ME, MYSELF, AND DEPRESSION: IDENTITY CONSTRUCTION AND DEPRESSION

by

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ABSTRACT

RACHAEL RENEE THOMAS. Me, myself, and misery: identity construction and depression. (Under the direction of DR. CHRISTINE S. DAVIS)

In this narrative autoethnography, I write about and analyze my experiences with depression in order to understand how my identity is socially constructed within that context. Through thematic analysis, I use Goffman's (1963) identity theory as a sensitizing concept. This thesis extends the literature on the issues of identity and major depressive disorder by suggesting my attempts at passing as normal essentially enable me to seek out social interactions which may help me to feel accepted and less likely to continually self-stigmatize myself with depression. This thesis extends and complexifies Goffman's identity theory in several important ways: it teases out the concept from within—from the point of view of the person; it contextualizes it within a stigmatizing condition; it illustrates how identity is not only interpersonally constructed but is also intrapersonally constructed; it illustrates how identity is fluid and transformed.

TABLE OF CONTENTS

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

1:00 p.m. Like every other Monday and Wednesday of this semester, the time arrives to walk to campus with my roommates and head to class. Today, something feels different. Stephanie and Kasey yell down the hall of our apartment. “Rachael, let’s go! We’re gonna be late!”

Their shouts reverberate down the long, narrow hall before entering my distant doorway. Every word, every syllable, a piercing reminder of my academic obligation to trek to class and gag my lasting grief. With my head buried deep into my palms, I warily open my tired eyes and peer through the imprisonment of my slender fingers. I slowly lift my heavy head and drag my hands down my face as I take in a deep, steady breath. Exhale. “Not today. No. Not today. I just can’t handle them today. Leave me alone,” I think to myself.

Glancing down at my widespread hands, I study my “prison-cell” finger position and think to myself, “Solitary confinement. Never thought I would be wishing for that.”

“Hey, go on over without me. I’m wrapping up an essay before class so I’ll be a while. See ya later,” I bellow back from the sanctuary of the puny space I call a bedroom.

“All right. See ya later,” they shout in unison.

I gently rest my ear to my bedroom door anticipating the signal of my roommates’ departure. The door shuts. Thud.

Finally, I'm able to bask in the fleeting moments of privacy, but the unsettling thoughts persist.

"What is going on?! Shake it off!" I tell myself as I sigh.

I retreat to my pitifully petite bed to sit and dangle my feet off the edge. With my eyes transfixed on the stark white wall ahead, I ponder over this new predicament. "This will pass. It has to. It's just a phase."

Faint sounds of laughter impede my impromptu pep talk. Gazing out the window, I pinpoint the source of the sound. Students just like me, walking to class with their friends, laughing. They seem happy, genuinely in high spirits, enjoying the company of their friends.

"I wish I would have walked over with them. Actually, no. No I don't. What in the hell is wrong with me?" I say to myself.

Juxtapositions dominate me today. I clench the soft comforter beneath me as I ruminate over my latest inconsistencies. I crave the same social interactions while simultaneously yearning for sustained solitude. I hunger for an opportunity to share my thoughts while longing to suppress my new found emotions (Karp, 1994a). I plead for death while begging for life.

I close my eyes and once more my chest sinks as I let out another deep sigh. I open my eyes and look over at the red illuminated numbers on my alarm clock. "1:45 p.m.! Already? Better get to class!"

The walk to class seems unspeakably long today. The stint of silence I coveted earlier seems torturous. Wretched sorrow, hopelessness, and despair rule over me, dominating my every thought. I scan the trees, searching for some semblance of

contentment. It's fall; my favorite time of year. Vibrant reds, yellows, and oranges paint the autumn foliage. As a brisk gust of wind runs through my hair, I remain unshaken. Before, I found every waft of the fresh fall air invigorating; stimulating my senses and bestowing hope for my very being. Now, I feel different. Amidst the perfect pigments and bracing breezes of fall, dejection emerges and I brood over the advance of another bleak and burdensome winter. I take a deep breath. The air is stale.

"Pull yourself together," I think to myself, trying to shake the persistent thoughts of despair.

I reach for my iPod as I wait to cross the hectic road to class. Perhaps music will tame this savage beast. Nothing else seems to be working.

Toxic fumes of passing semi-trucks fog my vision and saturate the atmosphere. The trucks pass at a staggering pace. One, then another, and then another. They seem relentless. The feelings of melancholy and misery materialize and haunt my thoughts.

I look to my left. Another semi approaches from the distance.

"One step forward. That's all it would take. One step and all of the inescapable pain and despair would be gone. One step," I wonder.

I look over to my right. Another student stands next to me waiting to cross the road. She prudently pulls her long auburn hair to her side and then continues to text in a frenzy. I imagine her texting her friends, eagerly anticipating some party planned for this weekend. She seems poised and pulled together. Her dark brown eyes shift to the left. She's noticed me staring. Trying to avoid eye contact, I hastily glance back to the steely asphalt. Another titanic truck advances in the distance. I continue to contemplate this

stranger. She emanates a sense of personal control. I envy her. But no, I envy her control. I need to go back to who I was before… this.

"But who am I now?" I think to myself. These persistent thoughts force me to redefine myself. I remember reading about how Fee (2000) describes depression as a "discursive and reflexive process of self-definition and identity construction" (p. 75). I agree that depression has changed me, but who exactly am I now? What is my new identity?

The semi passes and brings me back to the moment. The crosswalk sign illuminates and we stroll across the street. I seem to be walking at an unusually slow pace as if the rubber soles of my shoes were melting beneath me. Out of the corner of my eye, I see the girl advancing, preparing to pass me by. As she walks ahead of me, I wonder, "Can she tell? I wonder if other people can see how different I feel? How can I disguise this? I don't want to freak people out. No one can know."

I think back to some of the work I read by Fee (2000). He argues that depression is part of the self that informs self-construction (Fee, 2000). I suppose I agree. Maybe my depression instigates my constant hyper-awareness of my surroundings. Since I've been dealing with depression, all I do is worry about how my friends, my family, and even strangers will react or treat me if they find out (Hewitt, Fraser, & Berger, 2000). Even if I did tell people about my depression, what would that even mean to them? They don't have it. How does saying, "I suffer from depression" truly convey the immense inner feelings that tear me apart and smother my lust for life (Karp, 1994a)?

"They wouldn't understand. How could they understand?" I ask myself. "For God's sake, last week Stephanie flippantly said she was depressed about getting a B on

her accounting exam as she reached for a pint of Ben and Jerry's from the grocery freezer, laughing at her comment." They obviously wouldn't get it.

"If they knew, they would think I was weak, weird, and wired improperly," I think.

I suppose this does reflect some aspect of my new identity, but what part and how? What does this mean? I perpetually dwell on how inferior I'm afraid I will appear to others if they uncover the truth (Bakhtin, 1984; Johnson, 2010). How can I avoid this?

Some work I read in class this week by Goffman (1959) suggests a need to perform normalcy and redefine myself. People who fail to perform the expected social performance often experience stigmatization (Gergen, 1971, 2009; Goffman, 1959, 1963). I must perform "normal" (Jago, 2002). But what does that make me? My mind swarms with thoughts of fear and I try to pinpoint just how I can appear normal to others. My only defense from stigma is this act (Clarke, 2008). Depression affects the roles I play (Hewitt et al., 2008) and I must act "normal" for my own impression management (Goffman, 1959).

I scan every student that passes by, taking meticulous mental notes, "How to be normal: Chapter One."

Step by step, I continue my diffident dawdle to class. I enter the classroom, keeping my head pointed toward the ground. I need to learn to perfect this role (Burke, 1945). I need to learn how to look "normal." Until then, what I need to do is avoid any social interaction. I take a seat in the closest desk and pull out my notebook and pen to sketch doodles. I keep telling myself, "Don't look up."

Staring at the faint blue lines paralleling one another in my notebook, disgust suddenly overwhelms me. “I can’t believe I almost forgot to work on my paper for Research Methods class!” I say to myself. “I need to think of a research question by tomorrow.”

The sheer chaos of depression seems to demolish any shred of organization and control I once maintained and my school assignments slip through the cracks. “Come on, come on,” I mutter to myself. “Think of a research question.”

As I sit alone with my head buried in my notebook, a question bursts forth, “How do my experiences with depression contribute to my identity construction?”

As I ruminate over this, I wonder how others experience depression. Waiting for class to start, I pull out my phone and start searching Google for a place to begin. In the U.S. alone, one in four adults experiences a mental health issue in a given year and roughly 15 million of those adults suffer from major depressive disorder (National Alliance on Mental Illness, 2013). Where do my personal experiences with major depressive disorder connect with experiences of others with mental health issues? The question lingers and I ask myself again, “How does my depression experience connect to those people? How can my personal understanding of my depression experience link to others’ understandings of their mental health issues? Can my awareness help others?” The questions invade my mind like some mental interrogation.

I need to pursue this. I glance back at the blank lined paper in my notebook and then to the mechanical pencil resting in my hand. “Writing,” I suddenly think to myself. “That’s one sure way to comprehend this train wreck of depression.”

All of my questions of identity and connection to the larger social context; writing, narrative can sort this out. I think about a book I recently read for class and the words of Frank (1995) flash before me.

> Stories do not simply describe the self, they are the self's medium of being. Stories have to repair the damage that illness has done to the ill person's sense of where she is in life, and where she may be going. Stories are a way of redrawing maps and finding new destinations. (p. 53)

Maybe writing is the answer. Maybe Frank (1995) was right when he argued that storytelling gives new insight of the self and relationship to the world. The doorknob rattles. I warily glance on over my shoulder and see the classroom door open, interrupting my moment of epiphany.

The professor enters the room. The class hushes, but my depression wails.

Rationale

My depression wails and in this, I know I am not alone. Depression is the third most common cause of hospitalization in the United States (NAMI, 2013). Moreover, major depressive disorder stands as the leading cause of disability in the United States and is expected to be the second most leading cause of disability in the entire world by the year 2020 (World Health Organization, 2001). In fact, in May 2012, a World Health Assembly resolution called for a "comprehensive, coordinated response to mental disorders at a country level" (World Health Organization, 2012). The rising number of sufferers suggests that depression is a crucial domain of inquiry within the discipline of health communication.

Major depressive disorder consists of several debilitating symptoms that can include "depressed mood, loss of interest and enjoyment, reduced energy leading to diminished activity for at least two weeks… anxiety symptoms, disturbed sleep and

appetite and feelings of guilt or low self-worth, poor concentration and even medically unexplained symptoms and suicide" (World Health Organization, 2012, lines 25-30). Depression can also drastically inhibit the individual's ability to function "with social, work, or domestic activities, except to a very limited extent" (World Health Organization, 2012) and a person's quality of life may diminish as depression interferes with the roles a person plays in the workplace, relationships, and society (Kessler et al., 2003). In addition, Kessler et al. (2006) found that mood disorders, like depression, cost more than an estimated $50 billion per year in lost productivity as well as 321.2 million lost workdays, demonstrating the immense impact depression wields over the workplace.

CHAPTER 2: LITERATURE REVIEW

I first review the existing literature on depression and the gender differences of depression. Next, I examine the research on depression and stigma and explore the concept of depression and identity. Finally, I discuss the current literature on social constructionism in relation to depression and identity and review studies of depression narratives.

Depression

Despite the prevalence of depression sufferers, the exact cause of the illness is yet to be determined and is still disputed among scholars. Some claim depression is of biological origin while other scholars argue that the disorder is of psychological origins (Deacon & Baird, 2009; Van, 2004). However, a combination of these factors is a common explanation (World Health Organization, 2001).

Such differing explanations reveal the ambiguity and uncertainty of depression. This is an especially relevant characteristic in terms of the meaning sufferers attach to the experience (Kleinman, 1988). For example, sufferers often insist that words cannot perfectly portray the experience of depression, describing the experience as an indescribable illness. (Styron, 1990; Wolpert, 1999). Styron (1990) highlights this difficult description:

> Depression is a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self--to the mediating intellect--as to verge close to being beyond description. It thus remains nearly incomprehensible to those who have not experienced it in its extreme mode, although the gloom, "the blues" which

> people go through occasionally and associate with the general hassle of everyday existence are of such prevalence that they do give many individuals a hint of the illness in its catastrophic form. (p. 5)

While the cause of depression remains uncertain, one effect that is widely accepted is the sufferers' urge to withdraw from social interaction (Fee, 2000; Karp, 1996). In fact, individuals with depression experience a paradox from this social withdrawal where the urge to isolate themselves is accompanied by the realization that self-isolation will only intensify their suffering (Karp, 1996). However, because depressive feelings make interaction difficult and demanding, the need to withdrawal often supersedes the realization of its consequences (Karp, 1996). For this reason, the relationships of individuals with depression often suffer due to this retreat from interaction.

Another presumed consequence of depression is that the individuals' perceptions of reality are often affected (Alloy & Abramson, 1988; Beck, 1967; Beck, 1979; Beck, Brown, Steer, Eidelson, & Riskind, 1987). Some scholars believe depression brings about a distorted perception of reality from a negative cognitive bias leading to uncontrollable and reoccurring negative thoughts, behaviors, and beliefs of the world (Beck, 1967; Beck, 1979; Beck et al., 1987). However, others believe that this negativity creates a more precise assessment of the world and that non-depressed persons are more positively biased (Alloy & Abramson, 1988). These contrasting views of perception demonstrate yet another ambiguous characteristic of depression that may influence the sufferer's illness meanings.

Gender and depression. Gender is also a factor in depression as more women than men suffer from the illness (World Health Organization, 2001). This prevalence of

depression among women is often attributed to an excessive hormone imbalance (Noble, 2005; Studd & Panay, 2004; Studd, 2011). Lower socioeconomic status among women also plays a role (World Health Organization, 2001). Another possible explanation is gender bias among physicians, whereby doctors are more likely to diagnose women with depression over men (World Health Organization, 2001). Additionally, women are more often prescribed mood-altering medications than men (World Health Organization, 2001).

