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University students' accounts of living with depression

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Abstract

Depression is experienced by children and young people worldwide and can have serious long-term impacts, including high risk of suicide. To date there are few in-depth qualitative studies investigating young people's experiences of living with depression and how this affects their education. The current study investigated university students' lived experiences of depression. Three students, aged 19-21 participated in three sequential individual interviews, each with a different focus: before living with depression; the experience of living with depression; and reflections of the meaning of living with depression. Data were transcribed verbatim and analysed using Interpretative Phenomenological Analysis (IPA), identifying master themes. This paper reports on findings from two themes: 'the weariness of the world was upon me', and 'it all fell down to chance' which discuss students' experiences of living with depression; and facilitators and barriers to accessing help. These are discussed in relation to transition to university, help seeking and accessing support. Limitations of the study are considered and possible implications for practice outlined.

Keywords: young people; depression; phenomenology; lived experiences; student years

Introduction

Mental health and depression during emerging adulthood

The United Kingdom (UK) Government identified 16-25 year olds as a particularly vulnerable group within its strategic response to improving access to mental health support for children and young people (Department of Health [DoH] and Department for Education [DfE] 2017). In his report *Not By Degrees: Improving Student Mental Health in the UK's Universities* Thorley (2017) highlighted the increasing prevalence of reported mental illness, mental distress and low wellbeing amongst UK higher education (university) students, represented in a fivefold increase in students disclosing a mental health condition to their host institution within the last 10 years. While these figures are alarming, they should be considered alongside recent evidence from adults questioned via a YouGov survey, where 88% agreed that people are more likely to talk about mental health and that 84% felt that media coverage had increased within the last two years; and that increased awareness and dialogue might also have impacted reporting rates.

Thorley (2017) cited a number of potential reasons why prevalence rates had increased, including heightened academic demands, pressure to achieve a high class degree, and social and financial stresses. Universities UK (2017) noted that the proportion of young adults attending university continues to increase and that the student population is increasingly representative of wider society in terms of ethnicity, gender, country of origin, age, disability status, and sexual orientation and social economic status. Some of these students, including those being the first in the family to attend university and those identifying as LGBTQ+ may be

particularly vulnerable to mental health problems (Universities UK, 2017).

Additionally, the extent to which mass higher education (Mayhew, Deer, and Dua 2004) is within itself causing issues, for example through increased competition for postgraduate jobs, and pressure on universities resources causing issues such as overcrowding (Bushby 2018) and diminished tutor access, is not yet fully understood.

Problems arising from mental health issues can affect course continuation and academic achievement, and the most severe and tragic cases have led to suicide (Coughlan 2018). While the rise in student suicides in England and Wales has thankfully been much more gradual, several UK universities have experienced a number of student suicides within a short period of time (Universities UK 2017).

Depression is one of the major mental health difficulties experienced by children and young people globally (Kirmayer, Gomez-Carrillo, and Veissière 2017; Suhrcke, Puillas, and Selai 2008). Ibrahim et al. (2013) estimated the prevalence of depression amongst university students worldwide, with numbers ranging from 10.3% to 44%. Moreover, in the UK, these numbers for young people (within the age range 16-24) experiencing depression or anxiety vary from 26.1% for young women to 15.9% for young men, although male depression may be under-reported and manifest differently (Office for National Statistics [ONS] 2014).

Depression is conceptualised as a mental disorder in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders: DSM-V (American Psychiatric Association 2013). However, the features of depression are often similar to those experiencing sadness (Horwitz 2011). For young people these may range from: feeling irritable, persistent sadness, hopelessness, tiredness, low self-esteem, fatigue, failure of rejection, sleep disturbance, anger and risk-taking activities

(e.g. drug and substance misuse), wanting to withdraw from social life, sensitivity to criticism, lack of interest in previously enjoyed activities, and psychosomatic symptoms (American Psychiatric Association 2013). This list is not exhaustive as depression impacts all areas of life, including educational and social outcomes (Greig 2004, Lane 1996) and is also associated with a higher risk of suicide (Hawton et al. 2013).

Depression amongst university students

Rates of depression can be particularly high amongst young people aged 16-24 (Thorley 2017), the age at which many young people start university. Arnett, Žukauskiene, and Sugimura (2014) proposed that since the 1960s the transition to adulthood – a period described as ‘emerging adulthood’ - has become longer, with more time spent in education and typically later entry into marriage and parenthood. This has also led to changes in societal and cultural expectations.

