# A gendered experience of self-stigma of depression: an interpretative phenomenological analysis

# A Gendered Experience of Self-Stigma of Depression: An Interpretative Phenomenological Analysis

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PhD in Clinical Psychology

2016

## Declaration

I declare this thesis is entirely my own work, other than the counsel of my supervisors, is an accurate reflection of work, and has not been submitted as part of another degree at the University of Limerick or any other academic institution.

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Rachel Parkinson Date

## Acknowledgements

Firstly, I would like to thank Dr. Barry Coughlan and Dr. Ronni Greenwood for all the support and guidance over the course of this research project. Your guidance helped me immensely throughout the designing, data collecting, and writing process. Thank you to the individuals who took their time to partake in this study and thank you to all the staff in the local day hospital for all your help.

I'd also like to give a special thank you to Dr. Colette Grey for all her support, guidance and patience over the past three years. Thank you for reading over many drafts and offering advice and reassurance when needed. I really appreciate you giving your time and support.

Last but not least, many thanks to my wonderful parents for all the continuing support and encouragement over the past three years and longer. I would not have been able to complete the journey to becoming a Clinical Psychologist without all your love and encouragement.

# Abstract

**Introduction:** Self-stigma has many negative consequences for people with depression. However, there is a lack of research exploring how gender affects the self-stigma of depression. This study aimed to explore how men and women experience, manage, and possibly resist, the self-stigma of depression.

**Method:** This study was a qualitative research design, using semi-structured interviews. Four men and six women were interviewed to explore their subjective experiences of self-stigma. Data from these interviews were transcribed and analysed using Interpretative Phenomenological Analysis.

**Results:** Two superordinate themes emerged from the data: 'Self-stigma: Depression as a threat to gender identity' and 'Resisting the threat to gender identity'. The first superordinate theme described the participants' experience of self-stigma involved a loss of gender roles and a need to conceal their depression. The second superordinate theme described how participants resisted self-stigma by seeking help, disclosing to others, normalising, and viewing depression as an empowering experience. Although gender was mainly found to affect self-stigma experiences, occasionally, men and women were found to have similar experiences.

**Discussion:** This study allowed for a unique insight into how gender affects how self-stigma is experienced by men and women with depression. The findings of this study are discussed in relation to previous literature. The limitations and strengths of the study are considered, along with implications for clinical practice, policy, and future research.

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# Chapter One: Introduction

## 1.1 Overview of Present Study

The aim of this study was to explore how men and women experience, manage, and possibly resist self-stigma. Within the self-stigma literature, there is a dearth in research on how gender affects the experience of self-stigma, despite the evidence that depression can be a very much gendered experience. Although there are similar symptoms of depression being experienced by both genders, men and women appear to express and manage depression differently (Johnson, Oliffe, Kelly, Galdas & Ogrodniczuk, 2012). Gender plays an important role in the research of depression (Addis, 2008). Men and women with depression can be influenced by this broader societal views of depression, which can inform their experiences and decisions (Johnson et al., 2012). Thus, this study aimed to explore how gender affects the experiences of self-stigma. Due to the pervasive presence of stigma in society, people with mental illnesses, in any culture, have no choice but to be aware of the stigma of their illness (Corrigan, Rafacz & Rusch, 2011). As self-stigma has many negative consequences, such as reduced quality of life, lower self-esteem, reduction of morale, and increased avoidance behaviours (Manos, Rusch, Kanter & Clifford, 2009; Ritsher & Phelan, 2004; Yen et al., 2005), it is important to explore this phenomenon, in order to further our understanding of the challenges and also how self-stigma can be prevented. This study offers a foundation towards greater insight into how gender affects the experiences of people with depression in relation to self-stigma and how they successfully resist stigma.

## 1.2 Thesis Structure

The literature review is presented in Chapter Two. Chapter Three describes the data collection and methodology of the study. Chapter Four presents the study's results that are structured by superordinate, subordinate, and minor themes. Finally, Chapter Five presents the findings in relation to previous literature. The implications for clinical applications, policy, education, and future research will be discussed.

## 1.3 Chapter Two: Literature Review

This chapter examines the relevant literature in relation to stigma, self-stigma, gender, and depression. Models of self-stigma are presented, which explore the varying responses to stigma. The variety of strategies of how stigma can be managed is discussed. The literature that shows how gender can affect the experience of depression is presented. The dearth in

research on gender and self-stigma is then outlined. The research aim and question is outlined at the conclusion of the chapter.

### 1.4 Chapter Three: Method

This chapter discusses the thesis methodology. The reasons for choosing Interpretive Phenomenological Analysis (IPA) will be outlined. This chapter also includes details of the participants, ethical issues, recruitment details, and a description on how the researcher collected and analysed the data. The steps in ensuring reliability and validity will be outlined.

### 1.5 Chapter Four: Results

The results chapter illustrates the findings from the 10 interviews using IPA analysis. Two superordinate themes were identified: self-stigma: depression as a threat to gender identity; and resisting the threat to gender identity. A number of subordinate themes were identified with two subordinate themes containing two minor themes. Each theme is supported with relevant participant quotes. The researcher's interpretation of the participants' experiences is detailed within the themes.

### 1.6 Chapter Five: Discussion

The discussion chapter examines the research findings in relation to relevant literature. The studies strengths and limitations are then deliberated. The researcher details a critical reflection on the personal impact of the study. The implications of the findings on practice, education, policy, and research are discussed.

# Chapter Two: Literature Review

## 2.1 Literature Search

A systematic literature review was conducted which included finding relevant articles by searching several databases. Search databases used were PsychInfo, Embase, Web of Science, CINAHL Plus with First Text, and Cochrane. Exclusion criteria included literature on identity and coping as stigma literature was the sole focus of this study. Inclusion criteria was stigma, self-stigma, stigma coping and depression literature. Key words were used in various combinations to locate articles relating to stigma and depression. The key words that were used were: stigma, self-stigma, internalised stigma, stigma resistance, empowerment, stigma coping, depression, post-partum depression, gender, gender identity, human males, human females, sex roles, sex role attitudes, masculinity, femininity.

## 2.2 Introduction

Stigma has been recognised as a significant adversity for people who have a mental illness both internationally and in Ireland (National Economic Social Forum, 2007; World Health Organisation [WHO], 2012). The terminology 'mental illness' will be used throughout this study to describe a mental health disorder to fit with the term used in the self-stigma theoretical literature. In Ireland, the Mental Health Commission (2013) have noted that the stigma of a mental illness can be a more substantial obstacle to recovery than the actual mental illness itself. Despite many anti-stigma campaigns, a recent online survey found 65% of Irish people view being treated for a mental illness as a sign of failure (St. Patrick's Mental Health Services, 2014). Due to the pervasive presence of stigma in society, it has been argued that people with mental illnesses, in any culture, have no choice but to be aware of the stigma of their illness (Corrigan, Rafacz & Rusch, 2011). This awareness can lead to people with mental illnesses to internalise this stigma, which is known as self-stigma (Corrigan & Watson, 2002a). Although self-stigma can be widespread, self-stigma does not affect everyone and people can manage stigma differently. Some people do not internalise stigma and can react to stigma with empowerment (Corrigan & Watson, 2002b). This empowerment can be viewed as successful management of self-stigma (Corrigan & Rao, 2012). The pervasiveness of stigma, and its negative effects, highlight the importance of researching the negative consequences of stigma, such as self-stigma.

## 2.3 Chapter Overview

This chapter will firstly provide an overview of the concept of stigma in relation to mental illness. The two main types of stigma: public and self-stigma of mental illness will then be discussed. Following this, the concept of self-stigma will be further explored, and the specific theory of self-stigma that has been chosen for this study will be outlined and explained. Managing stigma is an important aspect of self-stigma that will be examined, with an emphasis on how it can be an empowering experience and how self-stigma can be successfully resisted. The specific mental illness that is the focus of this research, depression, will be introduced and the definition of depression will be briefly described. Research illustrating how depression is both perceived and experienced as a gendered illness will follow. The literature on the gendered experience of depression will set the criteria for a discussion on the literature specific to the self-stigma of depression. The limited research exploring how gender affects the self-stigma of depression will be presented allowing the gaps in research to be highlighted. Lastly, a rationale for this research will then be described and the research question will be outlined.

## 2.4 The Concept of Stigma of Mental Illness

Stigma has been used to describe several different concepts (Link & Phelan, 2013) and can be an "under-defined and overused concept" (Manzo, 2004, p. 401). In spite of that, as the stigma phenomenon is so complex, variations of definitions are allowed as long as the researcher is clear of the concept of stigma they are using (Link & Phelan, 2001). The definition that will be used in this study is Link and Phelan's (2001) definition. Link and Phelan (2001) describe stigma as the incidence of labelling, stereotyping, in-group/out-group separation, status loss, discrimination, and the exerting of power. This definition can be applied to various stigmatised groups including people with mental illness, specifically depression, which are the focus of this study. Stereotypes are culturally and socially constructed views and beliefs towards a certain group (Corrigan et al., 2011). Discrimination is the behaviour towards the stigmatised group due to prejudice (Corrigan et al., 2011). Link and Phelan's (2001) definition addresses the overlap of concepts like labelling, stereotyping, and discrimination by defining stigma as the relationship between these interlinking concepts. Although terms like stereotyping and discrimination are sometimes used to describe stigma, the term stigma is a broader and more inclusive concept (Major & O'Brien, 2005).

Link and Phelan's (2001) definition is built on Goffman's (1963) seminal work describing stigma as 'an undesired differentness' (p. 5) which leads to social distancing, discredited social identity and identity reclassification. Thus, stigma is an identity in which characteristics

differentiate the individual from others (Goffman, 1963). Link and Phelan's (2001) definition also addresses criticisms that definitions of stigma, such as Goffman's (1963) definition, can be too focused on the individual levels and, as a result, includes explicit behaviours at a more macro level addressing the significance of social power. It is important to view stigma as a complex process that has both individual and micro-social dimensions (Campbell & Deacon, 2006). Stigma operates at many levels within society; structural, interpersonal, and individual (Link & Phelan, 2001). Research that fails to consider the many aspects of stigma may not fully address the complexity of the phenomenon (Luke & Stamatakis, 2012). Indeed, Link and Phelan's (2001) definition is supported in the literature (Pescosolido & Martin, 2015). The definition also includes many levels, complementing this study's focus on how differing levels of stigma can affect an individual's experience of mental illness.

At the structural level, stigma can exist in larger organisations, media, and cultural norms that perpetuate discrimination and prejudice (Link & Phelan, 2001; Pescosolido, Martin, Lang & Olafsdottir, 2008). At the interpersonal level is public stigma, which is when the public have negative attitudes towards a group of individuals who are viewed as having a negative mark that connects these individuals to negative characteristics (Link & Phelan, 2001). At the individual level, both the individuals stigmatising and the individuals who are being stigmatised can bring cognitive processes to the social interaction, such as self-stigma (Corrigan & Watson, 2002b). Although the structural level of stigma is taken into account in this study, public stigma and self-stigma are more relevant to this study and so shall now be explored further.

### 2.5 Public Stigma and Self-Stigma of Mental Illness

The purpose of this section is to discuss the two types of stigma central to this study: public stigma and self-stigma. Although public stigma is not the primary focus of this study, it is important to understand public stigma as self-stigma occurs as a result of public stigma. Corrigan and Watson (2002a) define public stigma as negative beliefs that the general public have towards people with mental illnesses. The public endorse stereotypes and agree with prejudiced beliefs, and discriminate against people with mental illnesses (Corrigan & Watson, 2002a). Corrigan and Watson (2002a) and Corrigan and Rao (2012) defined self-stigma of mental illness as the agreement or endorsement of prejudiced views of the public by people who have a mental illness, and the resulting self-discrimination. These definitions of public stigma and of self-stigma will be used as they include socio-cognitive processes involved in

self-stigma that will be the subject of this study and support Link and Phelan's (2001) definition of stigma. The difference between public and self-stigma is outlined in Table 1 below.

Table 1.

*The difference between public stigma and self-stigma (Corrigan et al., 2002a).*

| | **Public Stigma** | **Self-Stigma** |
|---|---|---|
| Stereotypes | Negative belief about a group, e.g., dangerousness, incompetence, character weakness | Negative belief about the self, e.g., incompetence, character weakness |
| Prejudice | Agreement with belief and/or negative emotional reaction, e.g., anger, fear | Agreement with belief and/or negative emotional reaction, e.g., low self-esteem, low self-efficacy |
| Discrimination | Behaviour response to prejudice, e.g., avoidance of work or housing opportunities, withholding help | Behaviour response to prejudice, e.g., fails to pursue work and housing opportunities |

### 2.6 Theoretical Models of Self-Stigma

One widely used theoretical model of self-stigma is Corrigan's (and various co-authors) Socio-Cognitive model of self-stigma (2002a; 2004; 2011). Munoz, Sanz, Perez-Santos and Quiroga (2011), Drapalski and Lucksted (2013) and Corrigan, Bink, Schmidt, Jones and Rusch (2016) have empirically evaluated the Socio-Cognitive model and found evidence to support the effectiveness of the model. Corrigan et al.'s (2002a; 2004; 2011) model theorises that when an individual with mental illness becomes mindful of the prejudiced and devaluing labels society places upon them, their sense of self becomes threatened and they, in turn, internalise the stigma, which leads to a decrease in self-esteem and self-efficacy. Awareness, agreement, and application of the negative stereotypes of people with mental illness is influenced by the individual's behaviour, cognition, and socio-cultural and environmental contexts. The theory states self-stigma is socially constructed through stereotyping, prejudice, and discrimination (Corrigan & Watson, 2002a; Corrigan et al., 2011) and leads to individuals being harmed when they apply these concepts to themselves. This harm is both emotional (low self-efficacy and low self-esteem) and behavioural (why try to pursue personal goals; Corrigan et al., 2016). Emotional harm can lead people to question their worthiness or capability (Corrigan et al., 2016), which is outlined in Figure 1 below. However, this awareness, agreement, and

application may not be consciously experienced by an individual as self-stigma can be experienced explicitly or implicitly and can be outside an individual's conscious awareness (Rusch, Corrigan, Todd & Bodenhausen, 2010). Self-stigma can also be varying depending on the context the individual finds themselves encountering and so is more adequately described as a state as opposed to a trait (Corrigan & Watson, 2002b).