Depression representations. The relationship between depression and gender extends beyond the diagnosis and treatment of the illness. In fact, cultural sayings and metaphors that convey women as a more emotional gender are often adopted and "narrativized in relation to the gendered values of depression" (Clark, 2008, p. 111). These cultural representations are significant because social meanings of depression arise out of the language surrounding the symptoms of the illness (Kleinman, 1988). Sadness causes social misunderstanding as this depression symptom can be mistaken as nothing more than a "normal" emotion that has been medicalized (Horwitz & Wakefield, 2007; Leventhal, 2008). Lack of energy also causes misunderstanding as many view this depression symptom as weakness or laziness (Payne, 2008).

Media portrayals of individuals with depression continue to concentrate on the biomedicalization of the illness. This concept of biomedicalization assumes that every person with depression needs to be placed on medication (Smardon, 2008). Through this representational model, those individuals can then be placed into "productive" roles in our society only after receiving medication (Johnson, 2008). More specifically, women with depression are targeted due to perceptions of women as being biologically inferior

because of emotion, leading to the commodification of women via prescriptions sales (Kundrat & Nussbaum, 2003; Smardon, 2008). In addition, the public presumes that people with mental health issues are burdens to society (Edney, 2004; Wahl, 2001). These cultural representations of depression further stigmatize major depressive disorder and provide stereotypical portrayals that promote misunderstanding of depression for the public and stigma for the sufferer.

Stigma

Stigma is "the social rejection of individuals based on personal or social characteristics such as race, religion, and mental or physical health status" (Chung & Slater, 2013, p. 894). Goffman (1963) outlines three different types of stigma: (1) stigma of physical deformities, (2) stigma of a blemished character, and (3) tribal stigma of race, nation, and religion.

The stigmatized traits are ascribed by society to those who stray from social "norms" (Goffman, 1963; McHatton & Correa, 2005). The process of stigma commences and thrives from a four step process which includes (1) distinguishing and labeling differences, (2) associating human differences with negative attributes, (3) separating "us" from "them," and (4) status loss and discrimination (Link & Phelan, 2001). Stigma includes the role of a stigmatized person and a stigmatizer, by whom the stigmatized person is established as abnormal and different (Goffman, 1963).

One important factor of stigma is concealability, which refers to the degree a stigmatized condition or trait is visible or invisible (Jones et al., 1984). While visible stigmas arise from traits seen by others, invisible stigmas are the traits of a person that are not readily apparent to others (Chaudoir & Fisher, 2010; Jones et al., 1984). Both visible

and invisible stigmas influence the way stigma is experienced by the individual. A person with visible signs or traits of difference is a discredited individual (Goffman, 1963; Joachim & Acorn, 2000; Lingsom, 2008). A person with invisible signs of differences is a discreditable person, but not yet discredited (Joachim & Acorn, 2000). However, while many believe discreditable persons with invisible stigmas have an advantage over discredited persons with visible stigmas, discreditable individuals experience an additional threat to their identity as they run the risk of exposure (Joachim & Acorn, 2000).

These discreditable persons often face the issue of trying to decide whether or not to disclose information of their stigmatized condition or trait (Goffman, 1963; Joachim & Acorn, 2000). They can try to "cover," in which the person downplays their stigmatized characteristic or they can attempt to "pass" by deliberately concealing the unwanted difference (Joachim & Acorn, 2000). While "passing" as normal, discreditable persons often experience anxiety, embarrassment, and fear of being discovered or exposed (Goffman, 1963; Joachim & Acorn, 2000; Thorne, 1993). Also, these people often feel a sense of guilt as concealment may lead them to lie to others about their stigmatized trait (Goffman, 1963; Joachim & Acorn, 2000).

Whether the person is a discredited or discreditable individual, stigma produces several negative effects. Often the stigmatized person encounters immense psychological distress and loss of self-esteem from the discrimination experience (Zebrowitz & Montepare, 2003). They may experience a diminished social status, poor mental health, physical illness, and limited access to social opportunities (Quinn, Kahng, & Crocker,

2004; Weiss, Ramakrishna, & Somma, 2006). Stigmas mold the stigmatized person's identity and can impact their behavior (Miller & Major, 2000).

However, Goffman (1963) shares several helpful suggestions for dealing with the stigmatizers whom he labels as "normals" which include:

1. assume that 'normals' are ignorant rather than malicious
2. no response is needed to snubs or insults, and the stigmatized should either ignore the offence or patiently refute the views behind it, which often means adopting an unusually perceptive and analytic self
3. try to help by reducing the tension, breaking the ice, using humor even self-mockery
4. treats 'normals' as if they were honorary 'wise'
5. follow disclosure etiquette, for example by using disability as a topic for serious conversation
6. deploy tactful pauses to allow recovery from shock
7. allow intrusive questions, and agree to be helped
8. try to see oneself as 'normal' in order to put 'normals' at ease

Depression and stigma. Mental health-related stigma falls into the category of a stigma of flawed or blemished character (Goffman, 1963). Therefore, as a mental health issue, major depressive disorder is a stigmatized condition where the sufferers are considered to be inherently flawed (World Health Organization, 2000). Stigmas of mental health issues radically differ from stigmas of physical disorders simply because of the location of the disease in that, often the mind and body are viewed as separate entities,

with the mind representing the essence of a person (Duncan, 2000; Schramme, 2013; Wolpert, 2001).

Unless disclosed, depression is an invisible stigmatized condition, making the sufferer a discreditable person (Lingsom, 2008). Subsequently, attempts to disguise depression from others for fear of stigmatization reveal another dimension of the illness (Chesney & Smith, 1999; Corrigan, 2004). Individuals with depression, at some level, maintain a concealable stigmatized identity (CSI) in which their identities as individuals with depression are not immediately visible to others (Quinn & Earnshaw, 2011). Concealment of the depression experience is often considered an advantage as the option of passing as "normal" offers a certain amount of privilege that other people with visible stigmatized identities are not rewarded (Lingsom, 2008). This privileged ability is arguably considered an opportunity for the individual to construct a different identity (in place of their depression identity) by avoiding stigmatization (Lingsom, 2008).

However, the disadvantages far outweigh the presumed benefits of having a concealable stigmatized identity that people with depression maintain (Newheiser & Barreto, 2014; Lingsom, 2008; Quinn & Chaudoir, 2009; Quinn & Earnshaw, 2011; Sedlovskaya et al., 2013). Depression sufferers who attempt to conceal their depression identity can often increase the burden of the disease, which can lead to delayed help-seeking or termination of treatment (Lingsom, 2008; Weiss et al., 2006; World Health Organization, 2012). Additionally, CSIs arguably complicate the process of understanding one's own self as the individuals can often be in flux between pre- and post- impairment identities and may experience cognitive dissonance based on understandings of their public and private selves (Lingsom, 2008; Sedlovskaya et al.,

2013). Therefore, the trials of major depressive disorder most likely impact an individual's understanding and construction of their identity.

Effects of depression stigma. Stigmas of mental health issues like depression disqualify individuals from full social acceptance (Weiss et al., 2006). Credibility of the depression sufferer also comes under attack as mental health issues are viewed as more controllable than physical disorders, inferring numerous stereotypes to emerge such as the causal belief of depression as a weakness of character (Cook & Wang, 2011; Corrigan et al., 2000).

This lack of social acceptance is demonstrated when many individuals who do not know someone with depression or who lack familiarity with mental health issues have a higher chance of increased social distance from an individual with a mental health problem (Anagnostopulos & Hantzi, 2011). These attitudes often lead many to distance themselves from those with depression (Anagnostopulos & Hantzi, 2011). Therefore, the lack of education and understanding of mental health issues alone can lead to the construction of those individuals as "others" through this stigmatization and can even create social barriers that prevent the formation of relationships. Such factors of potential isolation and stigmatization influence an individual's decision to disclose mental health concerns with others.

Although disclosure of depression reduces the effects of self-stigma for the sufferer (Corrigan et al., 2010), concealment is often practiced and unfortunately, tends to further progress the affliction of depression, impair relationships, and decrease belongingness (Newheiser & Barreto, 2014). Also, hiding depression can lead people to avoid social support (Newheiser & Barreto, 2014; Quinn & Earnshaw, 2011).

While stigma can affect help-seeking behavior, another crippling effect of the stigma is that it increases self-stigma. Self-stigma exists when people with a mental health issue begin to stigmatize themselves (Griffiths, Christensen, & Jorm, 2008). This often occurs when a person lacks information about depression and obtains knowledge in different ways. Self-stigma often results in the development of negative attitudes and perceptions about individuals with depression as well as themselves (Corrigan, 2005; Manos, Rusch, Kanter, & Clifford, 2009). As Kleinman (1988) suggests, a person with a stigmatizing condition eventually comes to expect stigmatized reactions, preparing for such reactions "before they occur or even when they don't occur" (p, 160). However, a unique paradox can exist for individuals who experience stigma where it can also lead people to "become righteously angry because of the prejudice that they have experienced," encouraging them to seek treatment and advocate for better services (Corrigan & Watson, 2002, p. 18). However, such persons do not reflect instances of self-stigma because they lack a negative perception of themselves aligning with social stigmas of depression. Instead, this "righteous" reaction may be a stage of understanding for depression sufferers. Karp (1996) reports a similar need of public understanding of depression, but extends this empathetic desire by showcasing a conflicting emotion:

> Those with depression may collectively want a greater public understanding of their "illness," but in the midst of an episode of depression individuals feel a self-hatred far greater than could possibly be expressed by others toward them… Depression assumes a momentum as persons spiral downward into ever more profoundly difficult emotional feelings. In this process the dialectical intersection of self and society is most plainly seen. (p. 47)

Karp's (1996) description poignantly presents the ever-present trials of depression. Here, the crossroads of understanding and self-hatred present for depression sufferers seem to result in the triumph of self-hatred over public support. Furthermore, this tension highlights depression as a site of identity construction as the emotions toward the self can feel crueler than anything anyone else could say, while at other times, the consideration of perceived social identity can produce a desire for public understanding.

Despite concealment of depression, stigmatization can still be experienced by the sufferer (Newheiser & Barreto, 2014; Lingsom, 2008; Quinn & Chaudoir, 2009; Quinn & Earnshaw, 2011; Sedlovskaya et al., 2013). For instance, in efforts made to avoid revealing the illness, sufferers may experience anticipated stigma, dreading how they believe others could potentially react to a revealing incident (Goffman, 1959; Quinn & Earnshaw, 2011). Therefore, individuals with depression are constructed as "others" through stigmatization from others and from themselves. Nevertheless, individuals with depression can "resist the stigmatizing identity, or he may accept it; either way, his world has been radically altered" (Kleinman, 1988, p. 160).

Depression and identity

Scholars argue that stigma can also lead to the application of learned social norms and standards linked with social identity (Corrigan, 2004; Goffman, 1963; Oakley et al., 2012; Rusch, Todd, Bodenhausen, Olschewski, & Corrigan, 2010). Identity results from the performances in everyday life, in which the individual either (1) completely immerses his or herself in the act, truly believing the act to accurately represent his or her account of reality, or (2) is aware that the performance may not be accurate and the impression cultivated is simply an act (Clarke, 2008). Goffman (1963) describes three types of

identity – social identity, personal identity, and ego identity. Social identity concerns the characteristics and the category an individual retains in relation to others. Furthermore, virtual social identity concerns the attributes placed on strangers resulting from assumptions made (Goffman, 1963). Stigma is the divergence of social identity and virtual identity (Goffman, 1963). Personal identity concerns what makes a person unique and an individual, whereas ego identity is the subjective sense of ourselves or how we feel about ourselves (Clarke, 2008; Goffman, 1963).

Individuals with depression often feel a sense of relief upon hearing the words "mental illness" from their doctors' diagnosis (Karp, 1996). This demonstrates how discourse through interactions have the ability to shape the meaning of the depression experience for the sufferer and influence the meaning of the diagnosis in terms of their identity as well. Furthermore, depression sufferers also experience a series of identity turning points throughout their depression experience in viewing themselves and their depression (Karp, 1996). Karp (1996) outlines these turning points:

1. A period of *inchoate feelings* during which they lacked the vocabulary to label their experience as depression.
2. A phase in which they conclude that *something is really wrong with me.*
3. A *crisis stage* that thrusts them into a world of therapeutic experts.
4. A stage of *coming to grips with an illness identity* during which they theorize about the cause(s) for their difficulty and evaluate the prospects for getting beyond depression. (p. 57)

Social construction and depression

Depression and identity construction.

Goffman's classic types of identity embrace a social constructionist framework for constructing identity as a person with depression. Social constructionists believe that identity is constructed by the language present in our culture and through our social interactions with others (Burr, 2003) Furthermore, discourses present in our culture that construct our identities can also place limitations on what kinds of narratives we tell about our experience (Burr, 2003). For instance, the cultural discourse surrounding depression that constructs a person's identity directly influences what they say about their depression experience. As such, a person's identity is constantly being recreated (Gergen, 1971; Johnson, 2010). Social perceptions of depression via stigmatization experienced and witnessed and self-stigmatization converge to reflect social values that define what is considered "normal" in society. For example, "weakness of character" that is perceptually related to depression reinforces the idea that people with depression are not "normal" members of society (Cook & Wang, 2011). Such cultural discourses of depression shape the sufferer's identity and influence their discussions of "normality" and "depression," which constitutes the sufferer as subject of the discourse (Burr, 2003). Often such subjectivity in cultural discourse creates a struggle in positioning oneself in different discourses (Burr, 2003). Fortunately, a person gains agency in this positioning by acknowledging and resisting such unacceptable positions placed on depression sufferers and developing strategies to assume positions in different discourses (Burr, 2003). For this reason, the social constructionist framework examines language, which expresses social values demonstrated via stigmatization and other social interactions as a means of socialization (Berger & Luckman, 1989; Johnson, 2010).