In a small-scale study involving 12 student medical practices, Thorley (2017) reported depression to be the most common mental health condition experienced by UK students. Analysis of anonymised data found 8.4% of student patients experienced depression, according to medical records. In the United States (US) Mahmoud et al. (2012) looked into the reasons for rises in reported depression by asking 508 undergraduate students aged 18-24 to complete questionnaire measures looking at self-reported depression, anxiety and stress, as well as coping strategies and life satisfaction. The authors found the most significant independent predictors of depression to be maladaptive coping strategies (e.g. denial, self-blaming, substance use); and life satisfaction, in terms of their college and social/family life and financial situation.

Schools play a crucial role in supporting the mental health of their students (DfE 2015; Thorley 2016). However, embedding mental health support at a school level is a complex issue and often young people do not report their difficulties due to the

perceived stigma associated with mental health difficulties (Curtis 2010; Issakainen 2014). Rothi and Leavey (2006) explored the mental health help-seeking behaviour of young people in the UK. Their review revealed that often young people's needs only become recognised when their mental health difficulties are serious, missing the opportunity for earlier interventions. Moreover, Gulliver, Griffiths, and Christensen (2010) found that significant barriers to help-seeking for students were: people's attitudes towards mental health needs, self-stigmatising, issues of trust, and knowledge about mental health and services. Martin and Atkinson (2018) called for more sophisticated thinking amongst professionals working with young people, in order to help improve access to help seeking.

Rationale for the current research

Few studies have explored young people's narratives of depression and most of those which have, have done so from a medical perspective (*cf.* McCann, Lubman, and Clark 2012; Shaw, Dallos, and Shoebridge 2009). Oliffe, Kelly, et al. (2010) and Oliffe, Robertson, et al. (2010) looked at how perceptions of masculinity interfaced with depression amongst male Canadian-based college students. Oliffe, Kelly, et al. (2010) proposed that masculine ideals, such as being emotionally strong, physically tough and a self-reliant problem-solver created a recursive relationship with the lived experience of depression, in which notions of eroded masculinities created greater distress. Notably however, depression is twice as prevalent amongst young women aged 14-25 than young men (Albert 2015). This may be partly due to the way in which depression is socially-constructed. Feminist researchers (e.g. Stoppard 2000) have argued that within cultural meaning systems, beliefs about the nature of masculinity and femininity impact on the social conditions in which women's lives are experienced are not appropriately considered within conceptualisations of depression; and that subsequently narratives

about women's mental health can be unnecessarily pathologising. While explanations offered by Albert (2015) relate more to biological factors, MacKay and Rutherford's (2012) study of feminist women's accounts of depression suggests that conceptualisations sensitive to both social context and biological understandings may be helpful.

To date there has been little attention given to the lived experience of students who have experienced depression throughout their educational career, and the impact this has had on transition to university and during emerging adulthood. Thus, the aim of the current study was to explore experiences of UK university students of living with depression during their student years. The term 'student years' encompasses all educational settings. It was hoped that gaining a better insight and deeper understanding of the reality faced by young people, in wider context of their lives, would help to raise awareness amongst professionals working with young people about support, management of depression and inform future research.

Method

Research design

There are many variants of phenomenology used in psychology, with the common theme of trying to get an insight into the essence of a person's life (or lived) world (Langdridge 2007; Smith, Flowers, and Larkin 2009). One of the phenomenological approaches is interpretative phenomenological analysis (IPA), a methodological framework. IPA relies on language input, usually in a verbal form that requires listening to participants' experiences, what it is like for them to experience something (phenomenology), interpretation (hermeneutics) of participants' experiences, and then researcher interpretation (double hermeneutics) (Smith, Flowers, and Larkin

2009). This qualitative study employed IPA (Smith, Flowers, and Larkin 2009) in order to gain insight into experiences and meaning-making of living with depression of a self-selecting sample of young people.

The epistemological stance adopted was one of critical realism, which posits the world can exist independently, 'objectively' of multiple realities and social constructions, but can be known in the specific contexts, and through scientific inquiry and social interpretations (Bhaskar 2010). Specifically, this assumed that students defining themselves as having lived with depression would share common experiences, and while a diagnosis was not required, that these would broadly reflect the criteria defined within the DSM-V (American Psychiatric Association 2013). MacKay and Rutherford (2012) proposed that a critical realist perspective acknowledges both the individual's lived reality, but that the diagnostic label is shaped within a specific social, historical and cultural context which interacts with their experience and affects both individual and societal conceptualisations of "depression" (p.181).

