Anxiety, 7*, 3-14.
- Khawaja, N. G., & Duncanson, K. (2008). Using the university student depression inventory to investigate the effects of demographic variables on student depression. *Australian Journal of Guidance & Counselling, 18*(2), 195-209.
- Kitrow, M. A. (2003). The mental health needs of today's college students: Challenges and recommendations. *NASPA Journal, 41*(1), 165-179.
- Knudsen, P., Hansen, E. H., & Eskildsen, K. (2003). Leading ordinary lives: A study of younger women's perceived function of antidepressants. *Pharmacy World & Science, 25*(4), 162-167.
- Knudsen, P., Hansen, E. H., Traulsen, J. M. & Eskildsen, K. (2002). Changes in self-concept while using SSRI antidepressants. *Qualitative Health Research, 12*(7), 932-944.
- Kuwabara, S., Van Voorhees, B., Gollan, J., & Alexander, G. C. (2007). A qualitative exploration of depression in emerging adulthood: Disorder, development, and social context. *General Hospital Psychiatry, 29*, 317-324.
- Kwintner, M. (2005). Message in a bottle: The meanings of antidepressant medication for psychiatric patients. *Smith College Studies in Social Work, 75*(2), 27-52.
- Leino, V. E., & Kisch, J. (2005). Correlates and predictors of depression in college students: Results from the spring 2000 national college health assessment. *American Journal of Health Education, 36*(2), 66-74.
- Lenz, B. K. (2004). Tobacco, depression, and lifestyle choices in the pivotal early college years. *Journal of American College Health, 52*(5), 213-219.
- Liem, J. H., Lustig, K., & Dillion, C. (2010). Depressive symptoms and life satisfaction among emerging adults: A comparison of high school dropouts and graduates. *Journal of Adult Development, 17*, 33-43.
- Lindsey, B. J., Fabiano, P., & Stark, C. (2009). The prevalence and correlates of depression among college students. *College Student Journal, 43*(4), 999-1014.

- Luc, M., Drapeau, M., & Despland, J. N. (2003). A four session format to work with university students: The brief psychodynamic investigation. *Journal of College Student Psychotherapy, 18*(2), 3-14.
- Megivern, D., Pellerito, S., & Mowbray, C. (2003). Barriers to higher education for individuals with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 26*(3), 271-231.
- Malpass, A., Shaw, A., Sharp, D., Walter, F., Feder, G., Ridd, M., & Kessler, D. (2009). "Medication career" or "Moral career"? The two sides of managing antidepressants: A meta-ethnography of patients' experience of antidepressants. *Social Science and Medicine, 68*, 154-168.
- McKenzie, K., & Schweitzer, R. (2001). Who succeeds at university? Factors predicting academic performance in first year Australian university students. *Higher Education Research & Development, 20*(1), 21-33.
- McMahon, G. T., Gomes, H. E., Hickson Hohne, S., Ming-Jye Hu, T., Levine, B. A., & Conlin, P. R. (2005). Web-based care management in patients with poorly controlled diabetes. *Diabetes Care, 28*(7), 1624-1629.
- Michael, K. D., Huelsman, T. J., Gerard, C., Gillian, T. M., & Gustafson, M. R. (2006). Depression among college students: Trends in prevalence and treatment seeking. *Counselling and Clinical Psychology Journal, 3*(2), 60-70.
- Mikolajczyk, R. T., Maxwell, A. E., Naydenova, V., Meier, S., & Ansari, W. (2008). Depressive symptoms and perceived burdens related to being a student: Survey in three European countries. *Clinical Practice and Epidemiology in Mental Health, 4*(19), 19-27.
- Mitchell, N., & Dunn, K. (2007). Pragmatic evaluation of the viability of CCBT self-help for depression in higher education. *Counselling and Psychotherapy Research, 7*(3), 140-150.
- Moscick, E. K. (2001). Epidemiology of completed and attempted suicide: Toward a framework for prevention. *Clinical Neuroscience Research, 1*, 310-323.
- Moo-Estrella, J., Perez-Benitez, H., Solis-Rodriguez, & Arankowsky-Sandoval, G. (2005). Evaluation of depressive symptoms and sleep alterations in college students. *Archives of Medical Research, 36*(4), 393-398.
- Much, K., & Swanson, A. L. (2010). The debate about increasing college student psychopathology: Are college students really getting "sicker"? *Journal of College Student Psychotherapy, 24*(2), 86-97.