Different avenues of research have explored the relationship between the construction of identity and depression (Fee, 2000; Hewitt, Fraser, & Berger, 2000; Horwitz, 2012) However, additional research proposes that the nature of depression itself may play a role in constructing identity. Hewitt and colleagues (2000) explain that depression influences identity as it leads people to envision circumstances where they are typecast as unwanted people, spurring suspicions of their roles in relationships (Hewitt et al., 2000). Depression can also be understood as a mood extreme and "not an expression of the real self, but of something else" (Beike, 2008, p. 36). Such studies argue that depression is a contributing factor in the construction of self as the self is created from cultural awareness and reflexivity (Bakhtin, 1984; Fee, 2000; Gergen & Marlowe, 1970; Johnson, 2010). Another interesting finding is that some described depression as a living entity (Fee, 2000; Karp, 1996; Styron, 1990). Finally, the self that is often described while in the midst of depression, ironically, is a total lack of self altogether (Jago, 2002; Karp, 1996). Jago (2002) highlights this absence of self as she writes, "One of the worst aspects of depression is the ability to watch yourself disappear, unable to act in self-defense" (p. 743).

For this reason, depression can be understood as a fundamental site of identity construction to create meaning and understanding for the depression sufferer (Fee, 2000).

Social constructionists define the self as created in reference to cultural constructs and interactions in our lives (Cerulo, 1997), thereby making knowledge something that is co-constructed, which brings about the relational being (Gergen, 2009). The relational being suggests that the creation of identities is inseparable from relational processes and interactions with others and therefore, relational discourse holds significant weight in

shaping identity for the depression sufferer (Baxter & Montgomery, 1996; Berger & Luckman, 1966; Gergen, 1999; Mead & Morris, 1962).

Depression and narrative

Narrative theory has often been used to share stories of illness experience (Clark, 2008; Fee, 2000; Frank, 1995; Kleinman, 1988). The theory views the world as a set of stories from which we choose and through which we constantly re-create our lives (Fisher, 1987). Narratives often describe depression as a chaotic experience with a fluid frame for establishing a sense of self (Fee, 2000). Nevertheless, while depression may present a convoluted frame for constructing identity, it still provides a site for understanding that is ripe for exploration just as other 'tools of experience' for identity construction have been studied (Fee, 2000). However, many existing narratives fail to explicitly address why identity construction with depression can be viewed not only as a challenge, but as a necessity as well (Fee, 2000).

Understanding the influence depression wields over individuals in constructing their identities prompts the exploration of narrative. Franks (1995) writes, "The way out of the narrative wreckage is telling stories, specifically those stories that Schafer calls self-stories…The self-story is being *formed* in what is told" (Frank, 1995, p. 55). More specifically, narrative provides understanding of depression and functions "as repair work on the wreck" (Frank, 1995, p. 54).

Narrative may provide an outlet for cathartic understanding and sensemaking of depression as narrative identity gives birth to a new self through stories (Frank, 1995). Narrative provides a means of creating a new self that is separate from the "biological processes known only through socially constructed categories that constrain experience"

(Kleinman, 1988, p. 17). This also supports the social constructionist view that narrative can identify the varying identities that people with mental health issues occupy (Pickering, 2006). Desalvo (1999) writes “there cannot be a wounded body in need of healing without a wounded psyche or spirit that is also in need of healing” (p. 184). This restoration of order occurs through narrative. Frank (1995) describes this restorative process; “only the communicative body can reclaim interruption because only it associates with its own contingent vulnerability. The communicative body makes this contingency the condition of its desire, reaching toward others who share this vulnerability. (p. 165).

Narrative gives voice to the vulnerable whereby connections to other vulnerable persons are attainable. Storytelling not only invites a new perception of self, but a more profound relationship to the world (Frank, 1995).

Finally, because social meanings of depression are also constructed from the discourse surrounding the symptoms of the disease (Kleinman, 1988), narrative offers an opportunity for depression meanings to be reframed in a new light and understood from a social constructionist perspective. For this reason, this study will examine my depression narratives to understand how my depression socially constructs my identity. This leads to my research question:

RQ: How is my identity socially constructed in the context of my experience of depression?

CHAPTER 3: METHOD

This study consists of narrative autoethnography highlighting my experiences with depression. I first composed narratives that conveyed my experiences with depression through self-introspection and intensive review of my own journal entries. Then, the stories served as "data" as I examined how my identity was socially constructed in the context of my depression experiences.

In this study, I analyzed the narratives through the theoretical framework of social constructionism and Goffman's identity theory (1963). A social constructionist framework was "used as a means to understand the nature of the knowledge production and therefore can provide a researcher with philosophical scaffolding in the process of making sense of the research enterprise" (Maydell, 2010, section 5).

Data collection

I collected my narratives that convey my depression experiences through two primary means. First, I utilized self-introspection which enabled me to reflect on my most poignant depression experiences and construct my narratives from memory. Second, I also thoroughly reviewed my own journal entries that were written in the midst of the experiences. This method of data collection was a substantial supplement to self-introspection as it provided critical details that helped me to construct the most accurate narratives of my experiences. Finally, after I constructed the narratives, I arranged them in chronological order.

Narrative autoethnography

Narrative autoethnography best suits this study's research question in that it is the "idea of multiple layers of consciousness, the vulnerable self, the coherent self, critiquing the self in social contexts, the subversion of dominant discourses, and the evocative potential" (Cresswell, 2013, p. 75). The method enabled a deeper connection and revelation of the self and meaning identification not only through the process of writing the narratives, but through viewing and analyzing these personal stories as "complex, formative, meaningful phenomenon" that provided lessons on morals and ethics, introduced different ways of thinking and feeling, and enabled myself and others to make sense of ourselves (Bochner, 2001).

Fee (2000) mentions one of the most difficult communicative dilemmas for depression sufferers is the inability to convey the gravity of experienced emotions (or utter lack thereof) to those without depression. Writing my personal narratives gave my depressed self a voice through which I analyzed the experiences and their influence on my identity construction.

Data analysis

In this study, I analyzed the narratives through the theoretical framework of social constructionism. Often, the analysis of autoethnography comes from the writing (Ellis, 1999; Ellis & Bochner, 2000). For this reason, the analysis of data occurred by identifying and examining themes that emerged from my narratives and as I wrote the narratives. Spry (2001) warns that "good autoethnography is not simply a confessional tale of self-renewal; it is a provocative weave of story and theory" (p. 713). Taking this advice to mind for autoethnography, I performed thematic analysis from a social

constructionist perspective searching for emergent themes to identify how my experiences of depression, illustrated through my narratives, constructed my identity via Goffman's (1963) identity theory.

To follow a social constructionist perspective in my analysis, I focused on the meanings that I created, maintained, and changed within my social interactions with others, whether in the presence of others or not. By carefully examining my narratives from this perspective, I was able to identify how I viewed the world amidst my social interactions and how I constructed my depression identity. For example, often in the narratives, I would think about how I perceived that others were viewing me in an interaction, which led me to construct my identity as either unaccepted and stigmatized or accepted and in control.

More specifically, thematic analysis was performed to identify the meaning of the narrative texts by categorizing the data into thematic categories (Davis, Gallardo, & Lachlan, 2010). To assess the meaning of the narratives in relation to the topic of this study's research question, Braun and Clark's (2006) phases of thematic analysis was implemented. To manage and keep record of the coding strategies implemented, I used NVivo computer software. First, I ensured familiarization with my narrative texts. To do so, I read through the data several times to gain such familiarization. I used concepts from Goffman's (1963) identity theory as sensitizing concepts to develop thematic categories through a process of constant comparison. I used Goffman's (1963) concepts as sensitizing concepts by drawing attention to the three essential identity types: (1) personal identity, (2) social identity, and (3) ego identity. These concepts offered a means of organizing the analysis and understanding my depression experiences by reviewing the

narratives with these concepts in mind. These concepts informed the overall analysis and the emergent themes. The narratives that best illustrate my emergent themes are highlighted as support in the following results and discussion chapter.

Ethical considerations

While the analysis of my depression experiences brought about an in-depth understanding of the phenomenon, the ethics were carefully addressed. Being that I was writing about some of the darkest, traumatic, and painful experiences I endured with depression, the concern of relapse or elevated anxiety needed serious consideration. Ethical concern and responsibility for the researcher's wellbeing is often a topic that is rarely discussed. Chatham-Carpenter (2008) makes a few suggestions for researchers on protecting ourselves. For this study, I implemented some of these cautionary suggestions to protect myself from unnecessary harm. First, I scheduled regular meetings with my thesis advisor. These meetings served as an organized routine to maintain interactions with others while discussing my plans for revealing and analyzing my depression experiences in an environment that supported my exploration of the topic as well as my overall wellbeing. Another strategy to avoid harm to myself was to schedule regular appointments with the campus counselor where I shared the narratives written of my depression experience, ensured my wellbeing, and protected against a provoked reoccurrence of depression. These appointments also helped me to make sense of my depression experience.

Relational ethics. As this is a narrative autoethnography, the narratives included not only my experience, but the experiences of others as well (Ellis, 2007). The names of ancillary characters were replaced with pseudonyms so that no identifying features of

individuals were included. The only identifiable characters present in my narratives were my parents. However, my parents were already aware of these stories as many of the narratives were reconstructed from old journal entries I shared with them.

Criteria for my research

Criticisms of autoethnography argue that the method lacks scientific inquiry by relying too heavily on aesthetic appeal. However, autoethnography does not intend to separate science and art. In fact, autoethnography seeks to "disrupt the binary of science and art" (Ellis, Adams, & Bochner, 2011, paragraph 39). The method does not pursue validity, but seeks verisimilitude as it leads the reader to perceive the phenomenon as real and representative (Ellis, Adams, & Bochner, 2011).

Following Tracy's (2010) model, I argue that this study demonstrated many of the criteria for valuable qualitative research. First, my narrative autoethnography of my experience with depression is deemed as a worthy topic as I connected my experience to larger social issues. In doing so, this study addressed a relevant topic that plagues many people, but did so in an interesting and evocative manner that the existing literature often overlooked (Tracy, 2010, p. 840-841).

Second, this thesis displayed sincerity, meaning that the research was genuine and vulnerable (Tracy, 2010). I demonstrated this sincerity through the discussion of vulnerable issues of depression and self-reflexivity. In this narrative autoethnography, I exhibited reflexivity by acknowledging connections and sharing my motivations for writing this study (Tracy, 2010). For instance, in this study I clearly positioned myself within the study not solely based on the autoethnographic element that distinguished

myself as the subject of the study, but I also articulated what prompted my interest in this topic and what I gained through this investigation (Cresswell, 2013).

Third, this study demonstrated credibility through the thick description used to convey the often confusing experiences of depression (Tracy, 2010). Also, through such description, this study exhibited resonance and aesthetic merit. Resonance was achieved through transferability and natural generalization (Tracy, 2010) whereby the findings may spark an understanding of the larger connections and lead readers to see how the difficulties of having depression may also mirror other vulnerable populations' constraints. Natural generalizations may occur when the evocative and detailed accounts of depression enable readers to immerse themselves in the narratives and feel as if they can apply the findings to their own lives. Perhaps the reader will see that the study's identification of performed identities in depression relate to their own social performances.

Fourth, this study established a significant contribution to the literature in that it extended knowledge (Tracy, 2010) of depression by explaining it in a unique manner that connected the findings to larger social issues. Therefore, heuristic significance was achieved whereby the findings of depression are viewed in relation to larger social issues as a means to explore similar connections in future research.

Finally, this thesis demonstrated meaningful coherence (Tracy, 2010) through an interpretive theoretical approach as meaning emerged from the stories told (Tracy, 2013).

CHAPTER 4: LIFE WITH MAJOR DEPRESSIVE DISORDER

Diagnosis

Sitting in the stark white waiting room, I keep my head low, avoiding any eye contact with others sitting in the seemingly decrepit reception chairs pushed against the surrounding walls. I take a moment to think about what led up to this appointment with my psychiatrist.

About eight months ago, I finally decided to tell my general physician, Dr. Reed, about some of the uncontrollable feelings of absolute numbness and worry boiling inside me, keeping me from focusing on my college coursework. Initially, he believed my uneasiness and worry stemmed from a potential anxiety disorder, leading Dr. Reed to prescribe Klonopin. After a few months, the medication did little for the ceaseless feelings of worry and despair so I made another appointment with Dr. Reed, where he advised me to visit a psychiatrist. Eventually, I made the decision to set up an appointment, but before seeing the doctor, I was required to speak with the office's therapist. After that one meeting, she told me I had major depressive disorder and highly encouraged me to make an appointment as soon as possible with the psychiatrist Dr. Lindham.

Nearly a year after that appointment with the office therapist, here I sit in the chilly waiting room. After trying for over a year to convince myself that I could tackle my depression on my own, today, I accept that I can't do this on my own. My eyes peer down to the left to the end table beside my chair. Countless magazines fan out across the

table. All but one appear to be about psychology with their cover pages surrounded by text often referencing mental illnesses. The divergent magazine's title stands out: *Self*. *Self* surrounded by mental illness. The irony overwhelms me. I shake my head and look back down to the white linoleum floor.

The door to the waiting room opens.

"Rachael Thomas," one assistant calls out and I quickly grab my purse.

I begrudgingly follow the assistant back the hall to the office of Dr. Lindham.

She stops at the office door and motions towards a seat as she says, "Dr. Lindham should be with you in a few minutes. Just have a seat here while you wait."

I plop down in the small chair seated in front of the large desk of Dr. Lindham. While I wait, I examine her office. Several framed diplomas decorate the light pink walls and three shelves behind me are filled to the brim with *Precious Moments* figurines.

"Bizarre. I've never been in a doctor's office like this before. This place is ridiculously cluttered!" I think to myself. I feel as though I'm some intruder in her home rather than a patient in an office.

As I scan the room, I hear a shuffle and glance back to the door as Dr. Lindham enters her office.

"You must be Rachael. Hello," she says as she shuffles over to her chair and flipping through several loose papers.

"Hello," I respond.

For nearly an hour, we discuss my feelings of worthlessness and despair and Dr. Lindham continues to look down at her yellow notepad, jotting things down. Every time her pen touches the notepad, I can't help but wonder what she is writing.

"How much does she need to write down to figure out something like this? I mean, come on. Where does that chicken scratch go after this appointment anyway and what is it about what I'm saying that needs to be written down?" I think to myself.