Ethical considerations and inclusion criteria

Following ethical approval, posters with an invitation to participate were displayed across university, which is situated in the North of England, one of the largest in the UK, part of the prestigious Russell Group and ranked highly within university league tables. Prospective participants could enquire about the study via email. The first author contacted interested parties to arrange a telephone conversation to provide more detailed information and check eligibility criteria, which were: age range 18-25; current students with experience of living with depression who self-reported that they were managing it well. To ensure that the students were not especially vulnerable, an inclusionary criterion was that there was no history of suicide attempts; and to ensure that the

research did not impact any treatment that individuals might be receiving, no current involvement from outside agencies (for example, counselling or support from adult mental health services). Subsequently, the first three participants who met the eligibility criteria, out of twelve who volunteered, were invited to take part in the interviews and sent information about the study. This number of three participants (resulting in nine interviews) is congruent with IPA guidelines for professional doctorates and deemed sufficient to investigate the phenomenon of living with depression (*cf.* Smith, Flowers, and Larkin 2009). Participants were reassured about their right to withdraw at any time during data gathering, up to transcription and the anonymisation process. Consent was recurrently checked during each individual interview and a protocol for communicating distress revisited.

Participants

Three undergraduate students from different university courses, aged 19-21, volunteered to take part. Names and other identifiable data were anonymised, and pseudonyms (over which participants were offered a choice) are used throughout this paper. A brief overview of participant profiles can be found in Table 1.

[Table 1 near here]

Data gathering and analysis

Three semi-structured, open-ended interviews took place with each participant, according to the three-interview series from Seidman (2013). Each interview had a different focus: the first was on a life story before depression, the second on details of experience of living with depression, and the third on reflection of the meaning of living with depression.

This format of interviews was compatible with a phenomenological approach and allowed participants time to talk about and reflect upon their experiences in a safe environment, without feeling judged. This also allowed for building rapport with the researcher before discussing sensitive topics of living with depression. Each participant was individually interviewed three times, over a period of one month on average, with interview duration from 47 minutes to 92 minutes (mean = 70 minutes). Interviews took place in a designated private and quiet university space, with pre-established access to support if needed.

Interviews were digitally recorded and transcribed verbatim. The analysis followed the IPA framework from Smith, Flowers, and Larkin (2009), where completion of analysis of one interview enabled progress to transcription and analysis of a subsequent interview.

Findings

Four recurrent themes were identified (see Figure 2). Because exploration of all four themes would be beyond the scope of this paper, the findings will focus on the two most relevant to linking the lived experiences of depression with perceived barriers and facilitators to accessing help whilst living with depression: “The weariness of the world was upon me” and “It all fell down to chance”. This is in keeping with IPA literature,

within which there is a precedent for prioritising the most pertinent themes (Smith,

Figure 1: Process of thematic analysis (Braun & Clarke, 2006)

Flowers, and Larkin 2009). In the following extracts, underlining is used to indicate participants' emphases. Subthemes are highlighted through the use of italics (please refer to Figure 2).

“The weariness of the world was upon me”

Although triggers of depression were heterogeneous, all participants felt disengagement from the world, and experienced a gradual process of ‘getting depressed’. James Cared reflected how this started in boarding school, when constantly comparing himself to

others and eventually 'came to a halt' during his first year at university, although he did not realise immediately what he was experiencing.

I think a lot of people think it is like an immense just being sad, you know, being a bit blue. It's not that at all it's like I think you could describe it like imagine a *great steam engine just running out of steam and just coming to a halt* and just rusting. That's what it's like. It's not even like sad it's kind of just finding yourself grinding to a halt and just not being able to stop it and just inevitably just, you know, kind of entropy. And everything goes to just chaos and, you know, that's kind of what it is.

It seemed that James Cared sees himself as someone outmoded; who felt inadequate and ill-equipped to cope with everyday life.

By contrast, for both Lucy and Jules this process of gradual isolation and disengagement followed earlier experiences of being bullied and abused by peers. Lucy experienced two bouts of living with depression at primary and secondary school. Her first time living with depression was: 'hell on Earth, it was really awful... you're just in a completely different world, in a completely different mindset, you just cannot enjoy your life at all'. Her embodied experiences were conveyed through descriptions of feeling: 'trapped in your own body and you can't get out, you can't live your life... you're just so trapped in yourself... and in your own thoughts'. She felt 'trapped by fear' and reflected this period in a subdued, emotionless tone:

I got such in a bad way that I was not, I could not be thrilled, I could not understand why people are happy, why they could love in this life, or not, be miserable, I was not, not in a good way... I mean when you're depressed you're not, you're not there, you're not living your life, just existing, you're

just existing till the next day, even then, I was... just really wanted to go to sleep...

Figure 2 – Participant themes

Whereas Jules kept on piling on and on more work:

it was starting to get difficult...because I'd...I'd carried on piling on more things and obviously sixth form's a lot more work than it was previously and so I was... the low points were getting lower and the sort of... the length of them was increasing... and there were a few times where it came close to just being a full breakdown and not being able to carry on with work just because like having to take, take some time off because of a... but yeah, it became very difficult around that time...