*Figure 1: Corrigan and co-author's (2002a; 2004;2011) Socio-Cognitive Model of Self-Stigma*

Corrigan and Watson (2002b) also proposed a paradox to self-stigma that elaborated on the Socio-Cognitive model, in that, many people with mental illness seem either oblivious to public stigma's affects and report no loss of self-esteem or self-efficacy, or report righteous indignation of stigma (Corrigan et al., 2002b). This righteous indignation can be seen as the opposite of self-stigma and viewed as empowerment, where self-stigma is successfully challenged (Corrigan et al., 2002b; Corrigan & Rao, 2012). In effect, Corrigan et al. (2002b) proposed there is a continuum of self-stigma responses that range from internalisation to challenging stigma. They also contend that people who perceive stigma as legitimate have reduced self-esteem, and those who do not believe stigma is legitimate will have intact self-esteem (Corrigan et al., 2002b). Individuals who identify with the stigmatised group will become angry while those who do not will appear unaware of self-stigma (Corrigan et al., 2002b). These responses to stigma are outlined in Figure 2 below. Both Corrigan et al.'s (2002a; 2004; 2011) Socio-Cognitive model and Corrigan and Watson's (2002b) Paradox of Self-Stigma model are supported by the literature as considerable evidence has been reported from both perspectives; some research finds that stigma can have a negative impact on self-esteem in people with mental illness, whilst other research has shown some individuals can protect themselves from the negative effects of stigma (Link, Mirotznik & Cullen, 1991; Major et al., 2005; Shih, 2004). This suggests that there is a need to explore the variation in responses to stigma.

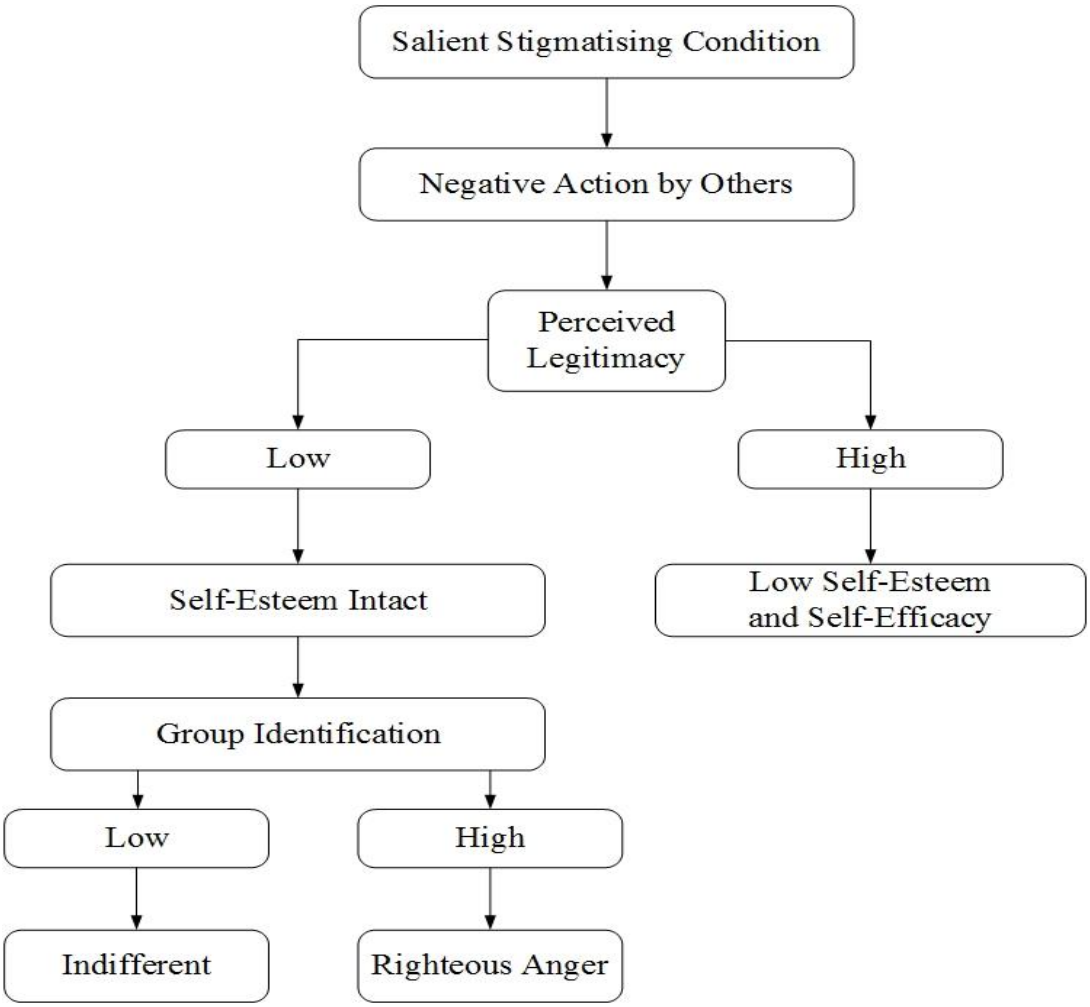


*Figure 2: Corrigan & Watson's (2002b) Paradox of Self-Stigma Model.*

Thus, Corrigan et al.'s (2002a; 2004; 2011) Socio-Cognitive model and Corrigan and Watson's (2002b) Paradox of Self-Stigma model will both be applied in this study as they include social contexts of self-stigma, which is an important aspect in this research. The view that social and cognitive contexts influence self-stigma is in line with the premise of this study, which aims to explore the cognitive and social experiences of gender and depression. The Modified Labelling Theory (MLT) (Link, Cullen, Struening, Shrout & Dohrenwend, 1989) focuses mostly on the individual and does not take into account the wider social context that the individual exists within. As outlined above, previous literature on the concept of stigma show that it is important to take societal systems into account when studying stigma. Corrigan and Watson's (2002b) aforementioned Paradox of Self-Stigma model also focuses more on the process of how individuals are not affected by stigma and thoroughly discusses the concept of stigma resistance and empowerment, unlike other self-stigma theories (Link & Phelan, 2001). The theory that self-stigma is not always inevitable and stigma can be managed effectively is

important in this study, as it aims to explore the varying different experiences of self-stigma in men and women.

### 2.7 Self-Stigma and Seeking Help

The relationship between self-stigma of mental illness and seeking help has been debated within the literature. Seeking help is the term used to describe an individual with a mental illness commencing and engaging with support from mental health services (Kovandizic et al., 2011). Previously, self-stigma of mental illness was theorised as a mediator between public stigma and less favourable attitudes towards help-seeking (Corrigan, 2004; Vogel, Wade & Hackler, 2007). Recently, there have been suggestions that the self-stigma of seeking help is related to help-seeking behaviour (Tucker et al., 2013). In addition, the self-stigma of mental illness and the self-stigma of seeking help are different constructs (Tucker et al., 2013). The construct of self-stigma of seeking help is described as an individual's negative feelings towards seeking help (Tucker et al., 2013). This construct is related to Corrigan's (2016) label avoidance construct, which involves people refraining from seeking help from services in order to avoid the label of mental illness. Lannin, Vogel, Brenner and Tucker (2015) proposed a theoretical model that supports and adds to Corrigan et al.'s (2002a; 2002b; 2004; 2011) theories by suggesting that self-stigma of mental illness and the self-stigma of seeking help are separate constructs, with only self-stigma of seeking help related to a person's intentions to seek help. However, this model has not been adequately evaluated by other research.

In addition, a recent systematic review examining the relationship between different types of stigma and seeking help revealed that self-stigma and treatment stigma, a similar construct to self-stigma of seeking help, both only show a small association with reduced help-seeking (Clement et al., 2015). Clement et al. (2015) concluded that multiple factors contribute to help-seeking, such as structural stigma, demographics, and strategies used by the individual. These strategies included rejecting stigma and ignoring what others think (Clement et al., 2015). Thus, it is still unclear how the construct of self-stigma of mental illness or the self-stigma of seeking help relate to help-seeking, though research points towards both being weakly associated (Clement et al., 2015). Other research has suggested anticipated stigma, fear of rejection, can increase self-stigma, which affects whether an individual engages in help-seeking and their need to be self-reliant (Jennings et al., 2015). Although there is limited conclusive research, help-seeking is clearly an important part of a person's experience of

mental illness. For the purpose of this study, self-stigma of mental illness and self-stigma of seeking help will be viewed as two separate constructs.

### 2.8 Stigma Management

Stigma management is the conceptualisation of an individual's reaction to public stigma. The different reactions to stigma have not been thoroughly examined and much is still unclear about what strategies individuals use to counteract the impact of stigma (Thoits, 2011). Some management strategies can mediate the harmful influences of stigma, such as self-stigma, and so focusing on stigma management allows us to ascertain what strategies are effective (Schomerus & Schulze, 2011). As previously discussed, although a person can experience stigma, the degree to which a person's self-esteem and self-efficacy is effected can be different depending on the individual (Corrigan & Watson, 2002b; Ritsher, Otilingam & Grajales 2003). Corrigan and Watson (2002b) outline the cognitive responses individuals use, they do not detail the full range of management strategies that can lead people to perceive stigma as legitimate or illegitimate and thus internalise or resist stigma. The strategies that people use when responding to stigma is of interest as it is a part of the experience of stigma, and can help us to understand more about the experience of self-stigma.

Stigma management can involve individuals feeling shame, socially withdrawing and becoming secretive (Goffman, 1963; Link et al., 1989). Secrecy and withdrawal are traditionally considered as both an ineffective process and a draining process (Link et al., 1989; Link et al., 1991). These strategies are seen as defensive and are used to protect the individual from negative attitudes and discrimination of others (Link et al., 1989; Link et al., 1991). Importantly, there are multiple, rarely explored strategies that may help individuals resist the negative effects of stigma (Thoits, 2011). Recent evidence suggests that stigma management can be a positive and empowering experience (Thoits, 2011). Society may view stigma as a major affliction, however, individuals who have a discredited social identity (such as depression), may have a different view (Shih, 2004). As outlined above, the opposite of self-stigma is people reacting to stigma with empowerment and righteous anger (Corrigan & Watson, 2002b; Rappaport, 1987). Empowerment can be described as a psychological sense of personal control or influence (Rappaport, 1987). Empowerment in mental illness involves lessening stigma, beating mental illness and supporting recovery (Corrigan & Garman, 1997). Many individuals report they gained strength and believe that they have learned valuable life lessons in confronting adversities caused by stigma (Shih, 2004). This supports Corrigan and

Watson's (2002b) theory that people with mental illnesses may not internalise stigma but react with righteous indignation which can be an empowering experience.

Deflecting and challenging have been suggested as effective strategies as they have been seen to protect an individual's self-esteem (Thoits, 2011). Strategies such as educating others, humour, and information seeking, or disclosure about their mental illness have positive results on both self-esteem and mental health, suggesting a sense of empowerment (Corrigan et al., 2016; Ilic et al., 2012; Ilic et al., 2014). However, other strategies such as withdrawal can lead to lower mental health and normalising (comparing mental illness to a physical illness) has no effect (Corrigan & Rao, 2012; Ilic et al., 2012; Ilic et al., 2014). Ilic et al. (2014) concluded that some strategies lead to empowerment and reduce stigma, whilst others do not reduce stigma. One major limitation of Ilic et al.'s (2014) study is their focus on perceived stigma alone without considering self-stigma. As self-stigma has been shown to be more related to self-esteem and self-concept (Lannin et al., 2015; Vogel et al., 2007), not measuring self-stigma of participants leaves a major part of the puzzle missing from any understanding of whether these strategies are effective at resisting stigma fully. Corrigan and Rao (2012) suggested the stages of disclosure of a mental illness can lead to resisting self-stigma specifically. Self-stigma can lead people to socially withdraw in order to protect their shame (Corrigan & Rao, 2012). Disclosing to others can be the first step to managing individual's self-stigma, however, it can be viewed as frightening as it can lead to negative reactions, which can be isolating (Corrigan & Rao, 2012). Others can practise indiscriminate disclosure and tell everyone about their mental illness, or even broadcast their experiences in order to educate others (Corrigan & Rao, 2012). This leads to a sense of empowerment and control over their experience of their mental illness and of stigma (Corrigan & Rao, 2012). Thus, disclosure has the possibility of being an effective stigma management strategy.

Stigma management also includes the importance of clinical interventions to help effectively resist stigma. However, many interventions are still in their early stages, although outcomes have been proven to be positive (Yanos, Lucksted, Drapalski, Roe & Lysaker, 2015). Psychoeducation on mental illness and narration in order for the individual to make sense and become active and empowered in their lives are common strategies within these interventions (Yanos et al., 2015). However, Yanos et al. (2015) noted that future research needs to assess how the various interventions can be most effective in certain contexts and cultures.

While quantitative studies and intervention studies contribute to our understanding of how stigma is managed, they do not explore the lived experience of stigma or how individuals experience the strategies they use to resist the effects of stigma. To provide a comprehensive understanding, it is important to look at how qualitative studies have explored the phenomenon. Using qualitative methods, Camp, Finlay and Lyons (2002) interviewed women with various mental illnesses and found that although these women were aware of the negative perceptions of others and the stigma attached to their mental illness, they did not show evidence of internalising this stigma. Although these women avoided interactions with groups from which they felt different and excluded, there was no evidence of these women blaming themselves (Camp et al., 2002). Thus, social withdrawal appeared not to relate to how they viewed themselves. This finding contradicts Link et al. (1991) who suggests that social withdrawal and secrecy are a sign of negative feelings in people with stigmatised identities. These contrasting findings highlight the importance of exploring qualitatively what the experience of these management strategies signify for the individual and whether they indicate agreement of prejudices. Although Camp et al.'s (2002) study added to the literature base, they did not explore how each specific mental illness related to women's view of themselves, thus it is unclear whether certain mental illnesses shaped the women's experiences in differing ways.