As we approach the end of my session, Dr. Lindham sets her notepad onto the desktop and says, "All right. Well, Rachael, I'm fairly certain you have major depressive disorder. There are several medications for this. Sometimes, the medicines that work for some don't work for others, so it could take some time before finding one that works for you. But what's important is that you keep taking your medicine. For now, I'm putting you on forty milligrams of Celexa a day for a few months and we'll see how you're doing on that. Now, let me send this in to your pharmacy for you. What's their phone number?"

"My pharmacy's number? I 'm not sure off the top of my head. It's called Community Drug Pharmacy and it's on Thirteenth Street in Franklin. I can look it up on my phone," I respond.

"You don't know it?" she asks with a raised brow. She seems genuinely surprised by my inability to recall such a number.

"No. Like I said, I'm not on any medications right now so that's not a number I use that often," I retort, a little irritated.

"Well I'll just have to look it up," Dr. Lindham responds as she turns to her computer and searches for the number. While searching, she seems to make an attempt at small talk. "So you're a college student. Communications, am I right? What are you planning on doing with your degree?"

"Well I was accepted into graduate school at the University of North Carolina at Charlotte so I'll be getting my Master's degree in Communication Studies," I say.

Dr. Lindham quickly asks, “Yeah, but what are you trying to do with that?”

Her quick response leads me to consider what she actually thinks of me.

Nevertheless, I reply, “Well, I’ve taken a few classes concerning the research process and I absolutely love all of the courses I’ve taken in my major so I think I would like to use my Master’s degree to teach Communication courses.”

She lifts her head from the computer and looks over to me. Once again, she doesn’t seem to spare a moment before responding, “Teach? You can’t teach with a Master’s degree. You need a PhD to teach.”

“No. I can still be a lecturer or instructor with my MA,” I assert, hoping my irritation wasn’t blatantly obvious.

“No. I think you’re mistaken. No one can teach with a Master’s. Now, wait one minute while I call this in for you,” she states.

As she calls the pharmacy, I sit in the tiny chair mulling over this experience. My blood seems to be boiling.

I can’t help but think to myself, “What was it about me that led her to treat me like this or is this typical for every patient? When did I become a blithering idiot? And why does she feel the need to call my medication in? Aren’t I competent enough to be handed the prescription? Why is she questioning my credibility with everything I say?”

Camouflage

Hard to socialize with friends like I used to. Talking to friends feels weird. It’s almost as if I’m putting on an act so no one can tell.

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The vibrant fluorescent lights above the bar flicker down onto the sidewalk illuminating tiny flashes of light amongst the darkness. Droves of people seem to flock to the bar like moths to a bug zapper. I enter a dimly lit bar with my friends and continue to mimic the role of the high-spirited enthusiastic friend. We head over to the bar, attempting to squeeze through the swarms of people to get a drink. With our festive green beers in hand, we mill around the bar and manage to find some space to dance and hang out for our Saint Patrick's Day celebration.

All of a sudden, my picture perfect performance is spoiled. My body feels out of place. Instantly, I realize what's going on and think to myself, "Freaking depersonalization. Of course this would happen tonight!"

Episodes of depersonalization occasionally accompany my depression. However, tonight's moment is different. Tonight I'm trapped in the virtually inescapable public eye.

The episode hits me like a brick. I literally no longer feel a connection to my body or my surroundings. I don't feel "real." My body completely detaches from my thoughts and the distance transforms me into a disturbing third-person spectator observing myself and my surroundings.

As a spectator, everything appears different. The people dancing around are suddenly moving much slower and the booming bass from the DJ now resembles a faint hum. Despite the experience, I don't feel vulnerable. But then I see my hands. I tell myself, "These are my hands, but why can't I feel them?"

I notice myself closely examining my hands and rubbing them together trying to feel them as part of my body. But every scan of my fingertips and brush of one hand on

the other feels like I am touching another person's hands. My body no longer feels like my own.

Looking around, I view a subtle haziness glaze over everything. "What's going on?" I ask myself. All of a sudden, Stephanie appears in front of me with a look of concern and asks, "What's up with you?"

Soon, the episode fades and I feel a part of my body and environment again.

I realize Stephanie is in front of me and I think to myself, "Oh shit! I hope I didn't stare at her for too long. She looks a little freaked out. How am I going to cover that up?"

Stephanie asks me again, "Rachael, are you okay?"

An idea finally hits me and I know exactly how to camouflage this faux pas. I tell myself, "Look around! You're in a bar. Just say you're buzzed."

I muster a simulated snicker and say, "Oh yeah! I'm having a blast! Guess I might have to take a break for a bit from the drinks"

Stephanie responds with a look of relief and smiles as she says, "Oh! You just look really spaced out right now! I thought something was wrong!"

"Me? Nah! How couldn't I be having fun?" I say.

After our conversation, I sneak off to the bathroom to get a minute away from it all. I think about how my depression and episodes of depersonalization like these that continue to wreak havoc on my life and worse yet, endanger my relationships. I ask myself over and over again, "When is this going to end? Why does this have to happen to me?"

"Lucky for me," I think sarcastically, "depersonalization makes the perfect supplement to my depression. Not only do I keenly mask feelings of sorrow, self-

loathing, and suicide on a daily basis, I also occasionally experience complete disconnect with my surroundings. “What a wonderful world,” I say to myself meaning just the opposite.

After my brief moment away from the busy bar, I leave the bathroom and head back to find my friends. I cake on my disguise to conceal the pain and mayhem I feel inside.

I look over to Stephanie and say, “I’m so glad I came! Want to grab a drink?”

“Definitely,” she says.

As we walk toward the bar, I covertly glance down to my hands and feel the faint glimpse of depersonalization fade away as the numbness departs from my fingertips and out of my body.

“I need to get away! I just want to crawl under the covers of my bed and hide from everyone,” I think to myself, desperate for solitude.

***

Walking around, I suddenly felt unreal. Literally not real. Dream state was back. Touched walls and seats at the bar and felt unreal. Stared at my hands and they felt fake or like I was in a dream. Walked back into bathroom stall and started balling. I couldn’t stop.

Admission

I reach out and wrap my hand around the cold metal handle to our apartment door. I pause.

“Normal,” I think to myself. “Just pretend.”

With my hand held firm, I rotate the handle and walk through the frame into our apartment. My eyes rapidly center on my roommate Kasey. She sits atop one of the tall bar chairs arranged around our kitchen's island table, eating her lunch. Her eyes finally meet mine as she peers above the dark rims of her eyeglasses.

"Hey, what's up?" I say, painting a wide grin across my face.

"Hey. What do you have there?" she asks as she points toward the small paper bag held in my hand.

"The bag!" I frantically say to myself. My fingers wrap tight as I quickly clench the small paper pharmacy bag that contains my antidepressants, the proof of my depression. Proceed with caution. Discretion advised.

"Oh, I had to stop by the pharmacy," I say. "What kind of sandwich is that?" I ask, cautiously steering conversation away from myself.

"Turkey and cheese," she replies.

"That worked!" I tell myself. "Now, keep it coming."

I peel off my heavy pea coat, throw my bags onto the island, and scan the refrigerator for something to snack on. While searching for a bite to eat, I continue meticulously managing our conversation.

"So, did I tell you what happened in Dr. Colley's class this morning? You're not gonna' believe what that Jimmy kid said. You know, that new guy Tonia has been hanging around with?" I say.

As I peruse the refrigerator, I hear an unexpected crinkling sound followed by Kasey's voice.

“Wellbutrin and Celexa. Aren’t these antidepressants? Why do you have these?” I feel her snide rebuke as I consider her comment.

The haunting moment I’ve dreaded for all too long finally appears. Someone knows about my depression. “How am I gonna’ hide my depression after she’s read I’m on antidepressants,” I woefully think to myself. “Where do I even begin?”

As I rapidly tap my feet against the hard linoleum, I frantically rummage my thoughts for some semblance of an excuse to mend this colossal blunder. “Come on, come on!” I tell myself. “Think!”

Nothing. Not one word. As the words seem to escape me, I clear my throat and notice my arid mouth. My heart sinks and my pulse skyrockets. Finally, I stumble upon something to say back and glance back to Kasey to respond.

“Yeah, those are mine. I’ve been taking them for a while.”

An unexpected rush of relief rises over me, but the sensation is short-lived.

“What?!” she quickly darts back. Her eyes tightly cinch as her eyebrow rises. “No. There’s no way you have depression.”

Her response hits like a sweeping blow to the head. “You’ve got to be kidding me,” I think to myself.

“What do you mean?” I ask.

“Yeah there’s absolutely no way that’s right. I mean look at you,” she says, motioning her hands up and down as she points in my direction.

“Look at what?” I ask as I try to keep my composure.

"You know what I mean! You go to class and laugh all the time when we hang out. You're all right. How is that depression? There's just no way. What doctor told you that?" she asks. Her crassness startles me.

Confused, I hesitate before responding. This moment has flashed through my mind before, but the response of my friends was never like this; never doubting the existence of my depression; doubting, me.

"I'm sorry, my doctor?" I respond.

"Doesn't matter," she says, shaking her head back and forth. "The point is you don't have it. What is it that you're even sad about anyway? You've got a great life!" she contends with a brashness that shocks me yet again.

Frustrated and infuriated, I feel a wave of heat wash over my face. "What's wrong with her?" I yell to myself.

"Kasey, it's depression, okay! It doesn't always happen because of some traumatic life event. There's not one cause for every person's depression. I don't know why this is happening to me, but it is! And last time I checked, I wasn't living with Kasey Masterson, MD." I retort, perhaps a bit too sharply.

"Did I just say that?" I think to myself. "I shouldn't have said that."

The pace of my breathing seems to increase and my chin begins to quiver. "Don't cry!" I tell myself.

"I don't know. It just doesn't seem right," she adds, pursing her lips and squinting her eyes as she looks me up and down. I feel her suspicion and skepticism as she positions her hands onto her hips.

"Right?" I say.

"Yeah, I mean have you ever even seen what a depressed person is like, Rachael?" she asks, in a matter-of-fact manner. "They never leave their house and a lot of em' cut themselves and do all kinds of crazy stuff like that. You see what I'm sayin'?"

"Kasey! You cannot be serious! You actually think everyone with depression does that? Good God, you're ridiculous!" I shout.

I quickly pluck my coat and belongings from the kitchen island, storm back to the sanctuary of my room, and slam my bedroom door. After I pounce onto my bed, I recoil under the covers for the remainder of the night.

Hours later, I hear our roommate Tonia enter the apartment. She calls out, "Hello? Stephanie? Rachael? Kasey?"

Kasey's door rapidly swings open and thuds against the thin wall between my room and hers. After today's conversation, her usual excitement to greet Tonia alerts me and I tilt my ear toward the hallway. I overhear the soft sounds of Kasey whispering.

"Oh my God, Tonia. You're not gonna' believe this! So Rachael walks in today and…" Kasey says before Tonia interrupts.

Tonia snickers, "What? I'm surprised she even came out of her room."

"So she brings in these antidepressants and says she has depression. What a crock! She's so full of shit! Depression. Can you believe that? I mean my grandma died last year and I'm not walking around claiming to have depression," Kasey murmurs.

"Are you serious? I don't know what her deal is anymore? She's been acting so weird. She never goes out with us anymore and she just holes up in that room. And now she thinks she's depressed? Cry me a river. Get over it, already! I'm seriously getting annoyed!" Tonia bellows back, probably unaware of her added volume.

"Get over it?" I wonder. The words viciously roll through my mind. I retreat to my pint-sized bed to tuck away under the sheets and bury my head into my pillow to muffle my violent sobs.

Get. Over. It.

***

Went to gym. Everyone says exercise will help this. Went for an hour. Throughout workout, a sudden feeling hit me like a brick: Hopelessness, misunderstanding, extreme sadness all piled up into one sickening feeling. Had to stop. Had to be alone.

Surrender

In my room and I had a weird thought: never suicide, but how would it be to just not be here. I don't want to be here. I don't want to exist.

***

Silence. Absolute silence. But my mind rages, screaming thoughts of desolation, dejection, and self-loathing.

My roommates left for the weekend to visit one of our friends. A carefully crafted lie about a class deadline freed me from the trip, and once again, I masked my depression from them.

"What's the point?" I ask myself, losing every square inch of the fading hope that remains within me. "Worthless!"

I twist the dial on my stereo clockwise to increase the volume and decrease the risk of having my neighbors hear me.

I lie outstretched on the firm bedroom floor with my limbs spread wide. I'm desperate to feel something. Anything. Desperate to break free from the wearisome thoughts of worthlessness that consume me. Desperate to end the numbing sensation.

"Give me something!" I scream aloud.

The numbness permeates my physical body. I repeatedly sweep my arms and legs across the course carpet bristles begging for feeling; pleading for custody of my old self.

Tears cascade down my cheeks and into my hair. The old me; the me before this hell has vanished. She no longer exists and never can again. Her passion, her impetus, her purpose. Gone.

I fiercely run my fingers through my tear soaked strands of hair and clutch my head. Sounds of music drown out my hysterical sobbing and barricade me from the threat of others hearing my struggles.

The insurmountable pain materializes. "This is too much," I cry out.

I leap up from the floor and dash towards my top cabinet drawer. "Tylenol. No. Benadryl. No. Come on! This is it!? Where's my leftover pain meds?" I ask myself as I frantically search through the drawer, chucking "inept" medications onto the floor.

Without hesitation, I run to my roommates' rooms searching for alternative means to finally slay this beast called depression and free myself from ceaseless suffering.

"What the hell! Nothing! Are you freakin' kidding me?! None of them have anything stronger!" I scream.

Determined, I pluck all of the medications into my arms and dart back to my room.

After unscrewing the cap of each bottle and pouring the capsules into the small of my hand, I pause and stare blankly at the tiny pills. These pills might finally save me. Save me from this nightmare and stop this pain.

I toss the medications into my mouth toward the back of my throat and follow with a few gulps of water.

"Now what?" I think to myself. "I've just got to wait."

Slowly, I pick myself up off the ground and walk toward my bed, monitoring every footstep.

In bed, I wait. "Please God!" I plead in prayer. "Take me out of this! I'm not strong enough! I can't do this! I want to die! I need to!"