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Eventually things spiralled out of control, resulting in a 'breakdown' when he started university.

For James Cared, difficult feelings are multi-faceted: he not only experienced shame and guilt himself, but also felt ashamed for the 'rotten' state of the world he lives in, and he does not wish to contribute to its degeneration. Overpowering feelings of shame and guilt were also present in the narratives of Lucy and Jules. For Lucy, this almost took a physical form of pain, 'hurting inside', powerlessness, and not being able to express how she felt. The following account also communicates her fear:

I wanted to cry all the time but it wouldn't come out, you know? I don't know if you've ever felt this level of despair, where you... so... scared... that you just want to cry and scream and it doesn't come out and it's so much worse, 'cos like when you're crying, you sort of get it out of you but when you're holding in it's just... just deeply, deeply depressing, everything was just... everything was just really terrible to me.

The participants felt lonely: for Jules it was:

Lonely but lonely with other people around me, so it was lonely in that I wasn't really sharing anything about my experiences with everyone ... anyone, even though I was seeing people, like around all of the time during school.

Whereas for Lucy the loneliness whilst living with depression had also another dimension - she did not feel she could be left on her own, as being alone was a terrifying experience:

I felt very lonely a lot, and then I felt better, and if anybody left me on my own I'd just get really terrified, just really scared of something, it was sort of like living in a constant, constant dread... of nothing...

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None of the participants knew what was happening to them at first, and whether it was '*serious or trivial*' even when they started noticing something was not 'quite right', as Jules exemplified:

I really needed someone to tell me how bad it was because in my head I was minimising it quite a lot and thinking... 'well, this isn't as bad as it could be...' and... not really... not really admitting to myself that things actually were getting really bad.

Despite the need for someone to legitimise his feelings, Jules felt he could not talk to anyone at school or at home about his feelings, because there were more important issues to be addressed. James Cared wondered if he was 'lazy' at first, then he started feeling 'groggy' and lacked motivation, and these feelings urged him to go to see a doctor. Following the medical consultation, he was advised it was carbon monoxide poisoning, so he went and bought a carbon monoxide detector.

To deal with difficult feelings of hopelessness, disengagement from life, powerlessness, physical and psychological pain, participants made use of helpful and less helpful coping strategies. Lucy, for example, found that going to school provided a distraction:

When I went to school I was quite distracted, but actually, I didn't feel as much effect, I felt a bit more normal... 'cos I needed to get on with my work and erm, but if I was left on my own I would just feel terrible.

Later on, she added that 'it was constant distraction that helped me a bit'. Similarly, Jules created increasingly more and more distractions when he was in high school and sixth form: 'piling on work', getting into a school orchestra and various after-school clubs. He also kept adding more subjects and set high expectations of himself to do great homework, even if this meant he was sitting until late night. But

in the end, these distractions did not help. At school, when things were becoming increasingly difficult for him, he would:

...just sit somewhere alone... and... somewhere quiet and not... not really do anything, I didn't have a phone that I carried round with me everywhere at this point and I didn't... I didn't really listen to music that much... and... it had rarely been a situation where I'd have something to read... I'd just find a quiet space and just sit there for a while.

This evocative account suggests how important it was to have a quiet, safe space where he could 'just be' on his own. Jules also worked with a therapist in sixth form, so he 'got a little bit better with managing stress.' All participants found routine was vital in managing their experiences of living with depression. For Lucy, it 'highlighted the importance of being productive and being an active person.' She now tries to maintain an active lifestyle to 'stay sane.' Jules lost a lot of weight as a result of not eating enough and now exercises to get back to healthy weight:

I started doing some exercise because... like... I'd spent several months not eating and when I was just eating toast so I'd gone down from... from about ten stone to just under eight stone. So I was pretty skinny at this point and so I was eating quite a lot and trying to exercise to get back to a healthy... just be a healthy weight and a healthy person.

For all participants, meeting with friends or having a 'strong' group of friends was a way of building resilience, James Cared noting: 'I'd like to have a stronger group of friends at uni and I'm jealous of people that do... I'd like to be a bit more varied and have a few different things that I do and that.' James Cared elaborated on this even more, talking about importance of work and having something to be proud of,

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including a small steps approach ('it's not just a grand scheme like it's not the big things it's the little things that get you and you have to start there'):

The participants report *developing physical and psychological issues* during the experiences of living with depression. Jules was having difficulties 'with the heart strain and the fainting stuff', blackouts where his 'vision would just go', and stopped looking after himself during his first year of university:

I stopped looking after myself, I stopped... stopped showering, stopped eating... there was a period of about six days at one point where I just never left my room for food or water. I'd got... like a two litre bottle of water... just that I'd had lying around and that was all I drank and I didn't eat anything for those, for those six days.