Mackay, Bradstreet, McArthur and Dunion (2015) used a mixed methods approach to study self-stigma in people with mental illnesses and found participants experienced mental illness as a redefinition of their identities. They experienced a sense of shame and failure, however, they endeavoured to lessen their self-stigma by telling others about their illness experience and taking responsibility for their recovery, leading to a sense of empowerment. These findings led Mackay et al. (2015) to suggest identity work as part of an intervention to reduce self-stigma in individuals. Mackay et al. (2015) also suggested that self-stigma and stigma resistance can occur concurrently.

Michalak et al. (2011) looked at one specific mental illness, bipolar disorder, and conducted a mixed methods study, which included focus groups and interviews. They reported that people can experience internalised stigma at first but have a gradual process of coming to terms with their mental health diagnosis and can integrate their illness into a positive social identity. Michalak et al. (2011) reported that participants described both empowering and anxiety provoking experiences regarding disclosure to others of their bipolar disorder. They concluded that the stigma of bipolar disorder did not always negatively affect participants' self-image (Michalak et al., 2011). As the study's primary focus was self-management strategies

and not stigma or self-stigma, there may have not been as great a depth and breadth of perspectives as might be expected if the study had been specifically exploring stigma.

### 2.9 Summary of Stigma, Self-stigma and Stigma Management

The above sections have introduced the concept of stigma and two main types of stigma: public stigma and self-stigma. There are differing ways people with mental illness can react to public stigma. Corrigan and co-authors (2002a; 2004; 2011) Socio-Cognitive model explores how individuals can internalise stigma, and Corrigan and Watson's (2002b) Paradox of Self-Stigma model states how individuals can be energised by prejudice and feel empowered. Corrigan and Watson (2002b) theorising the possibility that stigma may not be internalised but be resisted is an important phenomenon to consider. Corrigan and Watson's (2002b) suggestion of self-stigma and empowerment being on opposite ends of a continuum is reflected in the literature (Brohan, Gauci, Sartorius & Thornicroft, 2011; Ilic et al., 2012).

Reacting to stigma involves numerous management strategies (Corrigan et al., 2009; Ilic et al., 2014; Link et al., 1991) and, depending on the individual, can be effective at resisting stigma (Boardman et al., 2011; Corrigan et al., 2002b; Shih, 2004). Much of the self-stigma research and the managing stigma research have employed quantitative methodologies. Prior self-stigma research tends to focus on how a single factor or status affects people's experiences (Livingston & Boyd, 2010). Quantitative literature has been helpful in creating theories and discovering causes and effects of self-stigma (e.g., Corrigan et al., 2016; Ilic et al., 2014). However, as shown by the qualitative studies mentioned above, self-stigma is complex and individual experiences differ widely. The lack of qualitative methods in self-stigma research has prohibited researchers from exploring the wide range of experiences and strategies individuals can use to react to stigma. There is also limited research on self-stigma and specific mental illnesses, thus, there may still be a lot unknown as to how self-stigma is managed differently by individuals with various mental illnesses, for example, depression vs. anxiety. Studying specific mental illnesses would give more insight into how stigma is internalised or resisted. Thus, the mental illness depression is the subject of this study. The research objectives will be outlined in more detail at the end of the literature review. For now, the following sections will introduce the reader to perspectives of depression and how it is viewed and experienced as gendered.

## 2.10 Depression

Major depressive disorder (MDD), more commonly known as depression, is a very prevalent mental illness. The World Health Organisation (WHO) predicts that by the year 2030, depression will be the leading cause of disability (WHO, 2011). The symptoms of depression are debilitating and can affect daily functioning (American Psychiatric Association [APA], 2013). The symptoms of depression are outlined in the Diagnostic Statistical Manual 5th Edition which states that five or more specific symptoms need to be present for at least two weeks and these symptoms should represent a change from previous functioning (APA, 2013). These symptoms include depressed mood; marked diminished interest in activities, changes in weight or sleep patterns; psychomotor agitation; feelings of worthlessness; diminished ability to concentrate; and recurrent thoughts of death (APA, 2013). Peri-Partum depression (PPD) is a type of depressive disorder as it has similar symptoms except it occurs specifically after childbirth (APA, 2013). The causes of both these types of depression are debated within the literature. However, the majority of the meta-analytical and review literature supports the theory that all depressive disorders are complex and result from both genetic and environmental influences (e.g., APA, 2013; Sullivan, Neale & Kendler, 2000). Consequently, this study will take the view that depressive disorders are caused by both genetic and environmental effects.

## 2.11 Stigma and Depression

We have seen how stigma of mental illness is common and can lead to self-stigma. However, not all mental illnesses are stigmatised equally. Stigma exists on a continuum and so different mental illnesses have different levels of stigma attached to them (Pescosolido & Martin, 2015). For example, schizophrenia is one of the most stigmatised mental illnesses and depression is one of the least stigmatised mental illnesses (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Thus, as public stigma varies depending on the mental illness, how people respond to and manage this stigma may vary also. To allow for this, this study concentrates on one mental illness. The focus of this research is depression. While it is one of the lesser stigmatised illnesses, self-stigma still occurs in depression (Brohan et al., 2011; Oakley, Kanter, Taylor & Duguid, 2011). The reasons for this are likely to be complex, though it may be because there is a public perception that individuals should be more in control of their depression (Crisp et al., 2000). Thus, self-stigma and depression is a phenomenon that is important to explore.

## 2.12 Self-Stigma and Managing Stigma in Depression

Rates of self-stigma in people with depression are approximately 20% (Brohan et al., 2011), however, this is possibly higher as self-report measures may not capture implicit self-stigma (Rusch et al., 2010). In studies of individuals with depression, self-stigma has been associated with reduced quality of life, lower self-esteem, reduction of morale, and increased avoidance behaviours (Manos, Rusch, Kanter & Clifford, 2009; Ritsher & Phelan, 2004; Yen et al., 2005). Yen et al. (2005) maintained that individuals who report higher self-stigma have severer symptoms of depression. This has been theorised to be due to perceiving greater stigmatisation because of their depression (Pyne et al., 2004). Self-stigma and depression can aggravate each other as individuals can become depressed, experience stigma and then internalise public negative attitudes (Kanter, Rusch & Brondino, 2008). Experiencing a chronic illness, like depression, can lead to a threat to the self and so there can be a need to reconstruct this identity (Charmaz, 1991). This can lead to individuals avoiding talking to others about their depression, resulting in increased isolation, which may increase depression and lead them to avoid seeking treatments for depression (Kanter et al., 2008). These closely linked constructs can make it difficult to study self-stigma using quantitative measurements, however, self-stigma can be elicited by focusing on people's opinions of public stigma (Corrigan & Watson, 2002b). As previously mentioned, stigma of mental illness is so common and entrenched in society that people have no choice but to be aware of this stigma (Corrigan et al., 2012). However, self-stigma is not always inevitable; in a Europe-wide study, Brohan et al. (2011) found a significant amount of people with depression resist stigma by empowering themselves with social contacts, education and employment. As previously outlined, there is value in exploring stigma qualitatively as it allows the researcher to find out the experience and motivation behind management strategies and gain a deeper understanding of stigma and depression.

Two recent studies that included qualitative methods document that people with depression can successfully resist stigma. Ridge and Ziebland (2012), who studied participants with depression, found people did not disclose due to being afraid of being viewed as weak due to their self-stigma. However, over time, people can integrate their depression into their identity by viewing their depression as normal and common and come out about their depression (Ridge & Ziebland, 2012). Although the findings show how individuals can resist stigma, viewing depression through a coming out framework can neglect other elements such as history and context (Boxer & Cohler, 1989).

Using mixed methods, Boardman et al. (2011) stated that some individuals with depression took steps to resist stigma by drawing on existing support networks and expanding positive emotions. Interestingly, these same strategies were burdensome for other participants. This highlights how complex management strategies are empowering for some individuals and not for others. Boardman et al.'s (2011) qualitative methodology was limited by the selection of participants whose written texts scored high in stigma related questions and also by the fact that only a portion of each written text was analysed. This prevents a full exploration of either the experience of stigma or the events and context surrounding the experience of stigma in depression. Despite these weaknesses highlighted in both studies, these studies contribute to our understanding of managing the stigma of depression. They show individuals do not always internalise stigma and can resist stigma by integrating depression into their identity and utilising existing resources (Boardman et al., 2011; Ridge et al., 2012).

### 2.13 The Gender of Depression

Gender is an important variable to consider in any study of depression because there is both an actual and perceived difference between men and women experiencing depression (Boysen, Ebersole, Casner & Coston, 2014). West and Zimmerman (1987) describe gender as an identity that is a distinctively sociological, routine construct embedded in everyday interactions that can be an expression of masculinity or femininity. Thus, it is likely to be embedded in the everyday interaction of depression. We have seen how stereotyping is a fundamental part of stigma (Link et al., 2001). Recent literature has focused on the concept of intersecting stereotypes, an example being when stereotypes are gendered. A study conducted in the United States found that race can be viewed as gendered, with Blacks viewed as the most masculine race and Asians as the most feminine race (Galinsky, Hall & Cuddy, 2013). Much of the research on intersection of stereotypes has focused on the overlap of race and gender; however, there is evidence to suggest there is an overlap between gender and mental illnesses (Boysen et al., 2014).

Although mental illnesses are not explicitly treated or described as gendered mental illnesses by health professionals or the public, in general, mental illnesses have been found to be viewed as either a masculine or feminine illness by society (Boysen et al., 2014). Depression, in particular, is largely constructed as a feminine disorder (Boysen et al., 2014). This is likely due to ingrained societal beliefs about how men and women should behave. Classic research documents that people perceive psychological healthy men as unemotional, stable, and tough (Broverman, Vogel, Broverman, Clarkson & Rosenkrantz, 1972). In contrast,

psychologically healthy women are seen as expressive and sensitive (Broverman et al., 1972). In later studies, these stereotypical views on gender are reported to be still applicable today, with women expected to be nice and sociable, and men expected to be strong and self-reliant (Prentice & Carranza, 2002). In a more recent study, masculinity was still associated with self-reliance, control, independence, and providing and protection to others (Levant, 2011). Similarly, providing financially for the family is linked with masculinity despite the changing view of men's roles and an increase in women taking on provider roles (Bernard, 1981). Christiansen and Palkovitz (2001) stated the role of provider is still of importance in fatherhood roles. The media in recent times was noted to perpetuate gender stereotypes of depression, with men with depression portrayed as less emotional and women with depression viewed as relational and emotionally orientated (Bengs, Johansson, Danielson, Lehti & Hammarstrom 2008). In summary, depression is very much gendered, with it specifically being viewed as a feminine disorder. This gendered view is expected to affect how men and women experience depression.

### 2.14 Gendered Experiences of Depression

Despite similar symptoms of depression being experienced by both genders, men and women appear to express and manage depression differently (Johnson et al., 2012). Gender plays an important role in the research of depression (Addis, 2008). Men and women with depression can be influenced by this broader societal views of depression, which can inform their experiences and decisions (Johnson et al., 2012). However, while a lot of gender research has studied gender as a biological sex difference it has not addressed the influence of gender as a social construct in men's and women's health behaviours (Addis & Mahalik, 2003). The research that has explored gender as a social construct has highlighted striking differences between men and women's experiences of depression.

A study involving six European countries highlighted how men responded to depression by being more likely to believe their depression was caused by physical illness or work problems while women were more likely to associate their depression with interpersonal stressors and relationship problems (Angst et al., 2002). The qualitative research on the gendered experience of depression has consistently shown that there are more complexities and differences in the experience of depression in men and women, which shall now be discussed. Results from the Danielsson, Bengs, Lehti, Hammarstrom and Johansson (2009) study documented that men spoke of depression as something beyond their control with women feeling a greater sense of responsibility and concern for relationships. Men with depression

are aware of societal norms and can feel pressure to conform to masculine stereotypes such as being self-reliant which, in turn, can further contribute to depression (Chuick et al., 2009; Emslie, Ridge, Ziebland & Hunt, 2006). Discursive psychological research reported men attempt to keep their masculine identity intact by using the term stress instead of depression (O'Brien, Hunt & Hart, 2005; Noone & Stephens, 2008). Mahalik and Rochlen (2006) noted that men only disclosed to close individuals about their depression due to their self-esteem being at risk because of depression being viewed as non-normative. Johnson et al. (2012) explored help-seeking attitudes in men with depression and stated men were affected by gender norms and so men emphasised self-reliance and guarded vulnerability. However, there are ethical issues with this study as some of these men were self-diagnosed as having depression and it is unclear whether participants who reported high on the Beck Depression Inventory were informed of these clinically significant scores.

Spendelow (2015) conducted an analysis of qualitative studies of how men cope with depression and found that men can manage depression by reframing masculine norms of strength and independence as a part of the experience of depression, as opposed to depression being the cause of a reduction in strength and independence. Men were found to cope with depression by either socially withdrawing or concealing depression in public in order to protect their masculinity (Oliffe, Galdas, Han & Kelly, 2013; Oliffe, Robertson, Kelly, Roy & Ogrodniczuk, 2010). However, these studies included participants who self-identified as experiencing depression, limiting the validity of the findings.

Beauboeuf-Lafontant (2007) examined women's experiences of depression in a non-clinical sample and reported women normalised being selfless due to their views of female norms of self-silencing. Lafrance and Stoppard (2006) stated that depression is not compatible with the 'good' woman identity which expects women to be pleasing and self-sacrificing. This research ties in with Jack's (1991) suggestion that women with depression prioritise their relationships and sacrifice and silence their own needs in order to fit into the identity of a 'good' woman. However, during recovery women can reject the idea that self-care goes against their female identities of being self-sacrificing and reframe it as an important aspect of their recovery (Lafrance & Stoppard, 2006). Although the above studies contribute to the knowledge base of the gendered experience of depression, by only exploring one gender at a time these studies are not able to fully examine the similar and contrasting experiences of depression in the same context.