Soon, a swell of severe nausea bursts forth and my stomach feels as if it's splitting apart. I tightly clench my stomach as the gut-wrenching pain sweeps over me and waves of intense heat intermittently race through my body.

My focus drifts and the room seems to spin. Another wave of nausea crashes down on me, this one more powerful than the last. I jet towards the bathroom, stroking my hands along the walls for support and guidance through the dizzy haze.

Without a minute to spare, I heave into the toilet. The muscles in my body involuntarily spasm as I continue to retch uncontrollably with tears pouring down my face.

I glance down into the porcelain commode and see a few tiny capsules floating atop the water.

"Even in my attempt at death, I fail," I tell myself.

New beginnings

After two months virtually free of depression, I feel revived. I've escaped the treacherous depths of depression I was once trapped inside, yet the explanation for my escape seems lost. It feels as if I was suddenly lifted from the pits of hell without ever seeing the face of my hero. I don't know why my depression vanished, but I'm forever grateful it did. As I leaf through the pages of my journal, I see an abrupt halt to my old entries documenting my depression. The abysmal entries of depression ended so suddenly without any explanation. Nevertheless, I pick up where I left off in my journal to begin documenting my brighter existence. My entire way of living finally feels wholesome again. Now I approach every day with earnest enthusiasm and genuine gratitude that depression is no longer fueling my every thought. I no longer envision each day as a repulsive burden to endure, but I embrace every blessing God has given me. Once again, I feel I have a purpose.

Sitting on my comfy couch at my new apartment, I prepare for the new experience of becoming a graduate student as I meticulously review the assigned research articles for the first week of class.

"These are practically hieroglyphics!" I think to myself after reading over the same sentence for the fourth time.

"How am I gonna' cut it among the other students? I'm going to stick out like a sore thumb," I think as I bite my nails.

It feels like I've been sitting here reading these articles for days. My poor couch will likely have a deep, permanent imprint by the time this semester is over.

Suddenly, I hear the thoughts I'm allowing myself to perpetuate. Doubts, fears, self-deprecation. I can't allow myself to fall into this trap of negativity again. Focused, I take a deep breath, inhaling the fresh autumn air.

"No. You can do this. There's a reason you were accepted into grad school. It's going to be hard. You know that, but it will be worth it. You're not stupid," I tell myself.

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It's the third week of classes. The classes are surprisingly small, but I already feel a sense of connection with the other students in my cohort.

Tonight, I sit in one of my weekly classes around the long oval table with my classmates. Class ends, pencils drop, and notebooks close before they're carefully packed away into each of our bags. However, unlike most of my undergraduate classes, we all linger in the small classroom to chat with each other. Soon, I hear someone discuss topics for our upcoming research proposals.

As I pull out my car keys from a deep pocket in my backpack, I think to myself, "Finally! There actually are other people that are my age in this world who care about studying communication."

Suddenly, I chime in to share some of the topics I've been considering for my proposal. "Yeah, I don't really have a clue on where I plan on going with this, but I think I want to examine some aspect of depression," I announce, surprised by my call of attention to the disorder that I avoided discussing with anyone for years.

A little anxious and unusually enthusiastic, I begin swiveling the tall chair back and forth. I place my right hand over my mouth to cover the grin growing across my face.

"Excited about talking about depression? Who am I?" I jokingly think to myself.

Once again, I open my mouth and seem to recklessly discuss depression as I never have before.

"So I'm not sure what communication phenomenon I want to look at yet concerning depression, but it's a pretty big part of me so I thought I should explore it. I haven't had an episode in a few months, but I've dealt with depression for years so I figured it would be important for me to look at," I say aloud.

I notice a few interested nods before someone else speaks up to share their research topic amongst the group.

I did it. Without instigation or pressure from others, I deliberately admitted that I had depression. More importantly, no one, not a soul stared at me like I was weird or crazy. Unable to hide my perfect peace of mind, I allow myself to freely smile.

Setback

It's nearly the end of my first semester of graduate school and all of a sudden, a gnawing feeling begins to dig its claws into my soul as I walk across campus today. A feeling all too familiar. Terror washes over me. "No! This can't be happening again. It's been gone for a while now! I'm supposed to be better. This is supposed to disappear!" I tell myself.

The barbaric creature of depression tears through me once again. My head rapidly pivots back and forth. Left then right. Students seem to surround me as they walk down the brick paved paths to and from class.

"Not here! Not now! I just got here! I just started meeting new friends in the department. What if my depression freaks them out, too? What if my constant need to be alone offends them and alienates me?" I desperately ask myself.

I pull out my hair band and let my hair flow down over my face to mask my startled and confused expression.

“Elevator!” I think to myself as I spy a nearby sign. I rush toward the elevator to hasten my arrival to my office. I need to be alone. Buttons run down the side of the machine, but one stands out above the rest. It’s my destination. Fifth floor. Fifth. Five. Nearly five months without an episode, now shattered by this fleeting moment.

The doors slowly creak as they open to the floor where my office resides.

“I want to run! No. Jog? No. Walk. Carefully walk,” I tell myself.

One foot after the other, I see my feet strolling along the short patterned carpet that lines the hall.

I reach my office and my hands jitter as I attempt to bring the key to the door’s lock. Click. The door unlocks. I throw myself into my chair, shut the door, and drown out my weeping from others as I quickly turn on music from the small speakers of the desktop computer.

The same miserable sensations of hopelessness, despair, and utter chaos whirl through my mind dominating every thought, but something new seems to have emerged: sheer panic and fear. Fear greets me; fear that ultimately transcends every foreboding moment endured before.

This new accompaniment to my depression startles me and I begin to question this new feeling of terror, “Could it be anxiety or something? Dr. Reed first thought it could have been an anxiety disorder, but the meds just made me pass out. Plus, later he said it probably wasn’t an anxiety disorder. Was he wrong or is this something new altogether? What is this?”

The depression makes a comeback and this time, without any inkling of its arrival. Terror, trembling, and trauma. “Not now. Not after all this time. Not here,” I tell myself.

Attempting to regain control, I turn and face the computer monitor to document this experience. My fingers shake non-stop across the keyboard as I struggle to capture this moment. “There must be a reason. There has to be a reason. I thought I finally had it under control. How can it be back?” I ask myself, impatiently pressing for an answer.

The monster hijacks all control over my body. Helpless.

My eyes shift down to glance at the clock on my desk. Time seems to escape me. There’s 15 minutes until class. Breathe in. Breathe out.

I rest my right hand gently onto my chest and feel my heart pounding inside. The fear is palpable. Trying to relax and draw back the tears, I throw my head back to gaze towards the ceiling as I rapidly open and close my fists to combat the tremors in my hand.

The door rattles and interrupts my attempted wind-down. My office mate enters the room.

“Hey, what’s up?” she cheerfully asks.

“Oh, not too much. Just getting stressed. You know how it is with all of these readings and papers,” I say.

“Don’t I know it,” she says with a snicker. “This workload is insane!”

***

Dizzy and absolutely could not focus at al. Had to skip one class because I physically felt like I couldn’t do it with these feelings. I think it’s back.

CHAPTER 5: RESULTS AND DISCUSSION

Thematic analysis revealed three main themes and several subthemes present in the narratives of my depression experiences. The findings reveal how my identity is socially constructed within the context of depression. The three overarching themes include (1) imagined identity, (2) destigmatization strategies to regain control, and (3) looking-glass self (Cooley, 1922).These themes were mutually dependent steps in a broader circular process. Each step within the process represents one of the three emergent themes or subtheme. Figure 1 illustrates this circular process. Below, I discuss each theme and use excerpts from my narratives to support them.

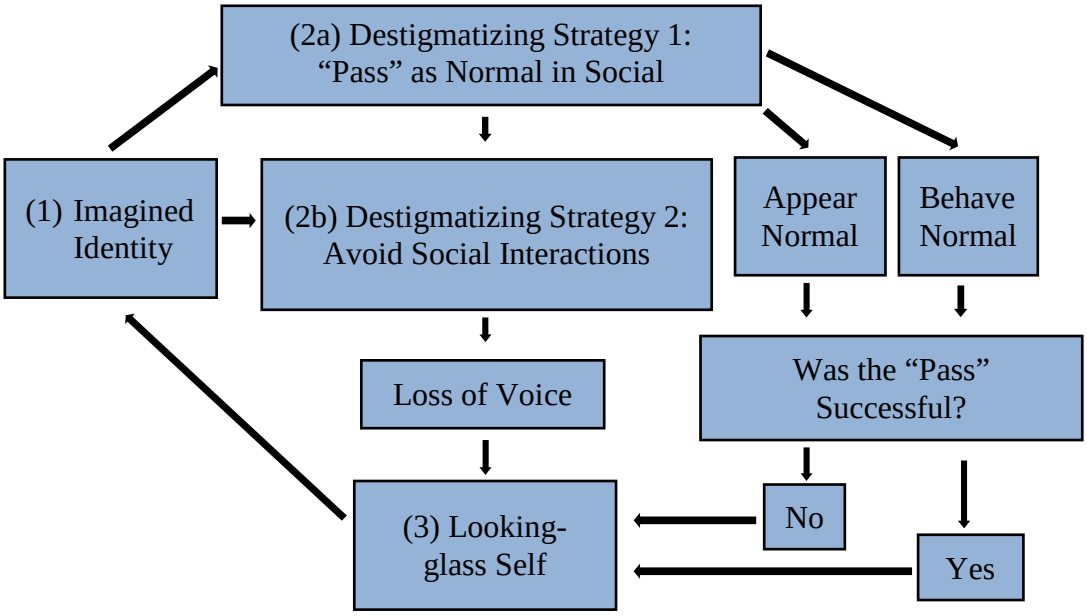

FIGURE 1: My socially constructed identity in the context of depression.

Theme 1: Imagined identity

The theme of imagined identity is the starting point to this circular process. While this theme functions as the initial point for the process, it is also observed over again throughout. For this reason, in this discussion, I refer to the first instance of my imagined identity as my initial imagined identity to differentiate it from its subsequent emergence.

The imagined identity is an extension of Goffman's personal, social, and ego identities (1963). At this point in the process, my personal identity now consists of the "identity peg" (Goffman, 1968, p. 74) of depression as this is now part of my life history. However, this imagined identity in my model consists of much more than a simple extension of Goffman's concepts. The formation of the imagined identity with depression seems to be a complex and intricate process. While Goffman's concept of personal identity (1963) is apparent in this theme, another concept seems to be present. This initial imagined identity did not develop amidst an interaction with others, but was formed through my initial imagined *imminent* interactions with others; essentially an imagined form of Cooley's looking-glass self (1922). Cooley's looking-glass self (1922) consists of three parts which include: (1) we imagine how we appear to other people, (2) we imagine and respond to what we think their opinion of our appearance is, and (3) we create our self from the opinions of others (Yeung, et al. 2003).

This initial imagined identity is similar to Cooley's concept of the looking-glass self, but with one slight difference: this imagination manifests not in present social interactions, but in retrospective interactions and in future imagined interactions. I develop my initial imagined identity by recalling interactions that occurred prior to my depression and envisioning how others would react (in the future) if I reveal my depression to them.

"Stephanie flippantly said she was depressed about getting a B on her accounting exam as she reached for a pint of Ben and Jerry's from the grocery freezer, laughing at her comment." They obviously wouldn't get it."

Encounters like the one shown above lead me to imagine how others would see me now that I have depression. In such narrative segments, my perception is always centered on how others would react if I accidentally or purposefully reveal my depression to them. However, in these early stages, I have not yet told anyone about my depression. Therefore, this initial imagined identity is influenced by imagined imminent interactions alone and not yet from interactions where I disclose my depression to others. In essence, this focus on imagined interactions showcases my perceived social identity (Goffman, 1963) - what others might think of me simply by considering the group (people with depression) that I now belong to.

"I perpetually dwell on how inferior I'm afraid I will appear to others if they uncover the truth."

"If they knew, they would think I was weak, weird, and wired improperly," I think.

"Even if I did tell people about my depression, what would that even mean to them?"

"All I do is worry about how my friends, my family, and even strangers will react or treat me if they find out."

The narrative excerpts above highlight how my initial imagined interactions focus on my potential social identity that could develop should I reveal my depression. However, my initial imagined identity does not develop solely through these early

imagined interactions. My initial imagined identity also develops by comparing my self with depression to that self which existed prior to depression- when depression was not part of my social identity. Social identity is a form of identity that is based in our relationship to other people and therefore enables consideration of what is normal in reference to our social categories (Goffman, 1968). Therefore, my hyper-attention to my potential social identity exposes my definition of normal. In my narratives, normal is my identity without depression, making me a "deviant" to my former self and others as noted above. A constant focus on feeling different or being different from my "old" self and others supports this definition of normal.

"I need to go back to who I was before this."

Another student stands next to me waiting to cross the road. She prudently pulls her long auburn hair to her side and then continues to text in a frenzy. I imagine her texting her friends, eagerly anticipating some party planned for this weekend. She seems poised and pulled together.

"The sheer chaos of depression seems to demolish any shred of organization and control that I once maintained and my school assignments slip through the cracks."

It's fall; my favorite time of year. Vibrant reds, yellows, and oranges paint the autumn foliage. As a brisk gust of wind runs through my hair, I remain unshaken. Before, I found every waft of the fresh fall air invigorating; stimulating my senses and bestowing hope for my very being. Now, things are different. Instead, amidst the perfect pigments and bracing breezes of fall, dejection emerges and I brood over the advance of another bleak and burdensome winter.

"I agree that depression has changed me, but who exactly am I now?"

Other narrative excerpts from my early stages of depression also support this preliminary definition of normal. For instance, I report feeling a complete loss of identity altogether or confusion over where this new depression peg of my personal identity places me within my perceived social identity.

"But who am I now?' I think to myself."

"Depression has changed me, but who exactly am I now?"

"These persistent thoughts force me to redefine myself."

"How does saying, "I suffer from depression" truly convey the immense inner feelings that tear me apart and smother my lust for life?"

"I suppose this does reflect some aspect of my new identity, but what part and how?"