Eventually, this had impact on his memory and ability to function:

I used to just eat lots and lots of toast and nothing else because I... I couldn't motivate myself to make proper food... and it was a time when my memory had just failed and I put on this toast and then left and not come back for it.

Jules described his struggles in a simple, yet very evocative way, illustrating this with making, or rather failing to make, some food. His memory 'failed', he could not look after himself, became incapacitated and powerless when experiencing severe symptoms of depression. His body went into shutdown mode and following his 'nervous breakdown', he had to take a year out of university. Both Jules and James Cared felt the academic impact of living with depression. While James Cared did not take a year out, he experienced similar struggles:

I got to the point where...writing it [*exam*] where I was... I think I had like a little breakdown or something because just the stress and the anxiety and

all these things, you know, feeling like... just like... I was just terrified of cocking it up I guess and in the end... at that point, you know, I was like... I really have an issue here, like this is... you know, it's stopping me from functioning as a person anymore, so I, I... at that point I called the counselling service.

It was difficult for James Cared to leave his room for weeks at times, and even when he managed to his lectures he felt inadequate and as if he did not belong. In describing his feelings about trying to catch up with the curriculum having missed lectures, he recalls:

It's like trying to join the motorway without actually being at the right speed or understanding how to drive a car. Do you know what I mean? It's literally like you're there behind the wheel and you're like what, how did this happen? I can probably handle like driving up and down my street at about five miles an hour but Jesus, you know?

James Cared has been recently diagnosed with attention deficit disorder (ADD) and dyslexia. This contributed to his difficulties with managing coursework on time and attending lectures. Forgetting lectures made him feel 'shameful' and consequently led to missing more lectures and work submission deadlines. Lucy did not feel any academic impact of living with depression whilst at primary school and enjoyed going to school and 'loved learning' which provided a welcome distraction for her. She had her second bout of depression when she was 17, prior to her A-level exams. However, due to her personal beliefs and values she did not ask for help or mitigating circumstances:

I've done all the work, it wasn't like I hadn't revised, I was at the end of my tether, it was my last exam... I think I was just too far gone with... studying and I had panicked because of that. Obviously, I was just too, too worked

up, it was too late, that's all it was. I went down, I felt really ill, I felt horrible, I went down and done it, and it was fine, 'cos I still knew my stuff, I haven't forgotten it overnight, so it was all OK in that respect.

Lucy later adds that she got an A in her exams.

"It all fell down to chance"

It seemed at first *nobody noticed* what the participants were going through. When Jules moved to another school, he made new friends. He recalls that 'much later that people started asking 'are you OK? Is there something wrong?' Specially, one friend recommended that Jules should seek help. The teachers in the new school only found out Jules needed some help when he had to ask permission to leave school earlier, in order to go to some therapy sessions at a local hospital. Once he was at university, living in the halls, he recalled:

I didn't really know the people in my flat well enough... so when I was in my room for a week and never came out... they never really noticed that I wasn't there... and... on the actual night I was leaving... I sat down and told someone in the flat what had happened and... she said the weirdest thing which was... 'you know, I had a feeling a few months ago that something was wrong because there was some toast in the toaster that had just been left and no-one came and collected it.' So even... even then people had noticed something was wrong, they didn't feel like they knew me well enough to... ask what was wrong until I said to them.

Both Jules and James Cared had similar experiences of staying in the room and nobody noticing. James Cared mentioned: 'you could sit in a room for three weeks at a time and people probably wouldn't notice you know? That's the thing. And I think I spent a lot of first year doing that and nobody noticed- [*sighs*]' These are

moving reminders that both participants experienced, at least initially, social isolation. This was also reflected in James Cared's thoughts about some students, who made an attempt to invite him on a trip: 'they didn't have any obligation at all... other than just being good people.'

Both James Cared and Jules grappled with their identities: *they knew they needed help* but did not know how to 'do it.' They seemed to face their own inhibitions, lacked knowledge of mental health and language of emotions, or even energy when trying to describe what they were going through. For Jules, it 'was frustrating' and 'just... got more frustrating... frustrating that I couldn't tell anyone and frustrating that I couldn't even really understand... myself.' He blames himself for not accessing help and constructs his experiences as an illness: 'the support was there and I knew the support was there but I didn't feel able to use the support because I was too ill or not too ill but... I didn't feel able to do it because of the illness.'