- National Alliance on Mental Illness. (2011). Education, Training, & Peer support Programs. Retrieved September 15, 2011 from http://www.nami.org/template.cfm?section=Education_Training_and_Peer_Support_Center
- National Institute for Clinical Excellence. (2009). *Nice Clinical Guideline 90. Depression: The treatment and management of depression in adults (partial update of NICE clinical guideline 23)*. Retrieved February 23, 2012 from www.nice.org.uk/CG90
- Nemeroff, C. B., Heim, C. M., Thase, M. E., Klein, D. N., Rush, A. J., Schatzberg, A. F., ...Keller, M. B. (2003). Differential responses to psychotherapy versus pharmacotherapy in patients with chronic forms of major depression and childhood trauma. *Proceedings of the National Academy of Sciences, 100*, 14293-14296.
- Oliver, J. M., & Burckham, R. (1979). Depression in University students: Duration, relation to calendar time, prevalence, and demographic correlates. *Journal of Abnormal Psychology, 88*(6), 667-670.
- O'Neil, M. K., Lancee, W. J., & Freeman, S. J. J. (1984). Help-seeking behavior of depressed students. *Social Science and Medicine, 18*(6), 511-514.
- Osbourne, J. (1990). Some basic existential phenomenological research methodology for counsellors. *Canadian Journal of Counselling, 24*(2), 79-91.
- Peden, A. R., Rayens, M., Hall, L. A., & Beebe, L. H. (2001). Preventing depression in high-risk college women: A report of an 18-month follow-up. *Journal of American College Health, 49*(6), 299-306.
- Price, E. L., Mcleod, P. J., Gleich, S. S., & Hand, D. (2006). One-year prevalence rates of major depression disorder in first-year university students. *Canadian Journal of Counselling, 40*(2), 68-81.
- Pritchard, M. E., & Wilson, G. S. (2003). Using emotional and social factors to predict student success. *Journal of College Student Development, 44*(1), 18-22.
- Quinn, N., Wilson, A., MacIntyre, G., & Tinklin, T. (2009). 'People look are you differently': Students' experience of mental health support within higher education. *British Journal of Guidance & Counselling, 37*(4), 405-418.
- Rawson, H. E., Bloomer, K., & Kendall, A. (1994). Stress, anxiety, depression, and physical illness in college students. *The Journal of Genetic Psychology, 155*, 321-330.

- Ravidran, A.V., Lam, R.W., Filteau, M.J., Lesperance, F., Kennedy, S.H., Parikh, S.V., & Patten, S.B. (2009). Research report: Canadian Network for Mood and Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. V. Complementary and alternative medicine treatments. *Journal of Affective Disorders*, 117, S54-S64.
- Reavley, N., & Jorm, A. F. (2010). Prevention and early intervention to improve mental health in higher education students: A review. *Early Intervention in Psychiatry*, 4, 132-142.
- Ridner, S. L., Staten, R. R., & Danner, F. W. (2005). Smoking and depressive symptoms in a college population. *The Journal of School Nursing*, 21(4), 229-235.
- Roberts, S. J., Glod, C. A., Kim, R., & Houchell, J. (2010). Relationships between aggression, depression, and alcohol, tobacco: Implications for healthcare providers in student health. *Journal of the American Academy of Nurse Practitioners*, 22, 369-375.
- Rosenthal, B., & Wilson, C. W. (2008). Mental health services: Use and disparity among diverse college students. *Journal of American College Health*, 57(1), 61-67.
- Rude, S. S., Gortner, E., & Pennebaker, J. W. (2004). Language use of depressed and depression-vulnerable college students. *Cognition and Emotion*, 18(8), 1121-1133.
- Ruthig, J. C., Haynes, T. L., Stupinsky, R. H., & Perry, R. P. (2009). Perceived academic control: mediating the effects of optimism and social support on college students' psychological health. *Social Psychology of Education*, 12, 233-249.
- Ryan, R. M., Lynch, M. T., Vansteenkiste, M., & Deci, E. L. (2011). Motivation and autonomy in counselling. Psychotherapy, and behaviour change: A look at theory and practice. *The Counselling Psychologist*, 39, 193-260.
- Schulberg, H. C., Raue, P. J., & Rollman, B. L. (2002). The effectiveness of psychotherapy in treating depressive disorders in primary care practice: Clinical and cost perspectives. *General Hospital Psychiatry*, 24, 203-212.
- Schramm, E., van Calker, D., Dykieriek, P., Lieb, K., Kech, S., Zobel, I., et al. (2007). An intensive treatment program of interpersonal psychotherapy plus pharmacotherapy for depressed inpatients: Acute and long term results. *American Journal of Psychiatry*, 164(5), 768-777.
- Schwartz, A. J. (2006). Four eras of study of college student suicide in the United States: 1920-2004. *Journal of American College Health*, 54(6), 353-366.