These passages indicate how I feel that I am not normal and therefore deviant by continually imagining what my perceived social identity and virtual social identity would be if others know of my depression. Also, expressions of feeling abnormal and stating how "weird" and "inferior" I may appear to others from revealing my depression show feelings of humiliation. Therefore, this initial imagined identity socially constructs my ego identity as well being that it displays how I feel about my potentially stigmatized self. I believe that my personal identity, which consists of depression, makes me exist within the stigmatized social group of people with depression. Therefore, I feel that I have a spoiled identity (1963) before ever actually experiencing any first-hand experiences with depression stigma because I do not reveal my experience in the early stages of depression. Being that I equate depression with stigma and deviance before sharing my depression with others suggests that I unintentionally self-stigmatize myself. This spoiled

identity confirms Kleinman's (1988) suggestion that a person with a stigmatizing condition eventually comes to expect stigmatized reactions, preparing for such reactions "before they occur or even when they don't occur" (p, 160). The theme of my initial imagined identity echoes this effect of stigma.

This intricate imagined identity stage identifies, in part, how my personal, social, and ego identities with depression are socially constructed. Goffman (1968) comments on all three forms of identity function in reference to stigma:

> The concept of social identity allowed us to consider stigmatization. The concept of personal identity allowed us to consider the role information control in stigma management. The idea of ego identity allows us to consider what the individual may feel about the stigma. (p. 130)

However, early on, I decide that my depression must be hidden in order for me to "pass" (Goffman, 1963) as normal and avoid stigmatization. This leads to the next stage of the circular process of my socially constructed identity with depression.

Theme 2: Destigmatization strategies

This theme presents the various destigmatizing strategies that I employ to pass as normal and avoid exposing my stigmatized depression identity. It appears that achieving a successful pass in my social interactions is crucial for me and thus these strategies are equally important.

"How can I disguise this? I don't want to freak people out."

"I must perform 'normal."

"All I do is worry about how my friends, my family, and even strangers will react or treat me if they find out."

However, there are also moments when I do not believe that I can successfully pass as normal and in those moments, I choose to avoid social interactions to elude exposure and maintain perceived normalcy. These strategies of passing as normal in interactions and avoiding social interactions demonstrate a need to regain control over myself and my interactions with others. Ironically, these attempts to "pass" as normal seem to provide me with a sense of control I believe I lost while experiencing depression. Below, I describe these destigmatizing strategies further.

"Pass" as normal in social interactions. After I acknowledge the existence of my depression, I understand that this means that I fall into the "depression" category, making depression part of my personal identity. Furthermore, as mentioned above, I believe that my identity is spoiled.

> *Countless magazines fan out across the table. All but one appear to be about psychology with their cover pages surrounded by text often referencing mental illnesses. The divergent magazine's title stands out: Self. Self surrounded by mental illness. The irony overwhelms me.*
>
> *"If they knew, they would think I was weak, weird, and wired improperly,' I think."*

These passages demonstrate how I view myself with depression as a person with a spoiled identity. Therefore, I am motivated to manage any potential stigma that could arise from interactions with others. There are two primary strategies that emerge in the narratives to "pass" as normal in social interactions: attempts to (1) appear normal and attempts to (2) behave normal. Attempts to appear normal are defined by my outward emotions and appearance while attempts to behave normal include my outward

mannerisms, behaviors, and the language I use in conversations. As mentioned above, I will discuss how the concept of control corresponds with my attempts to avoid stigmatization.

Appear normal. When attempting to "pass" as normal in social interactions, I work to appear normal in my outward emotions and appearance. This is a constant contemplation I express in my narratives.

"I need to learn to perfect this role (Burke, 1945). I need to learn how to look 'normal."

"Normal,' I think to myself. 'Just pretend."

Achieving a successful "pass" as normal is imperative to me as I stress this as a "need" rather than a simple wish. In addition, there seems to be a thin line between how I define normal appearance versus abnormal appearance. My understanding of normal stems from comparison of my old self before depression to my self with depression and comparison of others to my self with depression. Therefore, my definition of normal appearance also develops from relentlessly monitoring others in order to monitor myself.

"How am I gonna' cut it among the other students? I'm going to stick out like a sore thumb,' I think as I bite my nails."

"I scan every student that passes by, taking meticulous mental notes, 'How to be normal: Chapter One."

"I need to learn how to look 'normal."

Eventually, I develop loose guidelines to help me to appear normal. For instance, in the excerpt below, I recognize that being alone and secluding myself from others makes me appear abnormal.

"What if my depression freaks them out, too? What if my constant need to be alone offends them and alienates me?' I desperately ask myself."

Being that seclusion appears abnormal, I attempt to appear normal by occasionally surrounding myself with people.

"Students seem to surround me as they walk down the brick paved paths to and from class."

"I enter a dimly lit bar with my friends and continue to mimic the role of the high-spirited enthusiastic friend."

However, when mistakes are made in my attempts to appear normal, I immediately warn myself that I am walking on a very thin social line and I seem to prepare my defenses for imminent stigmatization.

"The bag!' I frantically say to myself. My fingers wrap tight as I quickly clench the small paper pharmacy bag that contains my antidepressants, the proof of my depression. Proceed with caution. Discretion advised."

"Oh, I had to stop by the pharmacy,' I say. 'What kind of sandwich is that?' I ask, cautiously steering conversation away from myself."

"I realize Stephanie is in front of me and I think to myself, 'Oh shit! I hope I didn't stare at her for too long. She looks a little freaked out. How am I going to cover that up?"

Even amidst a possible moment of exposure where I fail to appear normal with an out of the ordinary pharmacy bag in hand (as I am not on any other medications while living with my roommates), in this instant my mind immediately flies to another possible

way of concealing my stigmatized identity. In the following strategy, I describe means of mending these faux-paus further.

Behave normal. In my attempts to prevent revealing my stigmatized depression identity, I attempt to behave normal as well. Behaving normal is the destigmatizing strategy that I utilize most. This strategy pertains to my outward mannerisms, behaviors, and most often the language I use in conversations with others that I interpret as normal. Behaving normal is different from appearing normal in that behaving normal is a more active strategy and essentially an extension of appearing normal. For instance, if I decided to wear an oversized hoodie with my university's name plastered on the front in an attempt to blend in with other normals, this would be a strategy of appearing normal. If a friend approached me and asked if I was okay due to my sluggish demeanor (from my depression), I would attempt to behave normal by saying, "Oh yeah. I'm just so tired! I stayed out way too late at a party last night so I'm dragging today, you know what I mean?" This attempt to behave normal mimics my perception of the normal college students around me in order to hide my depression. Yet again, this strategy seems to be an essential means of feeling in control by avoiding any exposure of my stigmatized depression identity.

"My only defense from stigma is this act."

"I want to run! No. Jog? No. Walk. Carefully walk,' I tell myself."

Behaving normal is a vital means of avoiding stigmatization. I seem to be extremely aware of my behaviors when in the proximity of others.

"I enter a dimly lit bar with my friends and continue to mimic the role of the high-spirited enthusiastic friend."

"Hey, what's up?' I say, painting a wide grin across my face."

"While searching for a bite to eat, I continue meticulously managing our conversation."

"The pace of my breathing seems to increase and my chin begins to quiver. 'Don't cry!' I tell myself."

While moments like the ones above are very common, there are times when I feel that my stigmatized depression identity may be leaked to others due to my error. I immediately attempt to mend my errors by attempting to behave normal yet again as I search for the right words to say.

"The haunting moment I've dreaded for all too long finally appears. Someone knows about my depression. 'How am I gonna' hide my depression after she's read I'm on antidepressants," I woefully think to myself. "Where do I even begin?'

As I rapidly tap my feet against the hard linoleum, I frantically rummage my thoughts for some semblance of an excuse to mend this colossal blunder. 'Come on, come on!' I tell myself. 'Think!"

I frantically search for a way to behave normal after a revealing moment. For instance, the first passage conveys just how pivotal it is for me to maintain the façade of normalcy as I describe a potentially revealing moment as a dreaded nightmare. The mistakes I make represent a loss of control for me and by trying to mend the revealing incidents with the destigmatizing strategies, I seem to gain back a means of lost control.

"Did I just say that?' I think to myself. 'I shouldn't have said that."

"An idea finally hits me and I know exactly how to camouflage this faux pas. I tell myself, 'Look around! You're in a bar. Just say you're buzzed."

"I muster a simulated snicker and say, 'Oh yeah! I'm having a blast! Guess I might have to take a break for a bit from the drinks."

"My roommates left for the weekend to visit one of our friends. My carefully crafted lie freed me from the trip and once again, I masked my depression from them."

Success of the pass. The next step in the circular process of my socially constructed identity with depression asks whether or not my attempt at passing as normal is successful. The success of the pass seems to be marked by my assessment of others reactions in an interaction. For instance, I evaluate their reactions to identify whether or not the individuals treat me as they did before I had depression or as they would respond to normal others.

A successful pass is defined by appearing and behaving normal in my social interactions. If the pass is successful, I seem to construct a sense of control and satisfaction in my life. Being that depression takes away a feeling of control in my life, these successful passes help me to reestablish a feeling of control lost.

"My roommates left for the weekend to visit one of our friends. My carefully crafted lie freed me from the trip and once again, I masked my depression from them."

"That worked!' I tell myself. 'Now, keep it coming."

"Oh, I had to stop by the pharmacy,' I say. 'What kind of sandwich is that?' I ask, cautiously steering conversation away from myself."

Successful passes invite a sense of gratification by achieving my goal of passing as normal. Therefore, my emotions are lifted in these moments, even if the contentment is only temporary. The success is described much like a creative artistry. Furthermore, other means of control eventually appear where I am hyper-aware of my behaviors with

depression and take note of them to document the experience. This seems to help me as it enables me to experience my depression by allowing me to step outside myself to view myself with depression.

"Attempting to regain control, I turn and face the computer monitor to document this experience. My fingers shake non-stop across the keyboard as I struggle to capture this moment. 'There must be a reason. There has to be a reason. I thought I finally had it under control. How can it be back?' I ask myself, impatiently pressing for an answer."

"I scan every student that passes by, taking meticulous mental notes, 'How to be normal: Chapter One."

However, while the successful passes provide a sense of control, the unsuccessful passes lead me to feel even more out of control and stigmatized.

"As I rapidly tap my feet against the hard linoleum, I frantically rummage my thoughts for some semblance of an excuse to mend this colossal blunder. 'Come on, come on!' I tell myself. 'Think!"

"The haunting moment I've dreaded for all too long finally appears. Someone knows about my depression. 'How am I gonna' hide my depression after she's read I'm on antidepressants,' I woefully think to myself. 'Where do I even begin?"

"Nothing. Not one word. As the words seem to escape me, I clear my throat and notice my arid mouth. My heart sinks and my pulse skyrockets."

"All of a sudden, my picture perfect performance is spoiled. My body feels out of place."

"I quickly pluck my coat and belongings from the kitchen island, storm back to the sanctuary of my room, and slam my bedroom door. After I pounce onto my bed, I recoil under the covers for the remainder of the night."

"Get over it?' I wonder. The words viciously roll through my mind. I retreat to my pint-sized bed to tuck away under the sheets and bury my head into my pillow to muffle my violent sobs."

"All of a sudden, my picture perfect performance is spoiled. My body feels out of place."

Avoid social interactions. The second destigmatizing strategy I utilize is avoiding social interactions. There are various ways that I avoid social interactions in my narratives. First, in the early narratives of my depression I decide to avoid social interactions until I feel I am fully prepared to attempt to pass as normal.

"Step by step, I continue my diffident dawdle to class. I enter the classroom, keeping my head pointed toward the ground. I need to learn to perfect this role."

"Hey, go on over without me. I'm wrapping up an essay before class so I'll be a while. See ya later."

"Until then, what I need to do is avoid any social interaction. I take a seat in the closest desk and pull out my notebook and pen to sketch doodles. I keep telling myself, 'Don't look up."

In these early passages, the decision to avoid social interactions is based on my perceived lack of preparation to pass as normal. I decide that I will not actively seek out interactions at this point until I feel I am equipped with the means and knowledge of passing as normal.

After I believe I prepared myself to pass as normal through reflection of my normal pre-depression self and monitoring of normal others, there is another way that I avoid social interactions. As mentioned above, moments where I fail to achieve a successful pass often lead me to feel severely stigmatized, but most importantly vulnerable. In these moments, if I feel that I cannot easily repair the flawed pass I often avoid interaction by isolating myself from others.

"After our conversation, I sneak off to the bathroom to get a minute away from it all. I think about how my depression and episodes of depersonalization like these that continue to wreak havoc on my life and worse yet, endanger my relationships."

"I quickly pluck my coat and belongings from the kitchen island, storm back to the sanctuary of my room, and slam my bedroom door. After I pounce onto my bed, I recoil under the covers for the remainder of the night."

In these instances, it seems that I am avoiding interaction because of my error in my pass, but also the avoidance essentially acts as a form of unintended self-punishment. I immediately remove myself from a social setting and continually contemplate how I failed and how negatively others must view me (this is discussed further in the final theme). While successful passes lead me to feel a sense of contentment and accomplishment, unsuccessful passes often lead me to self-seclusion and negative self-talk. The avoidance seems to hinder positive understanding of my depression identity and encourage isolation from others, which essentially adds to the impact of depression.

Finally, the last means of avoiding social interaction occurs when I believe that my current state with depression is too overwhelming to simply attempt to pass as

normal. After I feel that I am able to attempt a pass as normal again, I give myself permission to leave solitude.

"Elevator!' I think to myself as I spy a nearby sign. I rush toward the elevator to hasten my arrival to my office. I need to be alone. Buttons run down the side of the machine, but one stands out above the rest. It's my destination. Fifth floor. Fifth. Five. Nearly five months without an episode, now shattered by this fleeting moment."

"Hey, go on over without me. I'm wrapping up an essay before class so I'll be a while. See ya later.

"After our conversation, I sneak off to the bathroom to get a minute away from it all."

"After my brief moment away from the busy bar, I leave the bathroom and head back to find my friends."

"I need to get away! I just want to crawl under the covers of my bed and hide from everyone,' I think to myself, desperate for solitude."

"I pull out my hair band and let my hair flow down over my face to mask my startled and confused expression."