James Cared experienced similar issues: 'it's hard to like... express what it's like when you're not... there.' He felt that others would not believe him, as he was an outgoing person. His constructions of masculinity withheld him from asking for help: 'I knew I needed help I just didn't know how to do it and I found straight up admitting my issue shameful so I couldn't do that'.

it's quite hard to like... I guess part of it, you know, being a bloke and that, like you're meant to be like - you have this thing about being strong, you know, you've got to be successful and all that kind of thing and like, you know, you don't need help, you don't ask for directions.

All participants *felt let down, to some extent, by the systems* they were in. When Lucy was a child, it seemed nobody at school noticed what she was going through.

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At home, her mum did not empathise with her, thinking that she was playing up or being stubborn about not eating her meals. Eventually Lucy's dad noticed his daughter's difficulties but no actions were taken to help her in terms of seeking professional help. It seemed Lucy felt a deep resentment, being let down by parent and teachers, particularly following a disclosure of abuse by another child that triggered her depression. Conversely, when she was in secondary school, she 'was offered all the counselling' but felt it was too little, too late.

Both Jules and James Cared felt that at university, they were let down by the pastoral support system in the halls: 'there wasn't really any' and that 'there were no checks and balances in place.' For both of them, accessing help was really difficult:

The university provides a lot of support but you have to go out of your way to find it. I didn't realise the counselling service was there until, you know, and like the first time I went and it was like it took me ages to find and I arrived late and I was just stressed out and the whole thing was stress so I just didn't go back and then I ended up going back because I needed it and actually it was just very hard to kind of access it at first and it's like... we provide this support for students but actually it's not, it's not about necessarily the support it's about the accessibility (James Cared).

By the time Jules accessed university support, it was too late for him as he had a 'nervous breakdown.' Ironically, although he was struggling at secondary school, he found support from some friendly teachers. However, he later found out that another student had dropped out of school due to living with depression: 'it is... difficult knowing it could have... could have very easily turned out... very differently and... I didn't massively have control of which way it turned out, it just fell down to chance...

which is scary to think about.' This poignant expression of 'falling down to chance' highlighted his powerlessness, lack of control and ability to access support. At sixth form, Jules's main source of support was through empathic friends, while James Cared, reflected how 'community and routine' were important, as before he started university, he had some 'strong support networks.'

When Lucy reflected back on her secondary school years, she recalled that some teachers were 'very supportive' and 'very sympathetic', especially her Head of Year. This referred both to Lucy being offered counselling, and her difficult home circumstances. She was allowed mitigating circumstances for her A-level exams and university exams, but did not take up this offer. Jules, was only offered help at secondary school 'during exam time', in the form of additional time.

All of the participants experienced, as Jules expressed: '*wellbeing treatment*'. For Lucy, this involved counselling but this was not helpful for her:

If that worked for another people, I think that's great, but it really did not work for me. Like some women [*laughs*] were just getting so desperate and one of them was like: 'oh well, you know, if you cannot do anything else, just say a prayer to God' [*laughs*], and I'm just saying: 'well, thanks for all of the suggestions, but you know, it's not very practical right now [*laughs*] at the moment.

At 17, during her second bout of depression, her dad 'made her go' to the doctors. She received help from a psychiatrist from children's mental health services. Lucy describes the professionals as 'gentle', 'kind', and 'caring.' She did not receive medication; and 'the fact that they understood me and... they understood what I was going through helped me'. She added: 'it was nice that I had someone who recognised what my illness, - and actually made me feel much better about it, made

me feel like I was a normal person for it.' This provided a powerful reminder of stigma, existing in society and community where Lucy lived, and also her deep beliefs about what constitutes 'illness.'

Jules experienced cognitive behavioural therapy (CBT), mindfulness, medication, and counselling: 'I thought it would be mostly receiving treatment and just fixing the depression and the anxiety but it was... much more of a well-rounded improving wellbeing treatment and I think it was a much more positive thing'; and 'this was needed in getting better.' He returned to university after taking a year out and is managing well. The participants expressed *longing for better support* when living with depression and their statements conveyed the psychological pain and distress they had experienced whilst living with depression.

Discussion

The aim of the study was to gain insight into young people's experiences of living with depression, and facilitators and barriers to accessing help. The data gathering process and analysis, using IPA, resulted in rich and vivid descriptions of participants' lived experiences. The reported themes are intertwined and present the essence of living with depression and while unique to each participant, there are common patterns in their experiences. These were unravelling through time and space, from primary school up to student years; difficult events and complex circumstances; psychological trauma, abuse (for two participants); and suffering and pain, experienced in relation to their bodies and to other people. The participants used lively and powerful metaphors to express their painful, lonesome experiences and existential struggles, for example: 'trapped by fear', 'what does it take to be alive?', 'steam train engine grinding to a halt', 'hurt inside' or feeling lonely 'with people around me'. In all cases, they communicate the distress and isolation experienced by the young people.