- Schwartz, A. J. (2006). Are college students more disturbed today? Stability in the acuity and qualitative character of psychopathology of college counselling centre clients: 1992-1993 through 2001-2002. *Journal of American College Health*, 54(6), 327-336.
- Segal, Z., Kennedy, S., Cohen, N.L, & The CANMAT Depression Work Group.(2001). Clinical guidelines for the treatment of depressive disorders: V. Combining psychotherapy and pharmacotherapy. *The Canadian Journal of Psychiatry*, 46(1), 59S-62S.
- Sharpley, C. F. (2011). Antidepressants in counselling psychology: Relevance, effectiveness and implications for practice. *Counselling Psychology Quarterly*, 24(2), 139-156.
- Silverman, M. M., Meyer, P. M., Sloane, F., Raffel, M., & Pratt, D. M. (1997). The Big Ten student suicide study: A 10 year study of suicide on Midwestern University campuses. *Suicide and Life Threatening Behaviour*, 27(3), 285-303.
- Skarsater, I., Dnecker, K., Haggstrom, & Fridlund, B. (2003). A salutogenic perspective on how men cope with major depression in daily life and lay support. *International Journal of Nursing Studies*, 40, 153-162.
- Soet, J., & Sevig, T. (2006). Mental health issues facing a diverse sample of college students: Results from the college students' mental health survey. *NASPA Journal*, 43(3), 410-20
- Spencer, D.C., Nashelsky, J. (2005). Counselling or antidepressants for treating depression? *American Family Physician*, 72(11), 2309-2310.
- Statistics Canada. (2009). Post secondary enrolment and graduation 2009. Retrieved April 2, 2012, from www.statcan.gc.ca/pub/81-599x/81-599-x2009003-eng.htm
- Statistics Canada. (2010). Changes in the age composition of college and university students over time. Retrieved April 2, 2012, from www.statcan.gc.ca/pub/81-004-x/2010005/article/11386-eng.htm
- Stephoe, A., Tsuda, A., Tanaka, Y, & Wardle, J. (2007). Depressive symptoms, socio-economic background, sense of control, and cultural factors in university students from 23 countries. *International Journal of Behavioral Medicine*, 14(2), 97-107.
- Stoppard, J.M. (1999). Why new perspectives are needed for understanding depression in women. *Canadian Psychology*, 40, 79-90.

- Surf, A., & Lynch, G. (1999). Exploring young people's perceptions relevant to counseling: A qualitative study. *British Journal of Guidance and Counseling*, 27(2), 231-243.
- Swanholm, E., Vosvick, M., & Chwee-Lye, C. (2009). Pessimism, trauma, risky sex: Covariates of depression in college students. *American Journal of Health Behavior*, 33(3), 309-318.
- Tjia, J., Givens, J. L., & Shea, J. A. (2005). Factors associated with under treatment of medical student depression. *Journal of American College Health*, 53(5), 219-224.
- Turner, K. M., Sharp, D., Folkes, L., & Chew-Graham, C. (2008). Women's views and experiences of antidepressants as a treatment for postnatal depression: a qualitative study. *Family Practice*, 25, 450-455.
- Uskun, E., Kisioglu, A.N., & Ozturk, M. (2008). Stress and its effects on depression and anxiety among undergraduates. *Primary Care and Community practice*, 13(2), 73-82.
- Van, H. L., Schoevers, R. A., & Dekker, J. (2008). Predicting the outcomes of antidepressants and psychotherapy for depression: A qualitative systematic review. *Harvard Review of Psychiatry*, 16(4), 225-234.
- Van Manen, M. (1990). *Researching lived experience: Human sciences for an action sensitive pedagogy*. London, ON: Althouse Press.
- Voelker, R. (2003). Mounting student depression taxing campus mental health services. *Journal of the American Medical Association*, 289(16), 2055-2056.
- Vredenburg, K., O'Brien, E., & Krames, L. (1988). Depression in college students: Personality and experiential factors. *Journal of Counselling Psychology*, 35(4), 419-425.
- Waite, R., & Killian, P. (2008). Health beliefs about depression among African-American women. *Perspectives in Psychiatric Care*, 44(3), 185-195.
- Weiner, E. (1996). An exploratory qualitative study of three university students with mental illness and the perceived role their families play in their university education. *Psychiatric Rehabilitation Journal*, 19(3), 77-80.
- Wong, J. L., & Whitaker, D. J. (1993). Depressive mood states and their cognitive and personality correlates in college students: They improve over time. *Journal of Clinical Psychology*, 49(5), 615-621.

Yorganson, J. B., Linville, D., & Zitzman, B. (2008). Mental health among college students: Do those who need services know about and use them? *Journal of American College Health, 57*(2), 173-181.

Zivin, K., Eisenberg, D., Gollust, S. E., & Golberstein, E. (2009). Persistence of mental health problems and needs in a college student population. *Journal of Affective Disorders, 117*, 180-185.