Johansson et al. (2009) did study both men and women with depression. They interviewed both genders to explore how depression was understood. Their findings highlighted that women and men described different reasons for experiencing depression. Men described environmental reasons were the cause of their depression. While women described a slower onset and emphasised personality as the reason for their depression. Johansson et al. (2009) interpreted these results as men and women conforming to gender stereotypes. They also noticed that men had more fear of being diagnosed for fear of the stigma attached to depression, suggesting men are more concerned with stigma than women.

Danielsson, Bengs, Samuelsson and Johansson (2011) interviewed young people aged 17 to 25 years who were diagnosed with depression and found participants spoke about gender stereotypes that led to feelings of shame and low self-esteem. These results suggest gendered norms are important even in the present day amongst younger generations. Being normal and fitting in was also important for their self-esteem as they wanted to conform to gender norms (Danielsson et al., 2011). These stark gendered differences emphasise how gender can affect experiences considerably. Thus, as gender influences how people respond to depression, it is likely that gender influences how people respond to the stigma of depression.

In contrast, Emslie, Ridge, Ziebland and Hunt (2007) found gender similarities as well as gender differences in men and women's experiences of depression. The similarities included both men and women had difficulty in recognising and speaking about mental illnesses, which had negative effects on how they communicated with health professionals (Emslie et al., 2007). This highlights how there can occasionally be gender similarities between men and women with depression.

### 2.15 Research on the Gendered Experience of the Self-Stigma of Depression

With gender being such an important part of the experience of depression, and stigma being an important part of the experience of depression, it is surprising that there is a dearth of studies exploring the gender differences of self-stigma of depression. Self-stigma is rarely considered a gendered experience yet self-stigmatising beliefs about depression are thought to represent the self-application of learned social values and norms associated with social identity (Corrigan, 2004; Goffman, 1963). As gender identity is an important part of social identity, it is not beyond reason to suggest that gender may affect how stigma is experienced. Plus depression is a feminine disorder, and this shapes the experience of stigma for women and men as stigma threatens masculine and feminine identity in ways that are different for women and

men. Both gender and stigma are social constructs with gender being shaped in continuing social interactions between men and women (Addis, 2008) and stigma also being constructed in social interactions (Corrigan et al., 2002b; Goffman, 1963). Thus, it is likely that they affect each other.

Theoretical models have been proposed to explore self-stigma and gender and depression. For example, both Levant et al. (2013) and Pederson and Vogel (2007) proposed theories that self-stigma partially mediates the relationships between male gender role conflict and traditional masculinity ideology, and willingness to seek counselling. However, these theories have only been tested on non-clinical samples (Vogel, Himerdinger-Edwards, Hammer & Hubbard, 2011) and both only explore one gender. In addition, as discussed above, recent literature has suggested the self-stigma of help-seeking may be a separate construct to the self-stigma of mental illness construct (Tucker et al., 2013), thus Levant et al. (2013) and Pederson and Vogel (2007) have not captured the full experience of self-stigma. The lack of theoretical literature highlights the need for more research conducted on the full experience of self-stigma and gender roles of men and women with depression. Latalova, Kamaradova and Prasko (2014) conducted a recent literature review of self-stigma and men with depression which only focused on studies employing non-clinical samples. However, it is interesting to note they found that conforming to masculine gender norms of self-reliance, endurance of suffering, and unwillingness to seek help is associated with self-stigmatisation (Latalova et al., 2014). Studies on clinical samples are needed to explore further the gendered experience of depression in men.

The literature base suggests that women with depression also view stigma through the eyes of their gender. Women with depression appear to be concerned about their female social identity being threatened due to the social expectation of females of care-taking (Gilligan, 1982; Oakley et al., 2011). Studies of women with Peri-Partum Depression (PPD) found that PPD was viewed as a character weakness both by the public and by PPD sufferers themselves (McLoughlin, 2013). New mothers report significantly greater internalised stigma than new fathers with PPD (Mickelson, Biehle, Chong & Gordon, 2016). These social expectations contribute to the social perception that being a ‘good’ mother and experiencing depression and PPD are incompatible. These findings are similar to women experiencing depression during pregnancy. Staneva, Bogossian and Wittkowski (2015) conducted a meta-synthesis of qualitative studies of pregnant women with depression and noticed a common theme to be the negative experience of dealing with stigma. Women were concerned of stigma as a result of

interpreting their experience of depression during pregnancy as deviant and against the 'perfect mother' view in society. Oakley et al. (2011) conducted a mixed methods study and found women with depression reported keeping the diagnosis secret was common, and depression severity and self-stigmatising beliefs were positively correlated. Although Oakley et al. (2011) do not report on the focus group findings, the quantitative section of the study highlighted that female social identity was intertwined with the self-stigma of mental illness (Oakley et al., 2011). The self-stigma of depression was present as being diagnosed with depression was a threat to this identity as it can weaken the psychosocial functioning within relationships (Oakley et al., 2011).

Qualitative studies are important as they can explore the complexities and subtleties of the lived experience of gender and self-stigma. Despite their importance, there are limited qualitative studies that have explored gender and self-stigma. We have seen how studies have explored self-stigma and depression but have not explored the gendered experience (Boardman et al., 2011; Ridge & Ziebland, 2012). Other studies have studied gendered experience of depression but not of public stigma or self-stigma (Johansson et al., 2009; Johnson et al., 2012). There have been three qualitative studies that have discussed stigma and gender. Two qualitative studies did not specifically explore the construct of stigma, but have explored how gender has affected the experience of depression (Schreiber & Hartick, 2002; Oliffe, Han, Ogrodniczuk, Phillip & Roy, 2011). In these studies, themes of stigma were discovered and discussed. These findings of stigma shall now be explored.

Schreiber and Hartick (2002) interviewed 43 women with depression to explore how they experience and manage depression. A grounded theory analysis was applied with results indicating that women used a biomedical explanation of depression to manage the stigma of depression. Women spoke of an internal sense of shame about their depression and saw themselves as deviant, suggesting experiences of self-stigma. They felt they were not 'getting on with life' and were lazy. Depression separated them from the female societal values of being productive, able, and cheerful.

Oliffe et al. (2011) interviewed 22 older men to explore the connections between masculinity, depression, and suicide. Oliffe et al. (2011) noted that stigma was a barrier for men to act on their suicidal thoughts. Men's desire to protect their families and friends from suicide-related stigma had inadvertently protected men from dying by suicide. Men's gender identities as provider and protectors affected how men experienced depression and suicide.

This study maintained that masculine ideals around work and family on men's depression were ever-present and helped bolster men's resilience. These identities gave men a purpose to stop thoughts about self-harm and suicide that occur frequently when experiencing depression.

One qualitative study has explored the gendered experience of public stigma in people with mental illnesses in Peru (Robillard, 2010). Robillard (2010) found men and women's inability to fulfil their typical gender roles of men providing and women caring for the children due to their mental illness led them to feel stigmatised. Gender was found to shape the experiences of stigma and how it was constructed (Robillard, 2010). However, this study only explored public stigma as opposed to self-stigma and participants had a variety of mental illnesses.

The few studies conducted on gender and depression have highlighted how gender norms and constructs of masculinity and femininity identity can influence how men and women experience stigma. However, as Schreiber et al. (2002) and Oliffe et al. (2011) were not comprehensively exploring stigma, or self-stigma, the full experience of stigma was not fully examined. Robillard (2010) studied public stigma and did not study depression specifically. With stigma such a pertinent part of the experience of depression, it is surprising that there is limited research exploring how gender affects self-stigma in depression. To the author's knowledge, there are no studies exploring the experience, management, and possible resistance of self-stigma, in both men and women with depression.

### 2.16 The Current Study

Stigma is a pervasive phenomenon that can affect people with depression. People can manage stigma in drastically different ways, essentially by internalising or resisting stigma (Corrigan et al., 2002b). Some people can resist the negative effects of stigma by viewing it as an empowering experience (Shih, 2004). Depression is seen to be a stigmatised illness (Crisp et al., 2000). How individuals manage this stigma of depression is of great interest to researchers, specifically in the contest of gender, as depression is largely seen as a gendered mental illness (Boysen et al., 2014; Johnson et al., 2012). Men and women are seen to react to the experience and the stigma of depression in different ways due to societal norms (Oakley et al., 2011; Johnson et al., 2012). As we have seen, despite the prevalence of gender differences in depression, self-stigma and gender have not been studied extensively. No study has explored how both gender and depression can influence each other and effect the ways in which stigma is managed. There are also many theorised stigma management strategies (Ilic et al., 2014),

however, there is a gap in the research on how gender can influence what stigma management strategies are employed regarding self-stigma. Thus, the research question of this present study is:

- How do men and women with depression experience, manage, and potentially resist, self-stigma?

This question aims to fill the gap in the literature base related to exploring the gendered experience and management of self-stigma in men and women with depression.

# Chapter Three: Method

## 3.1 Introduction

This chapter will describe the chosen qualitative research design, Interpretive Phenomenological Analysis (IPA), and provide detailed rationale for choosing this method. Following this, details of the study design, participants, materials, procedure, ethical considerations, data analysis, and considerations on ensuring validity and reliability will be described.

## 3.2 Rationale for Methodology

### 3.2.1 Qualitative Research

Qualitative research was appropriate for many reasons. Due to the exploratory nature of the research question, quantitative methods were not considered appropriate. Quantitative methods advocate that events that can be observed and measured and can be tested through quantifiable data in order to contribute to total knowledge (Ashworth, 2008). Although quantitative research has its place in testing theories in order to progress theoretical research, qualitative methodology can also reach this goal. Recently, there has been a significant increase in the use of qualitative methodologies in clinical research (Pietkiewicz & Smith, 2014). Qualitative research focuses on the meaning and the quality of the experience compared to quantitative research, which focuses on causal relationships (Pietkiewicz & Smith, 2014). Qualitative designs are derived from constructivism, in that both researcher and participant influence the constructions of knowledge (Smith, Flowers & Larkin, 2009). This view matches the research question and the research's interest in gaining a greater understanding of the experience of self-stigma in both men and women with depression. A qualitative approach is expedient as it will allow for an in-depth understanding and a unique insight into the construct of self-stigma. Quantitative methodology would not facilitate a full exploration of the intricacies of the lived experience of self-stigma. A qualitative exploration with in-depth interviews will afford rich insights into the complex phenomenon that is self-stigma. Semi-structured interviewing is a useful type of qualitative methodology as it allows for initial questions to be modified if other interesting and important areas arise (Smith et al., 2009).

### 3.2.2 Interpretive Phenomenological Analysis (IPA)

One qualitative method that is becoming increasingly popular in psychology research is IPA (Pietkiewicz & Smith, 2014). The main aim of IPA is to explore how individuals make sense of their experiences. To achieve this, IPA uses the fundamental principles of phenomenology, hermeneutics, and idiography (Pietkiewicz & Smith, 2014). The first principle of phenomenology involves focusing on the way events appear to individuals in their experience (Pietkiewicz & Smith, 2014). Phenomenological studies comprise of emphasising the individual's preconceptions, ideas, and concerns (Larkin, Watts, & Clifton, 2006).

Phenomenology also involves hermeneutics, the second principle, which focuses on the interpretation of the meaning of texts (Rennie, 1999). In IPA, the human experience is affected by people, language, relationships, and culture and it is impossible to separate these when disclosing their true experience (Larkin et al., 2006). IPA consists of a two-stage interpretation process, referred to as 'double hermeneutic' (pg. 8), in which the researcher plays an active role by impacting on the degree to which the participant's experience is accessed and how the researcher makes sense of the participant's personal world (Pietkiewicz & Smith, 2014). Both participants' and researchers' interpretations are taken into account thus allowing the researcher to gain rich, descriptive accounts of the phenomenon under investigation in order to understand the participant's lived experience (Pietkiewicz & Smith, 2014).

The third principle is idiography. This refers to achieving an in-depth analysis of single cases and unique perspectives before moving onto the next case or generating any general statements (Smith et al., 2009). Thus, the IPA researcher needs to describe what it is like for the participant and also think about what it means for the participant to make these statements in a wider social and cultural context (Larkin et al., 2006). In this way, the accounts of the experience are constructed by both the participants and the researcher and so it is important for the researcher to be aware of their own biases and preconceptions (Smith et al., 2009).

### 3.2.3 Rationale for Choosing IPA

IPA was chosen for a number of reasons, firstly, IPA is recommended for use where a study focuses on individuals' experiences of specific event or process (Larkin et al., 2006), and secondly, when purposive and homogeneous sampling is being used. Thirdly, IPA is appropriate if the research question is broad and open (Glaser & Strauss, 1967; Smith et al., 2009). This is important to address the broad research question in this study which asks an open question about the individual's experience of self-stigma, specifically in people with

depression. IPA research requires the researcher to be self-reflective, such as taking into account researcher bias and the dynamic relationship between researcher and participant (Willig, 2008). Reflexivity is an important part of Clinical Psychology and so the qualitative method can be valuable to Clinical Psychologists, thus IPA fits with the researcher's experience and background.

Other methodologies were considered for the current study: Discourse Analysis and Grounded Theory. Discourse Analysis (DA) explores the regulatory and constructive function of language (Parker, 1992). DA focuses on how people make use of language and how language creates a social reality. As this study wanted to explore participant's experiences and cognitions, as opposed to their function of language, IPA was deemed to be more appropriate.

Grounded Theory was also considered, this approach has the objective of generating a theoretical account of a phenomenon and requires a large sample size (Smith et al., 2009). Given that this study aimed to explore existing theories, not create a new theory, and the sample size is small; Grounded Theory was not considered appropriate. Grounded Theory also draws on individual accounts to illustrate theoretical claim (Smith et al., 2009). This study aims to explore the convergence and divergence of experience between participants on a more nuanced and detailed basis, reflecting the goals of an IPA study (Smith et al., 2009).

### 3.3 Participants

Participants for the study were ten service users of a community day hospital. Table 2 below gives an overview of the participants' characteristics. Smith et al. (2009) stated that homogeneity is defined differently depending on the IPA study. For this study, homogeneity was defined as adults who had a primary diagnosis of depression. All participants had a primary diagnosis of depression. Nine participants had a diagnosis of major depressive disorder and one participant had a diagnosis of Peri-Partum Depression (PPD). PPD was included as it allowed the researcher to explore an aspect of depression that is gendered. Thus, this individual was included as the research question was meaningful to them (Smith et al., 2009). Secondary inclusion criteria included participants were individuals who were over the age of 18 and currently a service user of a community mental health team. While co-morbidity was allowed, however, the primary diagnosis needed to be depression. Individuals who had current substance misuse disorder or current psychotic symptoms that would impede participation in the interview were excluded.