The participants' testimonies provided insight in to the extent to which they were prepared for university life and the extent to which they coped with their new life. They illustrate factors which both supported them and made them vulnerable. They also link to wider issues in relation to communicating depression, stigma about mental health and access to appropriate support. Some of these themes will now be considered in the sections below, with reference to previous literature.

Transition to university and preparing for adulthood

The participants' lifeworlds of transitioning to university were multifaceted as they were trying to establish and 'reinvent' themselves, whilst at the same time coming to terms with their past experiences. There are implications here for applying principles from the Preparing for Adulthood (2013) documentation, developed for young people with special educational needs and disabilities to a wider population, and to look at how support at university might be enabled through its four outcomes – paid employment, good health, independent living and community inclusion. Each area provides a template of what might need to be in place for students leaving home, particularly those who are vulnerable, or experience mental health issues. Notably, community inclusion was often an important factor in the testimonies of the young people in this research with the participants reporting how they found it helpful having friends they could talk to. How being listened to without being judged was important to them, and normalising their feelings enabled them to move on, minimising their overpowering feelings of shame and guilt. Conversely, the sense of isolation Jules experienced when living in halls left him vulnerable and exacerbated his feelings of depression. This suggests that while there is a need for activities which promote awareness and reduce risk of mental health difficulties (Thorley 2017), there is also a need to promote a caring and inclusive

culture, where students are vigilant, and are able to signpost help for, and support peers in distress.

Help seeking and accessing support

All participants discussed their experiences of accessing help. Some of the barriers to seeking help echoed findings from previous studies including: seeing this as a sign of weakness; constructions of masculinity (Danielsson et al. 2011); issues of stigma, associated with acknowledging difficulties (Children's Commissioner 2017); or not having anyone trusted to talk to (Kokanovic et al. 2013), as others' experiences and needs seemed more important. For Jules and Lucy this was particularly disempowering, as they felt insignificant in the context of both school, and family circumstances. It seems that they were in survival mode, struggling to understand the world around them and themselves, which impacted on their future experiences. However, this also relates to lack of awareness of mental health needs, as at the time neither of the participants knew what was happening to them. These findings link with what other young people experienced in terms of beliefs and lack of understanding about what is 'normal' (Danielsson et al. 2011; Issakainen 2014; Issakainen 2015).

Two of the participants were misdiagnosed with stress and carbon monoxide poisoning respectively, and as a result, received advice that although was not harmful did not help to understand their experiences or alleviate symptoms. Similar experiences of misdiagnosing or underdiagnosing depression in young people are echoed in wider literature (Farmer 2002; Ibrahim et al. 2013), although it should be acknowledged that in itself, a diagnosis is just a process of benchmarking against observable symptoms (American Psychiatric Association 2013) which does not take account of the historical, social or cultural context in which the individual's life is experienced. All participants wished they had more support when they were living with depression, including

counselling at primary school and in keeping with wider findings (DoH and DfE 2017) found that support was sometimes unavailable, insufficient, or hard to access when they really needed it. Two students were particularly vulnerable to isolation, overwhelmed by feelings, and not knowing where to turn to for support.

Previous research has highlighted issues in communicating depression (Martin and Atkinson 2018) and help-seeking (Rickwood and Thomas 2012). In this study, although attempts were made to seek support, there were issues with accessibility and timing, both of which emerged as problematic in Rickwood and Thomas's (2012) systematic literature review. Here the authors suggested that these elements are often poorly operationalised within the context of health seeking behaviour, with both timescales for support and the nature of the support itself not being transparent. Additionally, at one point Jules felt unable to use or access available support 'because of the illness'. With demand for student counselling services increasing (Thorley 2017), it might be that further discussion is needed about levels of provision, visibility and accessibility.

Lucy did not find counselling helpful as a younger child, and thus issues were unresolved and continued to cause problems when she started her university career. In terms of meeting students' expectations, Dunsmuir and Hardy (2016) promoted a more active role for young people in terms of setting aims, assessing progress and evaluating outcomes. It is not clear to what extent this sort of contracting might be possible, particularly when the counsellor offer may often be limited, for example to six sessions (Thorley 2017).

Stigma around concepts of mental health and mental illness might also have affected access to support. Lucy referred to a desire to feel 'normal' while James Cared talked about admitting his issue as 'shameful'. A study by Danielsson et al. (2011)

found that young people living with depression in Sweden just wanted to be normal, and felt pressure to conform to societal normative pressures. In this study, as in previous literature (Danielsson et al. 2011; Oliffe, Kelly, et al. 2010; Oliffe, Robertson, et al. 2010) stereotypical views of masculinity impacted on help seeking, with James Cared talking about 'being a bloke' and that 'you have this thing about being strong'.