One interesting insight into this reason for social avoidance is that it seems that I determine that I am a threat to my own pass at normalcy. In these times, I control the threats by avoiding interaction altogether.

"I throw myself into my chair, shut the door, and drown out my weeping from others as I quickly turn on music from the small speakers of the desktop computer."

"Sounds of music drown out my hysterical sobbing and barricade me from the threat of others hearing my struggles."

"I twist the dial on my stereo clockwise to increase the volume and decrease the risk of having my neighbors hear me."

Unfortunately, in moments like these, I determine that my depression is too much to handle and therefore I am not capable of attempting a pass at normalcy. Furthermore, by accepting these episodes as "too intense" I seem to spiral further into thoughts of inadequacy and failure rather than reflection of myself which leads to the following theme.

Loss of voice. After choosing the destigmatizing strategy of avoiding social interaction, what often follows is a complete lack of voice. As noted above, through social avoidance I essentially punish myself for poor passes at normalcy, I label my state with depression as uncontrollable, thus furthering the influence of my depression. In these moments, I drown out control of my thoughts and separate myself from others. These times do not enable moments of reflection over my thoughts or feelings to better understand my depression and emotions. They simply designate the current episode as too intense and not worthy of an attempt at social interaction. For this reason, I lose voice by denying myself opportunities to share my experience in depth with others to understand my depression.

Additionally, I lose voice by failing to attend to my immediate emotions and surroundings. By simply dismissing an intense depression episode as "too much to handle," I choose not to handle my feelings altogether and bottle myself up and away from other people. This obviously only furthers the effects of my depression.

Theme 3: Looking-glass self

Finally, the third theme identifies in this circular process of my socially constructed identity with depression is the looking glass-self (Cooley, 1922). In my interactions with others, I contemplate how the person may evaluate me due to my appearance and/or my responses. Often, I feel that others are viewing me as abnormal. This focus on the looking-glass self as being abnormal leads me to experience feelings of humiliation- a feeling that Goffman (1956) added to Cooley's (1922) concept of the looking-glass self- due to the belief that I am no longer "normal" and therefore less acceptable and unsettling in my interactions with others. The moment of exposure is terrifying for me and I fear the resulting humiliation as I imagine others view me negatively.

"*The haunting moment I've dreaded for all too long finally appears. Someone knows about my depression. "How am I gonna' hide my depression after she's read I'm on antidepressants," I woefully think to myself. "Where do I even begin?"*

However, another emotion results from this looking-glass self. Unlike the social emotions resulting from the looking-glass self that Cooley (1922) and Goffman (1956) revealed (shame, humiliation, embarrassment, and pride), these narratives uncover a deepened sense of insecurity that adds to the symptoms of depression and self-rejection.

"*And why does she feel the need to call my medication in? Aren't I competent enough? Why is she questioning my credibility with everything I say?"*

"*What if my depression freaks them out, too? What if my constant need to be alone offends them and alienates me?" I desperately ask myself."*

Furthermore, after I share my depression with others, this process of the looking-glass self seems relentless. With every move I make or thing I say in an interaction I immediately reflect on how others view me with depression. Most often, I assume a negative reaction. For instance, at my first visit to the psychiatrist's office I assume that every action or statement the doctor makes is a direct reflection of her negative view of me due to my disclosure of depression.

"No. Like I said, I'm not on any medications right now so that's not a number I use that often,' I retort, a little irritated."

"As she calls the pharmacy, I sit in the tiny chair mulling over this experience. My blood seems to be boiling."

"I can't help but think to myself, 'What was it about me that led her to treat me like this or is this typical for every patient? When did I become a blithering idiot? And why does she feel the need to call my medication in? Aren't I competent enough? Why is she questioning my credibility with everything I say?"

In these examples, I believe that the doctor views me as irresponsible and incompetent all because of my depression. I do not seem to take into account that her behaviors and responses are related to her overall demeanor or attitude, but I believe that these responses are all related to my disclosure of depression

CHAPTER 5: CONCLUSION

This study utilizes narrative autoethnography and thematic analysis to understand my experience with depression by identifying how my identity is constructed in the context of depression. My analysis unveils the intricate process of my socially constructed identity with depression and extended traditional concepts of Goffman (1963) and Cooley (1922).

To further explain the study's findings, a model was created to illustrate this circular process of identity construction. The first theme and initial starting point to this model of my socially constructed identity is my imagined identity where I imagine how others would view me with depression in future interactions prior to ever revealing my depression. This theme extends Cooley's (1922) concept of the looking-glass self as this imagined identity does not occur in a social interaction, but in my imagined potential future interactions. This stage of the model directly centers on my ego identity and personal identity. The second theme is destigmatizing strategies which consists of two main strategies and their subthemes. The first strategy is passing as normal in a social interaction. This strategy highlights a focus on my social identity as well as my personal and ego identity as I place myself in social interactions and attempt to appear and behave as normal, non-depressed people do based on my perceptions. After I attempt to pass, I decide whether or not the pass was successful, which directly affects my looking-glass self in my interactions with others (my third theme). The second destigmatizing strategy

is avoiding social interaction. In this strategy, I opt to avoid interacting with others which ultimately leads me to lose my voice. Finally, this strategy and its subtheme also influence the third theme of my looking-glass self.

This study demonstrates that identity construction with depression is not a simple process. The theoretical framework of social constructionism provides a necessary means of examining my identity construction as the construction centered on constant comparison of my new depressed self to others and my old self and developed through repeated passes in a circular process of my own evaluation. My identity with depression is socially constructed as my narratives reveal that I construct myself as my own prosecutor, defendant, and judge making my social interactions very complex being that in encounters I monitor myself, evaluate others' responses, and blame or defend myself. It seems that my interactions lead me to constantly evaluate others' imminent responses, their actual responses, and my own self.

Most importantly, by attempting to pass as normal, I provide myself with a means of control that often leads me to feel contentment if successful and with each successful pass I continue to put myself in other social interactions. Therefore, my attempts to gain control by passing place me in social situations where I am more likely to feel content and eventually feel normal once more by accepting my depression. This study reveals that my attempts at passing as normal essentially enable me to seek out social interactions which may help me to feel accepted and less likely to continually self-stigmatize myself with depression. Overall, attempts to gain control by passing construct a broader understanding of my depression as manageable. Therefore, as the successful pass leads me to view my depression as manageable, I also begin to construct a more positive image

of myself and my identity with depression. It seems that my assessment of the pass in social interactions directly influences the construction of my identity with depression. For instance, when I deem my attempt at passing as a failure, I often begin to believe that I maintain a spoiled identity and will be stigmatized. This also leads me to stigmatize myself further and avoid socialization which directly reflects my looking-glass self (Cooley, 1922) and my imagined identity. In conclusion, this thesis extends and complexifies Goffman's identity theory in several important ways: it teases out the concept from within—from the point of view of the person; it contextualizes it within a stigmatizing condition; it illustrates how identity is not only interpersonally constructed but is also intrapersonally constructed; it illustrates how identity is fluid and transformed. This thesis is significant because it provides a deep investigation into the interpersonal and intrapersonal dynamics of depression within the discipline of communication studies. Furthermore, this study highlights one depressed individual's social process of passing and adds a rich examination of identity flux with depression.

The method used in this thesis has several advantages—namely, that narrative autoethnography enabled a thorough critique of my depressed self in a social context through the writing of my narratives and the analysis. However, while the qualitative research method of narrative autoethnography does enable an in-depth examination of one experience of identity construction with depression, it is important to note that the resulting themes cannot be generalized to the population. However, this study does provide a deeper understanding of identity construction and depression within the discipline of communication studies. Added research in depression and identity

construction is necessary for the discipline of communication studies and this study provides a poignant starting point for such scholarly examination.

This study paves the way for a thorough examination of depression and communication. First, as this thesis includes a model of my socially constructed identity in the context of depression, it begs the question of how this model differs from a model demonstrating how non-depressed persons construct their identities, specifically one such as Eisenberg's (2001) model. Given the findings of this study, I propose that this model differs from Eisenberg's (2001) model in a sense of severity. This study's model suggests that as a depressed person, I fixated strongly on the interpersonal element amidst my identity construction. While Eisenberg's (2001) model does highlight this interpersonal element, it does not seem to consider this as the primary motivator in constructing identity. This study's findings suggest that the interpersonal element- "the rules, values, and patterns of behavior that define intimate relations" (Eisenberg, 2001, p. 543)- is the predominant motivator for identity construction in the context of depression. Furthermore, while Eisenberg's (2001) model consists of various elements that happen to equally influence identity construction in no particular order, this study's model demonstrates a cyclical process.

A second point of consideration in this study is the context of social constructionism and depression to understand how I knew what I was experiencing was depression. Early on in my depression narratives, I mentioned feeling overwhelmingly sad for long periods of time- a sadness that I had never experienced before. At this stage I my life, I had no prior knowledge of any family members that had depression, and yet I quickly labeled my experience as depression without ever consulting family, friends, or

physicians. So how did I construct my early experiences as depression? While the cause of my depression may not have been within the scope of this study, my construction of depression should be considered for further study. I propose that cultural influences such as television shows and other forms of media may have played a role in how I defined those early encounters as depression. Furthermore, it is quite possible that I recalled a loose understanding and definition of depression from old textbooks for health classes in high school and middle school. Further studies should reflect on the potential broader influences that may influence this depression construction and identification.

Finally, this study contributes to scholarship with its findings. There is a dearth of communication scholarship that examines the process of identity construction in the context of depression. While other disciplines have studied this identity process, communication studies are limited. This study extends classic concepts of Goffman's (1963) identity theory and demonstrates how malleable identity is as it's influenced by interpersonal and intrapersonal constructs. This finding is significant especially for its practical implications in field of health care. For instance, as this study demonstrates how equally critical interpersonal and intrapersonal encounters are for depressed persons, both types of encounters should be thoroughly examined and considered when diagnosing, treating, and even reaching out to potentially depressed persons.

Additionally, this study's focus on depression and communication also brings attention to the existing issue of depression stigma. There is no doubt that depression stigma has been a point of popular scholarly study in the field of communication studies for countless years. However, over the past 50 years, this concept may have transformed slightly since Goffman's (1963) early concentration on mental health issues and stigma. I

suggest that while depression stigma continues to reside in our society, depression itself is viewed differently in that now, it may be considered a curable disease. At this present time, we are constantly exposed to discussions of depression, whether it be via television commercials, radio advertisements, movie characters, or roadside billboards. Unlike 50 years ago, it seems that public discussions of depression are much more acceptable. However, there also seems to be a downside. It is possible that the continual coverage of depression constructs an understanding of depression as a disease that is undoubtedly curable if depressed persons simply take the medications aired on commercials. For this reason, depression stigma has changed in that those with depression who do not take the "necessary" means to cure their depression or are not being cured are now constructed as lazy or not trying hard enough. This may lead to a complete lack of empathy and understanding for depressed persons. Further studies should further examine this potential transformation of depression stigma.

REFERENCES

Anagnostopulos, F., & Hantzi, A. (2011). Familiarity with and social distance from people with mental illness: Testing the mediating effects of prejudiced attitudes. *Journal of Community & Applied Social Psychology, 21*(5), 451-460. doi: 10.1002/casp.1082

Bakhtin, M. M. (1984). *Problems of Dostoevsky's poetics* (C. Emerson, Ed. and Trans.), Minneapolis, MN: University of Minnesota Press. (Original work published 1929).

Baxter, L. A., & Montgomery, B.M. (1996). *Relating: Dialogues and dialectics.* New York: Guilford.

Beike, D. (2008). The language of madness: Representing bipolar disorder in Kay Redfield Jamison's *An Unquiet Mind* and Kate Millett's *The Loony-bin Trip*. In H. Clark (Ed.), *Depression and narrative* (pp. 29-39). Albany: SUNY Press.

Berger, P. L., & Luckmann, T. (1989). *The social construction of reality: A treatise in the sociology of knowledge.* New York: Anchor Books.

Bochner, A. P. (2011). Narrative's virtues. *Qualitative Inquiry, 7*(1), 131-157. doi: 10.1177/107780040100700201

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa.

Burke, K. (1945). *A grammar of motives*. Berkely, CA: University of California Press.

Burr, V. (2003). *Social constructionism*. London: Routledge.

Cerulo, K. A. (1997). Identity construction: New issues, new directions. *Annual Review of Psychology, 23*(1), 385-405. doi: 10.1146/annurev.soc.23.1.385

Chesney, M. A., & Smith, A.W. (1999). Critical delays in HIV testing and care: The potential role of stigma. *American Behavioral Scientist, 42*(7), 1162-1174. doi: 10.1177/00027649921954822

Clark, H. A. (2008). *Depression and narrative: Telling the dark.* Albany: SUNY Press.

Clarke, S. (2008). Culture and identity. In T. Bennett & J. Frow (Eds.), *The SAGE Handbook of Cultural Analysis* (pp. 510-529). London: SAGE Publications Ltd.

Cook, T., & Wang, J. (2011). Causation beliefs and stigma against depression: Results from a population-based study. *Journal of Affective Disorders, 133*(1-2), 86-92. doi: 10.1016/j.jad.2011.03.030

Cooley, C. H. (1922). *Human nature and the social order.* New York: Scribner's.

Corrigan, P. (2004). How stigma interferes with mental healthcare. *American Psychologist, 59*(7), 614–625. doi: 10.1037/0003-066X.59.7.614

Corrigan, P. W. (2005). Strategies for assessing and diminishing self-stigma. In P. W. Corrigan (Ed.), *On the stigma of mental illness: Practical strategies for research and social change* (pp. 239-256). Washington, DC: American Psychological Association.