The sample included six women and four men. Table 2 outlines the participants' details below. As IPA methodology proposes that a sample size between four and ten is sufficient for a professional doctorate, this sample size was considered adequate (Hefferon & Gil-Rodriguez, 2011).

Table 2

*Participant Profiles*

| Participant Pseudo Name | Gender | Primary Diagnosis | Age | Number of Years Since Initial Diagnosis |
|---|---|---|---|---|
| John | Male | Depression | 62 | 20 |
| Mark | Male | Depression | 60 | 1 |
| Laura | Female | Peri-Partum Depression | 36 | 10 months |
| Sarah | Female | Depression | 72 | 8 |
| Karen | Female | Depression | 36 | 3 |
| Catherine | Female | Depression | 27 | 2 |
| Jennifer | Female | Depression | 49 | 8 |
| Robert | Male | Depression | 51 | 19 |
| Jim | Male | Depression | 52 | 14 |
| Carol | Female | Depression | 59 | 3 |

## 3.4 Materials

### 3.4.1 Interview Schedule

A semi-structured interview was created by the researcher with the assistance of the supervisor and co-supervisor and based on prior literature (See Appendix A). The interview focused on the range of topic areas which the research wished to address:

- The participant's experiences of public stigma;
- How they manage these experiences;
- Their experience, or lack of experience, of self-stigma;
- How they manage self-stigma; and
- How their gender effects their experience of self-stigma

The interview questions were devised with the literature on IPA research in mind. IPA interviews attempt to come at the research question 'sideways', as it can be unhelpful or ineffective to ask participants about the phenomenon directly (Smith et al., 2009). With this in mind, the interview aimed to assist a discussion of these topics indirectly. Although participants were aware of the topic of the study for the purpose of informed consent, participants were not asked about self-stigma directly. This methodology allows the research question to be answered through analysis at a later stage (Smith et al., 2009).

## 3.5 Procedure

### 3.5.1 Recruitment

The consultant psychiatrist and senior clinical psychologist of a local day hospital were approached to recruit participants from this hospital. Once they gave informal consent, ethical approval was applied for and granted. The researcher then presented the research proposal to the staff at the local day hospital. Staff were asked to recruit participants that fit with the inclusion and exclusion criteria. Staff then recruited participants by verbally informing clients they felt fit the criteria of the research and providing them with an information sheet to read (See Appendix B). This information sheet detailed the aims and procedures of the study, including detailing that the researcher may need to check their files to ensure their primary diagnosis was depression. Once participants agreed to partake, participants signed a consent form (See Appendix C) and completed a contact details form (See Appendix D). As the number of participants recruited was small, the researcher did not need to turn away or refuse any participants from the study. These consent forms were collected by the researcher to enable contact to arrange an interview with the participants.

### 3.5.2 Interviews

The interviews were conducted in the local day hospital that the participants attended. These were arranged at a time and date that suited the participant and lasted from 20 minutes to 1 hour and 15 minutes. As there was a time gap between gaining consent at recruitment stage and interview stage, participants were asked to give written, informed consent again at interview (See Appendix E), interviews were recorded using a digital voice recorder. Once interview had been completed, information sheets were given to participants (See Appendix F). After the participant had left, the researcher wrote reflections and observations about the interview based on a set of reflective questions. An example of a research field note can be viewed in Appendix G.

## 3.6 Ethical Considerations

### 3.6.1 Ethical Approval

Formal consent was gained from the Research Ethics Committee at the Mid-West Regional Hospital on the 9th July 2015 (See Appendix H).

### 3.6.2 Informed Consent

Informed consent was ensured by verbally informing participants about the study and providing them with an information sheet which detailed the aims of the research and their exact part in the study (See Appendix B). Once the participants had read this information sheet and agreed to partake, they were asked to sign a consent form (See Appendix C). Informed consent was also verbally discussed at time of interview and written consent was again obtained at time of interview (See Appendix E). Once interview had been completed, information sheets were given to participants detailing their rights as participants (See Appendix F).

### 3.6.3 Confidentiality

The confidentiality of the research was explained to each participant both at initial recruitment and at interview stage. Participants were advised that the interview would be confidential, with the exception that if the researcher was concerned that the participant would harm themselves or harm another, their key worker at the day hospital would be informed. All identifying information, such as names and locations, were omitted from transcription in order to maintain anonymity. After each interview, the digital file was securely transported from the day hospital to the researcher's office where the file was uploaded on the researcher's personal, password protected computer. The voice recording was then deleted from the voice recorder. The file on the computer was encrypted and password protected.

### 3.6.4 Potential Distress

Due to the sensitivity of the research topic, the management of potential distress during or after the interview was considered. Details of a range of support services, including the day hospital crises number, were provided on both recruitment and interview stage through information sheets. The researcher also checked how the participants were feeling after the interview and verbally advised them to contact their key worker at the day hospital or one of the support services provided on the information sheet that if they became distressed at a later stage.

### 3.6.5 Data Analysis

All interviews were transcribed verbatim by the researcher for later data analysis. Identifying information was omitted from the interviews in order to maintain anonymity. Data was then formally analysed using IPA which involved a four step process.

1. *Multiple Readings*

The transcribed interviews were then read and re-read multiple times. This allowed the researcher to become familiar with the data. As each reading provided new insights, observations and reflections about the interview or about the transcript were noted down.

2. *Initial Noting*

Initial noting was then used on each transcript as it is recommended to use detailed, line-by-line initial coding in interview transcripts (Charmaz, 2006; Saldana, 2013). Initial noting, also known as initial coding, is a preliminary step that allows the researcher to discover analytic leads that can be further investigated (Saldana, 2013). Initial noting involves considering all possible directions of the data and analysing the substance and features of the data (Saldana, 2013). Following Smith et al.'s (2009) guidelines, the initial notes were divided into three different comments: descriptive comments (described the content), linguistic comments (explored specific language use), and conceptual comments (focused on interrogating on a more conceptual level). These were noted on the left hand side of the transcripts.

3. *Developing Emerging Themes*

The exploratory comments were then analysed to identify emergent themes. This stage involves using the notes created to generate a concise phrase at a slightly higher level of abstraction yet still grounded in the participants' account (Pietkiewicz & Smith, 2014). This was done on the right hand side of the transcripts (See Appendix I). The multiple readings, initial noting and developing emergent themes were done on a case by case basis. The emergent themes and their corresponding phrases that represented the emergent themes were written up in a separate document.

4. *Looking for Patterns Across Cases*

The final stage of the data analysis involved looking for patterns across each of the ten interviews. The document previously created in step three, the developing emerging themes stage, was printed out and each emergent theme was cut out. This allowed the researcher to have a visual overview of the emergent themes by placing them on a large surface (See Appendix J). These emergent themes were then grouped into minor themes, which in turn

made subordinate and superordinate themes, with gender similarities and differences noted. The researcher continuously refined themes by going back to the interview transcripts to ensure themes reflected the participants' accounts as well as the researcher's interpretations. Smith et al. (2009) outlines three categories of themes that can be found in IPA analysis: superordinate theme, subordinate theme, and minor theme. These three categories were used in the analysis. These themes are described in Table 3 below.

Table 3.

*Summary of Theme Categories (Smith et al., 2009).*

| | |
|---|---|
| Superordinate Theme | An overarching theme is a construct which applies to each participant in a corpus but which can manifest in different ways within cases. It represents an issue of thematic significance and similarity for participants arising throughout the data. |
| Subordinate Theme | A theme that it is influenced or influences the superordinate theme but has sufficient narrative accounts to warrant being a theme on its own. |
| Minor Theme | A theme which is influenced by or influences the subordinate theme yet it has sufficient narrative accounts to be a theme on its own. |

## 3.7 Ensuring Validity and Reliability

Ensuring the validity and reliability of the research was considered throughout this study. Smith et al. (2009) recommend using Yardley's (2000) framework to address validity and reliability when conducting IPA studies. Yardley (2000) proposes four principles which should be followed which are: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance.

### 3.7.1 Sensitivity to Context

Sensitivity to context was addressed by consideration of the relevant theoretical and empirical literature. By studying the relevant literature, the researcher was able to identify current gaps which led to formulating the research question. Sensitivity to the socio-cultural context of participants was also considered. The setting and the characteristics of the researcher (age, gender, and culture) were considered as they may have had an effect on the participants.

### 3.7.2 Commitment and Rigour

Commitment and rigour was ensured the IPA methodology procedures around data collection and analysis that are described in Smith et al. (2009) and in IPA publications were strictly adhered to. The researcher was committed to ensure the methodology employed was of high quality by attending workshops on qualitative methodology and providing supervisors with examples of analysis to ensure analysis was being carried out correctly.

### 3.7.2 Transparency and Coherence

Transparency and coherence was achieved by providing a detailed rationale for the current research as well as a detailed account of the steps in the methodology undertaken. Visuals of the steps were also provided in the appendices. Smith et al. (2009) also recommends providing verbatim extracts to allow readers to appraise the suitability of the data and its interpretation, which were included in the present study.

### 3.7.3 Impact and Importance

It is important for research to have an impact, the findings of this study will be useful to health professionals working with people with depression. Health professionals will be able to implement more effective interventions for people with depression who have self-stigma as they will better understand how gender can affect the self-stigma of depression. This in turn will positively impact on mental health services as well as stigma prevention initiatives provided for the public.

### 3.7.4 Reflexivity

Reflexivity is an important concept to consider when conducting IPA research. A researcher's own beliefs, assumptions, and understandings can assist or impede the quality of analysis (Smith, 2004) and so it is important to acknowledge these biases. For example, the researcher acknowledges that she has worked in the area of mental health and strongly believes in the importance of eradicating stigma of mental health. Reflective boxes were included in the results section to highlight the researcher's views and experiences of the data, which encourages critical reflection. As well as highlighting their perceptions from the outset, it is beneficial to also to record the researcher's thoughts throughout the research process. This was done by using reflective notes after each interview. A critical reflection was also included in the discussion section of the research which allowed for further reflection on the role of the researcher within the study.

# Chapter Four: Results

## 4.1 Introduction

In this chapter, the findings from the interpretive phenomenological analysis (IPA) of data that address the research question will be presented. The research question was: how do men and women with depression experience, manage, and potentially resist, self-stigma? Two main superordinate themes emerged from the research data, which are both mentioned below. This will be followed by a table which will present an overview of the data displaying the themes that emerged from the ten interviews conducted. The superordinate themes will be then be discussed in detail together with their respective subordinate and minor themes. Integrated within these descriptions are the researcher's own reflective accounts, presented within reflective boxes.

## 4.2 Overview of Findings

Given the complexity and the multi-factorial nature of the construct of self-stigma, many of the participants did not explicitly verify that they experienced self-stigma but the interpretation from their narratives is that the majority experienced self-stigma. Nine out of ten participants were found to have contended with self-stigma during their experience of depression, with John not expressing self-stigma in the past or presently. Given the nature of the data, much of the results focus on the management of self-stigma. Analysis of the ten interviews conducted identified a gendered experience of self-stigma and a mostly gendered experience of resisting stigma. Participants felt more self-stigma at the start of their illness, and appeared to accept their illness and resist stigma over time. Some participants described struggling with internalising and resisting stigma continuously, suggesting it was an ongoing process for some. The data illustrated the significance of gender on participants' depression identities in shaping the individual's view and experience of self-stigma, the two superordinate themes reflect this experience. The incidences where experiences are similar for both genders are outlined within each theme.

The first superordinate theme illustrates how gender affected participants' depression identities by describing how participants' experiences of self-stigma led them to perceive depression as a threat to gender identity: *Self-Stigma: Depression as a Threat to Gender Identity*. This stigmatised identity of depression involved a loss of family roles, and a need to conceal depression to protect further loss of self-esteem.

The second superordinate theme; *Resisting the Threat to Gender Identity* includes participants' resisting the threat of depression on their gender identity. This contrasting superordinate theme illustrates how participants resisted the threat of gender identity by resisting the stigma of depression. Participants' described how they went through a journey, over time, which enabled them to resist stigma. Participants' achieved this by seeking help, disclosing to others about their depression, making sense of their depression as a normal reaction, and viewing their depression as an empowering experience.

Two subordinate themes in the first superordinate theme each had two minor themes which elaborate on the differences in the gendered experience of self-stigma. Each pair of minor themes discusses the male gendered experience, followed by the female gendered experience. Each minor theme occurred in at least half of each gender, i.e., at least two men and at least three women discussed each minor theme. However, some subordinate themes did not have minor themes due to both genders expressing similar concepts and so minor themes were deemed not to fit the data. An overview of these themes is provided in Table 4 below.

Table 4.

*Themes Identified Within the Interviews*

| **Superordinate Theme** | **Subordinate Themes** | **Minor Themes** |
|---|---|---|
| Self-stigma: Depression as a Threat to Gender Identity | Loss of Family Roles | Loss of Male Head of Household<br>Loss of being a Good Mother |
| | A Need to Conceal | Social Withdrawal<br>Wearing a Sociable 'Mask' |
| Resisting the Threat to Gender Identity | Seeking Help: From a Label to Recovery | |
| | Disclosure: From Shame to Opportunity | |
| | Normalising | |
| | An Empowering Experience | |

Exploration of the above themes will form the basis of the chapter with each theme illustrated by verbatim extracts from the interviews. When presenting verbatim extracts, some minor changes have been made in order to improve readability. Word repetitions and hesitant utterances, for example, "eh", have been removed. Three full stops indicate the removal of some text. Square brackets indicate that material has been added to explain what a participant is referring to. All identifying information was removed or changed. Pseudonyms are used in this chapter in order to protect the anonymity of participants.