Strengths and limitations of the study

One notable strength of the study was that all of the participants found process of interviewing helpful. More specifically, for two of them the process of three interviews facilitated deep reflections into their own experiences, even in-between the interviews. They reported gaining a new understanding of their lifeworlds of depression, as thinking to 'such a deep level' helped them to make connections with their life contexts, circumstances, and perceiving living with depression as a result of a multitude of factors. Therefore it could be tentatively claimed the process opened 'new horizons of understanding' (Smith et al. 2009), both for the participants and the researchers, and that to some extent the interview could be deemed to be therapeutic encounters. This resonates to some extent with Lewis (2014) who found that breaking the silence and isolation in adult learning communities helped to facilitate support and wellbeing (p.370).

The epistemological position of the study was critical realist, predicting some similarities with the participants' lived experience of depression. However, it was small scale and phenomenological, and thus limitations to both the objectivity of the lived experiences and the researchers' interpretations of these should be recognised. However, it can be argued that the accounts offered by the students and the themes identified from the analysis seem credible and findings have transferability to other contexts (Lincoln and Guba 1985). Volunteer participants were selected to try and

represent a range on perspectives on a shared life experience and steps such as recording and transcribing the data were taken to try and reduce threats to reliability and validity (Green 1999). Thus, there is potential to scrutinise the findings further. Finally, given that IPA requires researchers to make interpretations, the researchers' own perspectives will influence how the participants' accounts were interpreted. However, every effort was made to try and represent, and stay true to the participants' narratives (Lincoln and Guba 1985) and ongoing, reflexive conversations were held between the authors with this in mind.

Another potential criticism of the study is that it defined depression broadly from the perspective of the dominant, medical discourse (American Psychiatric Association 2013) rather than understanding depression as something which is socially and culturally constructed. While this perhaps is better representative of current thinking about depression at university (Thorley 2017, Universities UK 2017) it perhaps belies some of the broader social and cultural factors which impact on mental health and wellbeing. Undertaking the research from a more social constructionist standpoint might have helped to offer a more humanistic and socially-informed perspective on depression (Lewis 2014). Looking critically at social construction of depression, including power relations within the society and complex interrelatedness of environments, societal expectations of gender roles could shed more light onto depression and the healing process of creating "adult learning communities" where community members can support each other (*cf.* Lewis 2014).

This research provides an honest, and at times very moving insight into young people's experiences of living with depression, which goes beyond the scope of quantitative studies. It is increasingly recognised that people's experiences help to shape services, for example listening to patients' views to inform commissioning the National

Health Services in the UK (Barker 2015, Green 1999). It is hoped that although the findings of the current study are situated in time, culture and specific location, they will contribute to improving students' experiences and informing practice.

Conclusion and implications for practice

The study aimed to explore university students' lifeworlds and meaning-making of living with depression during their student years. The participants identified what was helpful for them, barriers to accessing help as well as what they would have liked to happen when they were living with depression. The study, despite its limitations, has a number of implications for parents, young people, and professionals working with them. These include the importance of raising awareness about depression (as despite common themes it could be experienced in unique ways, and this can inform further help seeking/receiving), reducing stigma around mental health needs and mental health help seeking; and being aware of vulnerability to depression factors, such as transitions, bullying and abuse and complex environmental circumstances. There are also some implications regarding university student services and transition to student life, including not only providing support for students but also ensuring this is easy to access.

Idiographic in nature, the study valued individual and unique experiences of students, by exploring patterns of divergence and convergence between different narrative accounts. The lifeworlds of living with depression were complex and multi-faceted; however, one of the pertinent messages was that of being listened to was valued. Hobbs, Todd, and Taylor (2000) discussed how the importance of professionals listening to young people cannot be underestimated. It is through the process of listening that new meanings emerge that could make a positive change in people's lives.

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Table 1. Participant information.

Pseudonym	Age	Gender	Age when started living with depression
James Cared	21	Male	Experienced 'melancholy' in his life; living with depression started on transition to university. Managing living with depression well.
Jules	20	Male	Lived with depression during secondary school/ sixth form but experienced living with major depression on transition to university. Had to take a year out of university to 'get better'. Managing living with depression well.
Lucy	19	Female	At primary school but no support given. Second bout of depression during secondary school, when 16/17, support offered. Not currently living with depression.

Figure titles

Figure 1. Stages of IPA analysis. Adapted from Smith, Flowers, and Larkin (2009).

Figure 2. Findings: master themes (big circles) with subthemes.