Corrigan, P. W., & Matthews, A. K. (2003). Stigma and disclosure: Implications for coming out of the closet. *Journal of Mental Health, 12*(1), 235-248. doi: 10.1080/0963823031000118221

Corrigan, P. W., Morris, S., Larson, J., Rafacz, J., Wassel, A., Michaels, P., Wilkniss, S., Batia, K., & Rusch, N. (2010). Self-stigma and coming out about one's mental illness. *Journal of Community Psychology, 38*(3), 259-275. doi: 10.1002/jcop.20363

Corrigan, P. W., River, L. P., Lundin, R. K., Wasowski, K. U., Campion, J., Mathisen, J., Goldstein, H., Bergman, M., Gagnon, C., & Kubiak, M. A. (2000). Stigmatizing attributions about mental illness. *Journal of Community Psychology, 28*(1), 91-102. doi: 10.1002/(SICI)1520-6629(200001)28:1<91::AID-JCOP9>3.0.CO;2-M

Corrigan, P.W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1*(1), 16-20. doi: PMC1489832

Corrigan, P. W., & Wassel, A. (2008). Understanding and influencing the stigma of mental illness. *Journal of Psychosocial Nursing, 46*(1), 42-48. doi: http://dx.doi.org.librarylink.uncc.edu/10.3928/02793695-20080101-04

Creswell, J. W. (2013). Qualitative inquiry and research design: Choosing among five approaches. Thousand Oaks, CA: SAGE Publications.

Davis, C. S., Gallardo, H. L., & Lachlan, K. L. (2010). *Straight talk aboutcommunication research methods.* Dubuque, Iowa: Kendall Hunt.

Deacon, B. J., & Baird, G. L. (2009). The chemical imbalance explanation of depression: Reducing blame at what cost? *Journal of Social and Clinical Psychology, 28*(4), 415-435. doi: 10.1521/jscp.2009.28.4.415

Duncan, G. (2000). Mind-body dualism and the biopsychosocial model of pain: What did Descartes really say? *Journal of Medicine and Philosophy, 25*(4), 485-513. doi: 10916180

DeSalvo, L. (1999). *Writing as a way of healing*. Boston: Beacon Press.

Edney, D. R. (2004). Mass media and mental illness: A literature review. *Canadian Mental Health Association, Ontario, 20*(4), 343-352. Retrieved from http://www.ontario.cmha.ca/about_mental_health.asp?cID=7601

Ellis, C. & Bochner A. (2000). Autoethnography, personal narrative, reflexivity: Researcher as subject. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research (2nd ed.)*. (pp. 733-768). Thousand Oaks, CA: SAGE.

Ellis, C., Adams, T., & Bochner, A. (2011). Autoethnography: An overview. *Forum Qualitative Sozialforschung / Forum:Qualitative Social Research, 12*(1). Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/1589/3095#footnote_1

Eisenberg, E. M. (2001). Building a mystery: Toward a new theory of communication and identity, *Journal of Communication, 51*(3), 534-552. doi: 10.1111/j.1460-2466.2001.tb02895.x

Fee, D. (2000). The project of pathology: Reflexivity and depression in Elizabeth Wurtzel's *Prozac Nation.* In D. Fee (Eds.), *Pathology and the postmodern: Mental illness as discourse and experience* (pp. 74- 99). London: SAGE Publications.

Fisher, W. R. (1987). *Human communication as narration: Toward a philosophy of reason, value, and action.* Columbia, S.C: University of South Carolina Press.

Frank, A. W. (1995). *The wounded storyteller: Body, illness, and ethics.* Chicago: The University of Chicago Press.

Gergen, K. J., & Marlowe, D. (1970). *Personality and social behavior*. Reading, Mass: Addison-Wesley Pub. Co.

Gergen, K. J. (1971). *The concept of self.* New York: Holt, Rinehart and Winston, Inc.

Gergen, K. J. (1999). *An invitation to social construction*. London: Sage.

Gergen, K. J. (2009). *Relational being: Beyond self and community*. Oxford: Oxford University Press.

Given, L. M. (2008). *The Sage encyclopedia of qualitative research methods*. LoS Angeles, CA: Sage Publications.

Goffman, E. (1959). *The presentation of self in everyday life*. Garden City, NY: Doubleday.

Goffman, E. (1963). *Stigma: Notes of the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.

Griffiths, K. M., Christensen, H., & Jorm, A. F. (2008). Predictors of depression stigma. *BMC Psychiatry, 8*(25). doi:10.1186/1471-244X-8-25

Hewitt, J. P., Fraser, M. R., & Berger, L. (2000). Is it me or is it Prozac? Antidepressants and the construction of self. In D. Fee (Eds.), *Pathology and the postmodern: Mental illness as discourse and experience* (pp. 163- 185). London: SAGE Publications.

Holman Jones, S. (2005). Autoethnography: Making the personal political. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 763-791). Thousand Oaks, CA: Sage.

Horwitz, A. V. (2012). Creating an age of depression: The social construction and consequences of the major depression diagnosis. Society and Mental Health, 1(1), 41-54. doi: 10.1177/2156869310393986

Horwitz, A. V., & Wakefield, J. C. (2007). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. Oxford: Oxford University Press.

Jago, B. (2002). Chronicling an academic depression. *Journal of Contemporary Ethnography, 31*(6), 729-757. doi: 10.1177/089124102237823

Johnson, D. A. (2008). Managing Mr. Monk: Control and the politics of madness. *Critical Studies on Media Communication, 25*(1), 28-47. doi: 10.1080/15295030701851130

Johnson, J. J. (2010). *A qualitative study of identity construction in a battered women's shelter-United Family Services Shelter for Battered Women* (Master's Thesis). The University of North Carolina at Charlotte, Charlotte, NC.

Karp, D. A. (1994a). The dialectics of depression. *Symbolic Interaction, 17*(4), 341-366. doi: 152.15.236.17

Karp, D. A. (1994b). Living with depression: Illness and identity turning points. *Qualitative Health Research, 4*(1), 6-30. doi: 10.1177/104973239400400102

Karp, D. A. (1996). *Speaking of sadness: Depression, disconnection, and the meanings of illness*. New York: Oxford University Press.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., Rush, A. J, Walters, E. E., & Wang, P. S. (2003). The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication (NCS-R). *JAMA: The Journal of the American Medical Association, 289*(23), 3095-105. doi:10.1001/jama.289.23.3095.

Kessler, R. C., Akiskal, H. S., Ames, M., Birnbaum, H., Greenberg, P. A., Robert, M., Jin, R., Merikangas, K. R., Simon, G. E., & Wang, P. S. (2006). Prevalence and effects of mood disorders on work performance in a nationally representative sample of U.S. workers. *American Journal of Psychiatry, 163*(9), 1561-1568. doi: 10.1176/appi.ajp.163.9.1561

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books.

Kundrat, A., & Nussbaum, J. (2003). The impact of invisible illness on identity and contextual age across the life span. *Health Communication, 15*(3), 331-347. doi: 10.1207/S15327027HC1503_5

Leventhal, A. (2008). Sadness, depression, and avoidance behavior. *Behavior Modification, 32*(6), 759-779. doi: 10.1177/0145445508317167

Lingsom, S. (2008). Invisible impairments: Dilemmas of concealment and disclosure. *Scandinavian Journal of Disability Research, 10*(1), 2-16. doi:10.1080/15017410701391567

Manos, R. C., Rusch, L. C., Kanter, J. W., & Clifford, L. M. (2009). Depression self-stigma as a mediator of the relationship between depression severity and avoidance. *Journal of Social and Clinical Psychology, 28*(9), 1128-1143. doi: 10.1521/jscp.2009.28.9.1128

Maydell, E. (2010). Methodological and analytical dilemmas in autoethnographic research. *Journal of Research Practice, 6*(1), Article M5. Retrieved from http://jrp.icaap.org/index.php/jrp/article/view/223/190

Mead, G. H., & Morris, C. W. (1962). *Mind, self, and society from the standpoint of a social behaviorist.* Chicago, IL: University of Chicago Press.

National Alliance on Mental Illness. (2013, March). Mental illness: Facts and numbers [Fact Sheet]. Retrieved from http://www.nami.org/factsheets/mentalillness_factsheet.pdf

Newheiser, A. K. & Barreto, M. (2014). Hidden costs of hiding stigma: Ironic interpersonal consequences of concealing a stigmatized identity in social interactions. *Journal of Experimental Social Psychology, 52*(1), 58-70. Retrieved from http://dx.doi.org/10.1016/j.jesp.2014.01.002

Ngunjiri, F. W., Hernandez, K. C., & Chang, H. (2010). Living autoethnography: Connecting life and research. *Journal of Research Practice, 6*(1). Retrieved from http://jrp.icaap.org/index.php/jrp/article/view/241/186

Noble, R. E. (2005). Depression in women. *Metabolism: Clinical and Experimental, 54*(5), 49-52. doi: 10.1016/j.metabol.2005.01.014

Pelias, R. J. (2004). *A methodology of the heart: Evoking academic and daily life.* Walnut Creek, CA: AltaMira Press.

Quinn, D. M., & Chaudoir, S. R. (2009). Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology, 97*(4), 634-651. doi:10.1037/a0015815

Quinn, D. M., & Earnshaw, V. A. (2011). Understanding concealable stigmatized identities: The role of identity in psychological, physical, and behavioral outcomes. *Social Issues and Policy Review, 5*(1), 160-190. doi: 10.1111/j.1751-2409.2011.01029.x

Rathbun, G. (2007). Bootstraps: Disguises of illness. *Kaleidoscope: A Graduate Journal of Qualitative Communication Research, 6*(1), 85-97. Retrieved from https://librarylink.uncc.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ufh&AN=29994971&site=ehost-live&scope=site

Reed-Danahay, D. (1997). *Auto/ethnography: Rewriting the self and the social*. Oxford: Berg.

Rusch, N., Todd, A. R., Bodenhausen, G. V., Olschewski, M., & Corrigan, P. W. (2010). Automatically activated shame reactions and perceived legitimacy of discrimination: A longitudinal study among people with mental illness. *Journal of Behavioral Therapy and Experimental Psychiatry, 41*(1), 60-63. doi:10.1016/j.jbtep.2009.10.002

Oakley, L. D., Kanter, J. W., Taylor, J. Y., & Duguid, M. (2012). The self-stigma of depression for women. *The International Journal of Social Psychiatry, 58*(5), 512-20. doi: 10.1177/0020764011409820

Payne, J. (2008). "Saints don't cry": Exploring messages surrounding depression and mental health treatment as expressed by African-American Pentecostal preachers. *Journal of African American Studies, 12*(3), 215-228. doi: 10.1007/s12111-008-9044-7

Peluso, E. T. P., & Blay, S. L. (2009). Public stigma in relation to individuals with depression. *Journal of Affective Disorders, 115*(1), 201-206. doi: 10.1016/j.jad.2008.08.013

Pickering, N. (2006). *The metaphor of mental illness*. Oxford: Oxford University Press.

Schramme, T. (2013). On the autonomy of the concept of disease in psychiatry. *Frontiers in Psychology, 4*(457), 1-9. doi: 10.3389/fpsyg.2013.00457.

Sedlovskaya, A., Purdie-Vaughns, V., Eibach, R. P., LaFrance, M., Romero-Canyas, R., & Camp, N. P. (2013). Internalizing the closet: Concealment heightens the cognitive distinction between public and private selves. *Journal of Personality and Social Psychology, 104*(4), 695-715. doi: 10.1037/a0031179

Smardon, R. (2008). 'I'd rather not take Prozac': Stigma and commodification in antidepressant consumer narratives. *Health: An Interdisciplinary Journal for the Social Study of Health & Medicine, 12*(1), 67-86. doi:10.1177/1363459307083698

Spry, T. (2001). Performing autoethnography: An embodied methodological praxis. *Qualitative Inquiry, 7(*6), 706-732. doi: 10.1177/107780040100700605

Studd, J., & Panay, N. (2004). Hormones and depression in women. *Climacteric: The Journal of The International Menopause Society, 7*(4), 338-346. doi: 10.1080/13697130400012262

Studd, J. W. (2011). A guide to the treatment of depression in women by estrogens. Climacteric: *The Journal of the International Menopause Society, 14*(6), 637-642. doi:10.3109/13697137.2011.609285

Styron, W. (1990). *Darkness visible: A memoir of madness*. New York: Random House.

Tracy, S. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10), 837-851. doi: 10.1177/1077800410383121

Tracy, S. J. (2013). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. Chichester, West Sussex, UK: Wiley-Blackwell.

Van, P. H. M. (2004). Can stress cause depression? *Progress in Neuro-Psychopharmacology & Biological Psychiatry, 28*(5), 891-907. doi: 10.1016/j.pnpbp.2004.05.031

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes towards counseling. *Journal of Counseling Psychology, 54*(1), 40-50. doi: 10.1037/0022-0167.54.1.40

Weiss, M. G., Ramakrishna, J., & Somma, D. (2006). Health-related stigma: Rethinking concepts and interventions. *Psychology, Health, & Medicine, 11*(3), 277-287. doi: 10.1080/13548500600595053

Wolcott, H. (2004). The ethnographic autobiography. *Auto/Biography, 12*(2), 93-106. doi:10.1191/0967550704ab004oa

Wahl, O. F. (1992). Mass media images of mental illness: A review of the literature. *Journal of Community Psychology, 20*(4), 343-352. doi:10.1002/1520-6629(199210)20:4<343::AID-JCOP2290200408>3.0.CO;2-2

Wolpert, L. (1999). *Malignant sadness: The anatomy of depression*. New York: Free Press.

Wolpert, L. (2001). Stigma of depression-a personal view. *British Medicine Bulletin, 57*(1), 221-224. doi: 10.1093/bmb/57.1.221

World Health Organization. (2001, October). *Mental health: A call to action by world health ministers. World Health Assembly. Ministerial Round Tables (54th: 2001: Geneva, Switzerland).* World Health Organization. Retrieved from http://www.who.int/mental_health/advocacy/en/Call_for_Action_MoH_Intro.pdf

World Health Organization. (2012, October). *Depression* (No. 369) [Fact Sheet]. Retrieved from http://www.who.int/mediacentre/factsheets/fs369/en/index.html

Yeung, K., & Martin, J. L. (2003) The looking glass self: An empirical test and elaboration. *Social Forces 81*(3), 843–879. Retrieved from https://librarylink.uncc.edu/login?url=http://search.ebscohost.com.librarylink.uncc.edu/login.aspx?direct=true&db=edsjsr&AN=edsjsr.3598178&site=eds-live&scope=site