## 4.3 Superordinate Theme: Self-Stigma – Depression as a Threat to Gender Identity

Participants' circumstances changed dramatically due to their depression and this had a psychological impact involving feelings of grief, shame, and frustration. There was a clear sense of self-stigma when participants spoke about their views of public stigma and how it related to their experiences of depression:

> *'I have prejudice against mental health issues and I have mental health issues. But it's what you were raised like'*. (Laura)

Participants' accounts were congruent with the social cognitive perspective of self-stigma in that they spoke of negative attitudes and prejudices about themselves that led to loss of self-esteem. Participants expressed their self-stigma of depression as a threat to the ways they saw themselves as women and men, that is, their gender identity. Thus, their identities of gender and depression were found to intersect with each other and affect how this threat was experienced. The attitudes and prejudices of their depressed identity were seen to involve a loss of family roles, and a need to conceal the identity from further loss of self-esteem.

### 4.3.1 Subordinate Theme: Loss of Family Roles

An important part of participants' gender identity was their roles within their families. Participants wanted to care for the families and their depression hindered this role. They spoke of this in relation to stereotypical gender roles, that is, men being head of household and women being carers of children. These roles affected their experience of depression as depression was viewed as incompatible with these separate gender roles. This shaped how participants experienced self-stigma. As men and women described differing roles, they will be discussed as separate minor themes.

#### *4.3.1.1 Minor Theme: Loss of Male Head of Household*

Men described the importance of being the male head of household, which was a part of their masculine identity. The male head of household is signified as being a strong male for their family. Men's negative attitudes and prejudices of depression related to the loss of male head of household, which led to men feeling sadness and shame. As being a financial provider was as an important expression of masculine identity, losing a job could trigger depression, which was the case for Mark:

> *'You're kind of classed as head of the household but then [my wife] would say we are not able to spare money this week to pay for this bill'.*

Loss of a job had led to the loss of Mark's family role as head of the household. Mark feels guilty for not being able to provide. Depression compounded this sense of loss as suffering from the symptoms of depression made Mark feel even further stripped of his masculine gender identity:

> *'When I was lying inside of the bed feeling useless, the power was gone from me then. Well, not power, but the man of the house.'*

Depression now further prohibits Mark from having a purpose and feeling useful and so his masculinity continues to be diminished. His self-stigma of depression is related to a loss of usefulness as he cannot fulfil his gender role as provider. Thus, self-stigma of depression and loss of gender roles were experienced as a cycle of continued loss of self-esteem. This makes Mark feel ashamed and disempowered. As the researcher was a female, Mark's correction from discussing *'power'* to *'man of the house'* was interpreted as Mark attempting to explain to an outsider how disempowering and emasculating the experience was for him.

Being the head of the household signified a strong male role. Jim describes how he felt when he was first diagnosed with depression: *'it was alien to me.'* For Jim to receive the diagnosis, it was a shock. Jim is emphasising how out of character depression was for him and how it was a completely new part of his identity by describing it as *'alien'*. He discusses how his view of depression added to his struggle to accept his diagnosis:

> *'To me, someone at [my] age shouldn't be getting something like this'*

Jim's male identity did not fit with him being diagnosed with depression. He experienced depression as being weak:

*'I was looking after my family 'cos my father was away at the time. I was the man of the house … I was used to being knocked down and getting up. Standing up for myself. But then all of a sudden, this time, I got knocked down [and] I couldn't get back up again.'*

Jim's identity from a very young age was a stereotypical strong male identity. At first he talks about physical fights that occurred when he was younger, but then switches to talking about his depression. Jim compares his depression to a physical fight. This is interpreted as Jim using this metaphor to exaggerate the strength of masculinity he had when he was younger and how weak he feels now. This metaphorical fight Jim has had with depression has depleted him psychologically. For Jim, the inability to recover from depression is more devastating than losing a fight physically, as it signifies a lack of control and a weakness. This psychological battle has made Jim feel vulnerable for the first time in his life. Depression has made him question his masculine strength as he can no longer defend himself. His gender identity has been shaken and he must try to make sense of this experience. He attempts to make sense by viewing it as a sudden, unexpected incident. The use of the words *"all of a sudden"* highlight how Jim experiences depression and emphasises the dramatic and negative impact it had on Jim's identity as a strong, capable man. Jim has no control over the depression, which makes him feel powerless and emasculated. It is clear that by not winning this fight of strength, Jim's masculine identity as a strong, defiant man is damaged. The changing dynamics of personal relationships resulted in emasculation for Robert:

*'They kinda molly coddle me now. My mother and father ring me every night of the week.'*

Robert views his parents caring for him since his depression as infantilising and disempowering, which can be viewed as the opposite of the gender role of male head of the household. For Robert, depression is incompatible with masculine gender identity and this causes him distress. Robert's self-stigma of depression is experienced as a diminished sense of masculinity due a regression in the relationship he has with his parents as he now feels like he is being treated like a child. John was the only participant who did not experience self-stigma.

*'I started work with my dad when I left school … I liked helping people out. I was always involved with things.'*

This text shows how having a job is an important part of John's experience as it gave him a sense of purpose and a feeling of being useful to others. For John, remaining employed despite his experience of depression was a sense of pride that was evident throughout his interview:

*'As the years went on, I remained self-employed.'*

It is possible that remaining as a provider assisted John in successfully resisting self-stigma. Although John's experience is contrasting, it complements the other accounts by highlighting how significant having a job can be is to a man's identity. Employment could also be significant issue for women. Karen spoke about the importance of her job to her identity:

*'I used to define myself as someone who worked, I worked hard. I was working every single day and then I was a mum on top of that.'*

This highlights the occasional gender similarities that emerged from the data. Losing her job due to depression was a significant loss to Karen's self-esteem. However, her discussion of work immediately leads her to speaking about her mothering role which highlights how Karen's identity is very much related to her role as a mother. This highlights the importance of motherhood to women, which shall be further detailed in the following minor theme.

**Reflective Box:**
As a female researcher, I expected men would feel uncomfortable discussing their views on how depression affected them as men. Instead the participants seemed to feel relaxed and opened up about their experiences as men more so than I anticipated. However, I did wonder would they express themselves differently if I was a male researcher and possibly talk more about their experience in relation to their masculinity.

#### *4.3.1.2 Minor Theme: Loss of Being a Good Mother*

Women spoke of the importance of their family role as a mother. Depression affected this role and resulted in negative attitudes and prejudices towards themselves. Being a good mother was seen as being selfless in the nurturing role. Being a good mother and experiencing depression was seen as incompatible both by society and also by the participants themselves. Many of the female participants spoke of their anger at their ability to be a good mother being called into question, whilst others experienced shame. Women viewed motherhood as an important role that must be fully separated and protected from stigmatised identities such as depression or Peri-Partum Depression (PPD).

*'Being a mother is a status. Someone would say to you; what do you do? And you would say oh I'm a mum. And as a mum when you suffer with depression, or [PPD], you feel like you've failed. You feel you've done something wrong'*

Laura experiences a sense of pride and purpose from motherhood. This is similar to the men's accounts of feeling pride and purpose from providing financially to their families. By experiencing PPD, she loses this sense of pride and believes she has *'failed'* because she has not lived up the social expectations of caretaking that are important to her female identity. She internalises this PPD identity as something within her control and something she has done: *'done something wrong.'* This personal responsibility compounds her self-stigma of depression as she feels she could have prevented this loss of status of a good mother, a theme which runs through many of the participants' accounts. This personal responsibility compounds the self-stigma of depression for participants as they feel it is partly due to their own fault their gender roles have been diminished. Even when a woman had older children, like Jennifer, the importance of being a good mother still prevailed:

*'I don't want to be a whiny mother.'*

Jennifer associates depression with being a mother who attends to her own needs. This is viewed as selfish to Jennifer and, thus, detrimental to her identity. This links with Jennifer's negative views of depression:

*'People self-create depression, oh she's looking better than me … she's more popular than me.'*

Jennifer views depression as within someone's control and a sign of self-involvement. Thus, for Jennifer, women who are self-involved cannot fulfil their nurturing role. Jennifer's self-stigma of depression is due to her loss of her identity as a good mother and to becoming a new, unwanted identity of a depressed, *'whiny'* mother. Women were also found to attempt to challenge and resist the experienced stigma.

*'[People were saying] she has depression, why is she having a baby? It's not like I planned to have a baby. What could I do?'*

As Catherine is psychologically preparing for motherhood, her identity as a good mother is threatened by others viewing her as selfish to have a baby when she is experiencing depression. This is distressing for Catherine and so in order to protect this identity, Catherine defends her pregnancy by maintaining that it was unplanned. In this way, Catherine is actively resisting

self-stigma by becoming angry and challenging the stigma. However, this resistance of stigma does not appear to be lasting. Catherine's experience of public stigma has shaped her depressed identity and Catherine now feels her depression is preventing her from being the mother she wants to be and so she experiences loss of self-efficacy:

> *'I feel like I should be doing more … [my son] doesn't need to know that mammy can't do anything on her own'*

In contrast, Karen was able to successfully resist self-stigma. Karen, who was recovering from depression when she became pregnant, describes how having a history of depression made her feel judged:

> *'I was treated differently in the maternity [services] because of [depression] being listed [on my chart] … They also said you might be at a higher risk of [PPD] … but I feel fine for ages so go away, that's not me anymore.'*

The suggestion of possibly developing PPD had a negative connotation for Karen. It signified to her that she will lose her identity as a good mother. In order to protect this loss of identity, Karen separates her two experiences completely; she views her pregnant self and her depressed self as two different, separate selves: *'that's not me anymore.'* Karen is attempting to actively separate the intersection of her gender and depressed identities and, thus, resists self-stigma as a threat to her being a good mother.

Men also spoke about the importance of being a good parent, but there appeared to be no evidence of self-stigma related to their role as a good parent, which is an interesting finding that is considered important enough to be mentioned. Men's role as parents and caretakers provided an unlikely positive outcome for men. This was interpreted as due to men wanting to protect their children from the physical loss of a father through suicide.

> *'I was suicidal. I was thinking of doing away with myself but I wasn't able. The kids were keeping me alive as such. Although couple of weeks after [my wife] died I lost interest in my kids, I didn't want to look after them.'*

Robert reflected on the conflicting concept of his children protecting him from dying by suicide yet losing interest in parenting them. Robert places importance on his role as a protector and provider for his children rather than on a more nurturing, parenting role. This can be understood that as parenting and nurturing are not as important to his gender identity, Robert is more at ease to speak about his difficulty in caring for his children. This highlights the

potentially lesser social expectations of parenting on men in comparison to the expectation for women. Robert does not appear to internalise stigma of depression in relation to his parenting role, which is dissimilar to Laura's experience:

> *'I would be trying to make up for the fact that mommy had [PPD]* so *I over indulged [my son]*.'

Laura's guilt of having PPD is linked with the stigma of not living up to being a 'good' mother. Overall, being a good mother and a good father appeared to affect participants' depressed identities differently.

### 4.3.2 Subordinate Theme: A Need to Conceal

As previously outlined, participants experienced depression as a threat to their gender identities, this caused participants to lose self-esteem. This, in turn, resulted in participants reacting by implementing defensive stigma management strategies. These strategies involved concealment. Participants concealed depression due to shame of their depression and as a form of protection from public stigma and a further loss of self-esteem. The data showed how men and women would often conceal using different strategies, which shall now be outlined.

#### *4.3.2.1 Minor Theme: Social Withdrawal*

Withdrawal was a common theme amongst the men's discussions. The experience of withdrawing was seen as a strategy to cope with their self-stigma of depression. Men felt social engagement would lead to them feeling exposed and result in further loss of self-esteem.

*'You develop the impression it's like you have leprosy … you're embarrassed about it.'*

Jim's experience of public stigma has led to him to experience self-stigma. We have seen previously that Jim viewed himself as a strong man. The comparison to leprosy is Jim emphasising how vulnerable he views himself now that he has depression, which can be interpreted as the opposite to a strong male role model. It also highlights how exposed he feels. To Jim, depression is very easy to notice, just like leprosy. This exposure leads him to feel vulnerable, which brings on a sense of embarrassment and a need to protect himself from further embarrassment by socially withdrawing:

> *'I'm not the outgoing person I used to be ... I find it hard to talk to my wife, I find it hard to talk to my family, friends. Just couldn't. I was afraid, I was embarrassed.'*

Jim's contrast of his new identity to his old identity emphasises how he feels depression has completely overtaken his identity, highlighting how all-encompassing depression felt for Jim. This draws attention to the sadness Jim feels for the loss of his masculinity. This new identity has changed social interaction from a source of enjoyment and now is a source of discomfort as Jim grapples with his self-stigma of depression. The changing of tenses in this extract points towards Jim's struggle with self-stigma both in the past and in the present.

Although withdrawal protected the participants from perceived further threat, it also did not allow men to refute their perception that their identity was diminished. Once men engaged with the social world, their self-stigma of depression was seen to dissipate, thanks to positive social interactions.

> *'I remember when I did get the courage to go out 'twas just as silly, well it wasn't silly to me ... by going out I got talking to [my neighbours] and they were the same. They shouldn't be cos I was depressed and, around a day or two later, I could've gone down the street and I never had any anyone laugh at me or anyone talk bad of me.'*

Robert's conflicted feelings about his experience of leaving the house highlight his continuing identity battle. On the one hand, his self-stigma of depression leads him to criticise himself for feeling vulnerable: *'twas just as silly.'* On the other hand, his current self tries to be compassionate to his vulnerable, emasculated identity. Thus, Robert is still struggling between his critical, self-stigmatising self that feels he needs to be stronger, whilst another part of him feels he should have a more compassionate view. Experiencing a lack of prejudice brings a sense of surprise and relief. Consequently, his self-stigma begins to dissipate once public stigma is not experienced. This begins Robert's journey to accepting his depression and realising his depression is not a threat to his identity as he once feared, as he is not experiencing public stigma:

> *'I never felt that there was anything wrong with me by their reactions.'*

As social withdrawal was found to be a more common thread within the male participants in this study, it was interpreted to be a more common stigma management strategy for men. This may be due to less social pressures on men to be sociable as there are for women. However, there was one woman, Sarah, who spoke of socially withdrawing:

> *'I try to avoid people so I wouldn't have to talk, in case I'm asked any questions.'*

This text highlights how experiences of managing self-stigma of depression can be similar for men and women. Sarah also wants to protect her self-esteem by concealing her stigmatised identity, as she is afraid interaction will lead her to be forced to disclose her depression, which would be difficult for her. However, Sarah also spoke of managing self-stigma and public stigma by wearing a 'mask.'

**Reflective Box:**
As social withdrawal is also a symptom of depression, I was concerned that participants were describing the experience of depression as opposed to a reaction to self-stigma. Given that participants' experiences of depression often were interwoven with their experiences and perceptions of self-stigma, it was at times difficult to discern the two separate experiences. However, it was interpreted that participants were describing their experiences of self-stigma due to the conversation being focused on their view of stigma and self-stigma, but it is acknowledged that there may be a possible overlap of concepts being discussed due to the similarity between symptoms of depression and self-stigma. This highlights how some aspects of the experience of depression and the experience of self-stigma are possibly both seen as interlinking experiences for people with depression.

#### *4.3.2.2 Minor Theme: Wearing a Sociable 'Mask'*

All the women in this study spoke about how their self-stigma of depression is managed by putting on a 'mask' when out in public. This mask was a defensive management strategy of concealing their true selves and providing a false, socially acceptable self in public due to their shame at their threatened gender identity. While depression is typically a female mental illness, women in this study did not feel it was socially acceptable to show their depression. This is interpreted as, although depression is compatible with femininity, women did not want to be associated with that particular type of woman. They wanted to have the differing female identity of being pleasing, sociable, and friendly, and not the female identity of being emotionally expressive. Putting on a 'mask' was viewed as a socially acceptable way to conceal their stigmatised identity of depression. The pressure women felt to be sociable is perfectly captured by both Sarah and Laura:

> *'My son keeps encouraging me to meet people and I have done … put on the face for the few hours.'* (Sarah)

*'That doesn't mean that half the time you couldn't be putting on a mask cos that's what everyone wants to see and inside you're thinking OK I can hold this mask for about another hour and then I just have to go home and switch off.'*(Laura)

Both Sarah and Laura conform to society's rules that being unsociable is unacceptable for women. As their depression is detrimental to their gender identity it should be hidden. This 'mask' allows them to continue to be viewed as sociable and friendly, which is important to Sarah and Laura. Their description of a time limit shows how tiring it is for them, however, leaving the *'mask'* on is a necessity. Laura uses the phrase '*switch off'* to emphasise the sense of release after having to appear socially acceptable. Thus, this 'mask' is seen to serve others even more than Sarah and Laura. Laura's use of the phrase *'half the time'* captures her struggle with resisting stigma. Throughout her interview, Laura described times she would internalise stigma and times she would resist stigma, suggesting it was an ongoing battle for her. Sacrificing and silencing their own needs allows them to protect their gender identities and their social relationships. The function of the 'mask' to aid acceptance was a common theme amongst women in both their personal and professional lives, for example:

*'At work I definitely felt like I needed to put on the act and cover it up. Cos I knew it was not going to be accepted.'*

We have seen previously how Karen resisted self-stigma as a threat to being a good mother. However, Karen describes a time in her past when her experience was different regarding other aspects of her female identity. For Karen, acceptance in the workplace was important to her female identity and so she self-silenced her depression in order to avoid risking damaging work relationships. Depression signified for Karen that others would view her as unpleasant and unsociable, a view she fought to prevent.

*'I didn't want anyone else to know [because] I'd be found out that I was really this misery guts. I'd manage to go have a shower and do my hair and makeup and put on something nice and go out and put a smile on and then go home and cry.'*

This concern for being viewed negatively shows how Karen's identity is heavily influenced by how others perceive her. Describing her depression as *'misery guts'* highlights how negatively she viewed her depressed identity, and possibly how she still views it negatively. Her self-stigma of depression affected her view of how a woman should be: pleasant and cheerful. As depression strips a woman of a friendly and sociable identity, Karen forced herself to go through the motions of presenting herself to the world with *'hair and makeup'* and *'a smile*

*on'*. The threat to her gender identity was too jeopardising to her sense of self so Karen felt she needed to continue to be sociable and friendly despite feeling the opposite. There is a sense that Karen wishes she could still be the woman she presents on the outside, but depression has stripped her of the woman she once was and all is left is negative qualities. It is interpreted that Karen's fears other people imposing their own set of qualities associated with depression, which would be devastating to her sense of self. Thus, this protection is only surface level, as Karen struggles psychologically with self-stigma underneath the 'mask'. The mask is self-sacrificing as it protects others from her deviant identity but does not protect Karen from her own self-stigma. Her shame and embarrassment at her depressed identity is clear from this text. This mask also serves to protect her relationships. Karen's experience reflects a common premise of women prioritising their relationships over their own needs.

> *'I do my best to hide my feelings. You can say I am master of that. I work in a [workplace] and you can ask anybody there, they will never see me miserable. It's always a big tooth smile on my face … No matter how miserable I'm feeling inside, I always manage to keep my smile.'*

Jennifer's concealment of her depression is viewed by her as an achievement. The 'mask' is something to be proud of as it is viewed as a normal part of female identity. This is in contrast to depression, which Jennifer perceives to be abnormal and so should be hidden. Jim was the only male participant who spoke about a 'mask':

> *'[The nurse] says I tend to put on a mask. This mask where I could sit and talk to you and laugh and joke but she can see … straight through the mask that there's someone behind that mask hurting.'*

Jim was given the language of putting on a mask, interestingly, from a female health professional. For Jim, there is a sense of relief that someone can see through the mask to his real self. The mask is a great protector of his stigmatised identity but it appears that being seen for his real self and having a connection to another person is comforting to Jim. This is in contrast to the women's experiences which suggested someone seeing through their masks would be distressing and a threat to their identity. Importantly, it may be that a health professional seeing their depression is less threatening than exposing depression to family and work colleagues.

**Reflective Box:**

It was at times difficult to hear the stories of participants who struggled with feeling ashamed about their depression. It really struck home how difficult it is to have depression; not only due to the symptoms but because of the gendered and social connotations it has for individuals. It made me reflect on how I would react if I experienced depression and whether I would put on a 'mask' also. This made me, in turn, reflect on the times I have put on a 'mask'.

### 4.4 Superordinate Theme: Resisting the Threat to Gender Identity

Although many participants spoke about their experiences of at first internalising a stigmatised identity, there was a contrasting, common theme throughout the data of participants resisting the self-stigma of depression. Resisting stigma was often seen as a result of disagreeing with public stigma:

*'There's a stigma out there but I don't think it's accurate.'* (Karen)

While both men and women both resisted stigma, the experience was influenced by participants' gender identities. As participants struggled to come to terms with having depression, initially they had negative attitudes and prejudices but yet, over time, many of them were able to resist the stigma of depression. This resistance was seen as participants restoring their threatened identity by reframing their negative attitudes and prejudices. There was a sense of empowerment at challenging this stigma.

#### 4.4.1 Subordinate theme: Seeking Help: From a Label to Recovery

While the self-stigma of seeking help is not necessarily linked to the research question asked in this study, it is an interesting finding which has emerged from the data. Seeking help was a significant part of the participants' experiences of depression as it was viewed at the start as an action that would be damaging to participants' gender identity. Both men and women expressed how seeking help signified that they were acutely unwell and would lead to an unwanted label of a person who attends mental health services. This label was something participants were keen to avoid and so participants would suffer in silence for an extended period of time before seeking help.

*'If I had stopped and I said: look I need help, I need [to] go in and see a counsellor because I'm depressed, everyone would go oh my God she must be really down if she's doing that.'*

Laura's comment encapsulates how the participants viewed seeking help and how it was related to public views. Participants at first viewed it as detrimental to their identity due to receiving a label of a mental illness service user. This label implied to participants and to others that they were considerably unwell. However, over time, many of the participants accepted seeking help as an important part of their recovery. Seeking help was a step towards self-stigma decreasing and being able to resist public stigma and self-stigma. Although the self-stigma of seeking help for depression was experienced similarly for both genders, participants' experiences was often related to differing gender identities.

At the beginning of men's experiences of depression, men considered seeking help as threatening to their sense of self as self-reliant. Depending on others to help them recover would hinder this self-reliant view. Seeking help for depression also typically involves talking about one's problems, which was seen as an abnormal activity for men to engage in. Thus, seeking help for their depression was going against the masculine norm of self-reliance and not talking about problems.

*'There were maybe 8 of us altogether and there was only 2 men so there's your ratio straight away, 4 to 1. You're thinking that men aren't inclined to come and talk more. Macho, you know … A lot of them are working, if they're working they are the head of the family or they're bringing in the dole … they probably wouldn't have time.'*

The lack of men in Robert's therapy group confirms for Robert that seeking help and talking about problems is something that is not typically masculine. By seeking help, Robert must contend with the fact that he is no longer self-reliant or *'macho'*. Seeking help is incompatible with being *'head of the family'*. Seeking help is viewed as a luxury for men who have *'time'*, suggesting Robert feels seeking help is almost self-indulgent. Although Robert has accepted help, this indicates Robert still struggles to assimilate seeking help into his masculine identity. However, this struggle appears to have lessened over time as Robert experienced significantly more distress when seeking help at first:

*'I remember the first visit that I did come in [to the day hospital] there was a few people walking around the place. To me, they were patients, or they were people being seen and I got upset because I was telling myself that I wasn't one of them.'*

The first time Robert sought help was a significant event for him. Seeking help signifies a turning point for Robert psychologically as his identity at this moment is about to be irrevocably changed. By seeking help, his new depression identity is no longer avoidable. He resisted this identity by not seeking help but now he must face the stigmatised identity. Robert struggles with the fact that the stigmatised label of a help seeker and possible mental health patient is now relevant to him. Becoming a *'patient'* signifies Robert is exposed and helpless, which ties in with his loss of masculinity. This loss of masculinity is too distressing for Robert and so he rejects the notion that he was similar to other people seeking help: *'wasn't one of them'*. This is interpreted that Robert is resisting this identity in order to save himself from the shame associated with having a mental illness. His distress highlights his own public stigma towards mental illness. Crucially, his own public stigma is now becoming self-stigma as the stigmatised identity now applies to Robert. These negative views led to Robert experiencing seeking help as a painful event that diminishes his self-esteem.

> *'It took me a while to come up because a part of me was like well what am I going to say to [the nurse] but [the nurse] pulled it out of me, dragged it out of me.'*

The reluctance Mark felt to speak about his problems was due to a sense of initial reluctance to admit he needed help for his depression to himself and to professionals: *'what am I going to say.'* This phrase also captures Mark's uncertainty about what seeking help entails. This unknown was too much for Mark as it signifies a lack of control. Emotional control is a key component of masculinity and so is important to Mark who feels seeking help would undermine this sense of control. This concern of an undermined masculine identity is seen to continue even when Mark does seek help. Mark's problems were *'dragged'* out of him, emphasising Mark's continued desire to be self-reliant and have emotional control even during the seeking help process. However, over time, he experienced seeking help as the reason for his recovery:

> *'From that day on then, I got better.'*

Seeking help is now associated with recovery by Mark and is viewed as a positive experience as opposed to an experience that undermines his emotional control. This journey is also seen in Jim's account:

> *'I was being brought along to these things and [my wife] would wait outside for me … I didn't want to do it at first. I was like a child: you do it, it's for your own good.'*

For Jim, the implementation and lead up to seeking help as a whole was also disempowering. Jim's description depicts this sense of emasculation as he is being told what to do *'like a child'*. This is particularly significant for Jim as he no longer has control of his own illness and so is no longer self-reliant. In this way, seeking help for depression accentuates Jim's self-stigma of depression as it signifies to him he is no longer his old, '*strong'* self. However, for Jim, seeking help became to be viewed as a way to regain his masculinity over time.

> *'Eventually I started, like a toddler, crawling on his own two feet. That's what I started to do then; because my sessions were every week starting off and eventually I started thinking for myself.'*

Jim now considers seeking help as a component of rebuilding his sense of personal control and self-agency; in effect, his masculinity. Seeking help is now experienced as a responsible action that increases independence: *'what I started to do'*. This is liberating for Jim and, as a result, seeking help is something that contributed to his regaining his masculine identity. By reframing the experience of seeking help, men's masculine identities were no longer threatened by the action of seeking help but seen as an important step to recovery. This recovery allows them to reclaim their masculinity.

Similar to men's experiences, women wanted to avoid the label of seeking help as it would threaten their gender identity. In contrast to the men participants, women participants expressed this diminished identity in relation to how others would view them. Men were concerned about their own views of their diminished identity. By seeking help women feared being viewed negatively by others and being viewed as a 'mental health patient.'

> *'If I'm honest I was afraid anyone would see me coming in because I didn't want anyone to think that I was ready for the white coats.'* (Carol)

> *'It was more what other people were going to think of me rather than actually yea I'm going to get help for myself.'* (Catherine)

Carol's and Catherine's above texts highlight how their perceived identity in public is more important to them than their own personal views of seeking help. Thus, their self-stigma is interlinked with acceptance by society. Carol was particularly worried about encountering public stigma, possibly due to her own stigma that depression is associated with prejudiced, stereotypical views of mental illness: *'white coats'*. This fear of being perceived negatively is connected to the minor theme of wearing a 'mask' as it shows how important to women how

they are perceived by others. By seeking help, there is a chance that their diminished gender identity behind the 'mask' will be undermined and their relationships threatened, which is threatening to their self-esteem. Revealing this identity would be distressing to women as they would not only have to face their own stigma but in addition the public's stigma. Over time, seeking help became less about what others would think of them and more about their recovery:

> *'When I came first I wouldn't look at anybody in case I recognised someone … I don't think much of it now.'*

Over time Sarah's self-stigma of seeking help has lessened as she has stopped caring about what people think, possibly due to the benefits she gains from seeking help. This is the opposite to her self-stigma of mental illness as we have previously seen her worry about concealing her stigmatised identity. This highlights the possibility of Sarah viewing depression negatively and seeking help positively. These benefits of seeking help are highlighted in Carol's text:

> *'[The social worker] put a lot of things into my head … [She said] you have to stop, you have to think about [Carol], because if you don't think about [Carol] nobody else will.'*

Seeking help taught Carol the importance of looking after herself. She no longer views seeking help as a possibility of encountering public stigma which could threaten her identity but an imperative part of re-gaining her well-being:

> *'It has helped me and I know myself I have improved.'*

Self-care is no longer a threat to her identity but an important step in recovery. In this way, Carol has re-framed her stigmatised views of seeking help.

At times, resisting self-stigma was not seen to be directly related to gender identity. The re-framing of views sometimes involved a psychological, internal struggle of resisting stigma. This struggle is illustrated in Karen's text below:

> *'Now I just waltz in and not care. Because I've accepted it and I've learned an awful lot since and if someone questioned it, I mean, that's where [another health service] is as well, it's a lot easier to come in the door and say oh I was just picking up something [from another health service].'*

Karen conveys confidence at the beginning of the text. She attempts to shake off the burden of caring about society's views of seeking help for depression. By focusing on the positives of

seeking help, Karen is resisting the stigma of seeking help. She is fighting the threat to her identity by reframing the negative views of seeking help. However, as the text continues there a sense that she still struggles with some remaining self-stigma. Karen's difficulty in admitting why she is attending her local health centre highlights her struggle to assimilate the experience of seeking help into a positive part of her identity. Other's negative opinions of seeking help for depression affect how she feels about herself. Her identity is still tied up in other's opinions of her, suggesting her gender identity as a woman still affects her experience of seeking help. Karen's change of opinion within this texts shows how Karen is attempting to resist self-stigma and reclaim her sense of self as a confident woman. However, her journey to fully resisting self-stigma is not yet complete. This highlights the enduring psychological battle between resistance and internalisation of stigma that some participants continued to experience when dealing with seeking help. Conversely, John, who did not experience self-stigma of depression, also spoke of not worrying about seeking help:

> *'I have no issues with parking my car [in the day hospital car park] and walking in the front door. I've never had an issue with that.'*

Thus, this suggests that seeking help never was a threat to John's identity as he never experienced self-stigma of seeking help. This subordinate theme highlights how these two experiences of the self-stigma of mental illness and self-stigma of seeking help are both pertinent aspects of an individual's experience of depression.

**Reflective Box:**

As somebody who has worked in the mental health area for over three years, it is easy to forget how significant it is for someone to walk into a mental health service. Participants reflecting on how difficult it was for them to seek help opened my eyes to how daunting seeking help can be and how much of it the process and procedures is unknown to them. It affected how I worked as a clinician and I now make sure to be considerate of the fears clients may have during my first session with a client.

### 4.4.2 Subordinate theme: Disclosure - From Shame to Opportunity

Many of the participants initially managed their self-stigma by not disclosing to anyone their depression. Thus, there was a gap between diagnosis and disclosure to close family and friends. Participants avoided disclosure due to the shame they felt about their depression. However, once participants did disclose to others, they often found it a positive and liberating

experience. Therefore, disclosure was another one of the first steps towards most participants' self-stigma decreasing and participants resisting stigma. Although, disclosure experiences were similar for both genders, disclosure was still found to be influenced by participants' gender identity resulting in gendered experiences.

> *'You don't tell anybody there's something wrong with you. You can't talk about it … My wife was telling my family for me cos I was embarrassed more than anything cos I'm the eldest in the family.'*

The shame Jim felt about his depression led him to struggle with disclosing his depression to his family which resulting in his wife disclosing it for him. As Jim views depression as a character weakness and something faulty within himself, that is, something is *'wrong'* with him, disclosing his depression will lead to others seeing this character weakness leading to further loss of self-esteem. Being the eldest in the family is an important aspect of his identity, and as we have seen earlier, he views himself as a strong, protector for his family, for example, *'I was the man of the house'*. Disclosing his depression to his family may significantly alter and diminish his role within the family leading to a diminished gender identity. Thus, it is too painful for him to disclose to his depression to his family himself. The risk of disclosure was acutely felt by most of the participants.

At times disclosure was a positive experience that rebutted their fears of being stigmatised by their family and friends. At first, women worried about being believed. This fear of credibility was interpreted as being due to women's use of 'masks' in social situations because of their self-stigma as discussed previously. Although the mask allowed women to protect their gender identity as cheerful and sociable, it had unintended negative consequences, which was a fear of lack of credibility when they did disclose.

> *'I think some people just think you're making it up'* (Catherine)

> *'You're afraid that they're going to say ridiculous, that's stupid talk … You're just being silly. Cop yourself on.'* (Carol)

However, the positive experience of disclosing led to less worry about negative views by others, which in turn, lessened self-stigma:

> *'I was so nervous. I was sick coming out in the car because I said oh God what am I going to get now … but I have to say that it was the best thing I did because it was a weight lifted off my shoulders and I knew now that they're OK with it'*

Carol's experience changed disclosure from a source of shame to a sense of relief. Disclosure is now seen as an opportunity to receive reassurance that her family do not stigmatise her due to depression. The *'weight'* is interpreted as Carol's self-stigma and shame that is now lessening due to her lack of experience of stigma from her family. Carol can now begin to accept her depression as this lack of public stigma can, in turn, lead her to experience less self-stigma.

This journey of disclosure was also reflected in other participants' accounts. Disclosure was no longer experienced as a threat but as a positive opportunity to gain a sense of power over their experience of depression. For Laura, disclosing was initially a threat of stigma:

> *'For the first couple of months of having this, I wouldn't tell anyone, I was like no I'm not having people judging me like that. Nowadays I just say yea I have [PPD] or I get counselling each week.'*

For much of Laura's interview, she spoke of how at the beginning of her PPD experience, she felt she had failed as a mother due to PPD. Thus, Laura's shame led her to believe disclosure of her PPD was a significant threat to her identity as a 'good' mother and she would experience stigma. However, over time she begins to accept her stigmatised identity, her self-stigma decreases and so disclosure is no longer viewed as a threat but as an opportunity.

> *'By being honest it educates them that bit more and it takes away a bit of that stigma.'*

Laura views disclosure as a form of activism and so it gives her a sense of freedom from her self-stigma. She has come to terms with her depression and is no longer ashamed, thus stigma is no longer a threat to her gender identity. Although Laura still struggles with self-stigma, this is interpreted as a lessening of self-stigma over time and Laura restoring her previously threatened gender identity. This resistance of self-stigma is found throughout John's interview and is reflected in his description of disclosure:

> *'I wouldn't be worried about stigma. I would talk to anybody about it. [If] somebody wants to know something I would feel free to tell them … If I thought I could help somebody else, I would do that.'*

John is not worried about public stigma and also does not experience self-stigma. He has fully resisted stigma and now feels his experience of depression is an opportunity to help others with their experience of depression. His successful resistance of stigma has led him to feel anger when he experiences others stigmatising people with mental illnesses:

*'I'd be annoyed at what they're saying … I'd feel angry with them.'*

John is successfully challenging public stigma as he does not agree with the public's view of mental illness. Thus, he does not feel stigma is a threat to him.

### 4.4.3 Subordinate Theme: Normalising

A subordinate theme within the data was that of normalising depression. Participants were found to make sense of depression as an experience that is a normal reaction to negative experiences in daily life, which is interpreted as accepting their depression identity and, in turn, resisting the stigma of depression. While men and women both normalised their depressed identity, many participants spoke of differing reasons for the normalisation of their depression which was related to their gender identity.

Men were more likely to resist stigma by making sense of depression as a normal reaction to financial stress. As men were often found to be concerned with the loss of their male role as financial provider, this way of normalising depression allowed men to resist this threat of male identity:

> *'If you think about it, nearly everybody has some bit of depression. Even the housewife worried about the bills … The Celtic Tiger died and people had these big mortgages … I think it went rampant since the Celtic Tiger.'* (Mark)

> *'A lot of people [are] going through a lot of things especially in the last few years the way this country has gone.' (*Jim)

In the minor theme Loss of Male Head of Household, we saw how both Mark and Jim experienced a loss of male roles. Mark and Jim are mitigating this loss by externalising the cause of depression to financial stress in the form of the economic recession recently experienced in Ireland. They are now accepting their depressed identity as it is a normal reaction to an abnormal, stressful environmental situation and so there is no need to be ashamed of depression, thus attempting to restore their self-esteem. Thus, normalising can be seen as resisting a diminished male identity.

> *'Things got on top of me. It was just money, it included a bank deal which they stalled on and then they paid it through. When they paid it through I was OK, I settled back to the way I am.'*

Robert describes his first bout of depression as a reaction to financial stress. This fits in with his identity as a man who is a provider and so there is a sense that he experiences depression as an understandable reaction. Without financial stress Robert is his true self: *'the way I am'*. Making sense of depression as a normal experience strengthens his resolve to resist stigma. However, when he suffered with depression after his wife died, he struggled with accepting the diagnosis:

> *'I probably didn't agree with [it] myself that I was depressed but I know myself looking back now that I had all the symptoms that they were looking for.'*

Depression as a reaction to bereavement did not fit Robert's gender identity of himself and so he struggles with accepting this diagnosis. For Robert, depression is understandable if someone does not have financial security:

> *'People that would be at home with nothing to do. I can understand myself now how a person would get depressed if they were out of a job.'*

Men were able to resist self-stigma by reframing depression as understandable. By reframing depression as something that is due to external, financial factors as opposed to character weakness, the threat to their gender identity is lessened and their self-esteem is restored.

Women also spoke about how they view depression as normal part of life and a normal reaction to life stress, though there was less emphasis on financial stress. However, Carol was the one woman that did speak of how financial stress can lead to depression:

> *'I realise now that people get depression for not having a job.'*

Carol's text shows how women can also be affected by financial stress and signifies the potential of changing gender patterns. As more women are becoming providers, these pressures may begin to be just as pertinent to women as men. In addition, her normalisation included regaining her threatened gender identity.

> *'You are normal and it's OK. It's ok not to feel well. You can't be on top of the world all the time.'*

Carol is working towards her acceptance of her depression by minimising depression to a simple case of *'not feel[ing] well'*, which is presenting depression as ordinary feelings. Using the phrase *'on top of the world*' is highlighting how unnatural she perceives it is to always present as happy and pleasurable in society. This suggests Carol is resisting against the

pressure to have a 'mask' on in society that we have seen in the previous minor theme: Wearing a Sociable 'Mask'. Carol is beginning to resist against this social pressure of a woman to always present as cheerful and friendly. Carol is resisting the threat that depression has to her gender identity by normalising low mood, a symptom of depression. Normalising depression could also be met with a sense of frustration:

> *'People have to try treat you as normal as possible because you are normal. You're just a bit down at the moment. You just suffer with depression ... If I was diagnosed with diabetes tomorrow would I be treated differently because I have diabetes? No. But I'm treated differently because I have depression.'*

There is a sense of anger and frustration in Laura's text demonstrating her attempt to resist self-stigma. She struggles with being treated differently due to her PPD. Laura emphasises the normalcy of PPD and depression by comparing them to diabetes, a traditionally less stigmatised illness. This also highlights how she wishes her illness to be viewed as something that is medically out of her control, as opposed to a psychological weakness. At the core of her viewpoint is Laura's desire for herself to view PPD as something that is not her fault, as opposed to viewing herself as a *'failure'* , which we have seen her express in earlier themes. This highlights the struggle participants can experience on the journey from internalising to resisting stigma.

### 4.4.4 Subordinate theme: An Empowering Experience

Another theme that emerged from the data was that of participants describing positive aspects and outcomes of having depression. By viewing their experience in a more positive light, they were interpreted to be rejecting both the public's current, negative view and the negative view they themselves used to experience. In this way, they were resisting self-stigma. Participants spoke about how they now saw depression as an empowering, learning experience as opposed to an integral part of their identity, thus restoring their self-concept. Men and women both spoke about feeling empowered and it was often related to their gender identity.

> *'I have changed. I look out for all the things that I'm doing right to keep me in a good place and all the things that are wrong that put you in a bad place.'*

Robert's self-awareness allows him to feel independent and self-reliant. He is in control of his recovery, and so he feels empowered and this restores his masculine identity.

> *'It's made me feel more mature cos I have recognised what's going on.'*

John's increased self-awareness has made him feel more in control of his depression. Viewing depression as a positive experience reframes the typically stigmatised, emasculating identity to a positive identity. In this way, he is resisting feeling emasculated by experiencing depression as a maturing experience that has empowered him.

> *'Before I had depression, I never really thought about it. I just went on doing my own thing, not thinking … but then when the depression came in, I could see life a bit differently. I appreciated every day.'*

This is in contrast to how drained and depleted Mark felt when first experiencing depression. The empowerment took time for Mark. His self-stigma has diminished and now Mark feels energized and empowered by his experience of depression. Successfully resisting stigma allows him to feel less vulnerable. This was similar to some women's experience of reclaiming their identity by reclaiming strength.

> *'I just said to myself that there is life at the end of the tunnel. You go through the bad patch and it is hard and it is tough and you don't see any way out but there is a way out. It will come.'*

Carol's experience of depression is now viewed as a sign of her strength of getting through her experience of depression. She actively resists depression being a permanent part of her identity and identifies it as a passing experience. There is a sense of resilience in Carol's text that depression will not claim her identity. This description of it as a transient experience allows Carol to resist self-stigma. As relationships were a key concern for women throughout the data, it is understandable that women were also found to discuss depression as an empowering experience in relation to their relationships:

> *'It was a huge learning curve for me, not one I enjoyed but … I'm trying to take a positive from it. Another thing that's massively changed in me is I don't take any crap from people.'*

Karen wants to experience her depression as a learning curve as opposed to a draining experience. It is interpreted that Karen is at times struggling to view her depression positively as she uses the word *'trying'*, which reiterates her struggle with resisting self-stigma reflected throughout her discussion. Karen wants to positively reframe her stigmatised identity through her view of her relationships. Depression led her to re-evaluate her relationships and has given

her strength to set boundaries. In this way, self-stigma is resisted as she feels empowered in her relationships.

> *'I'm going to be a lot stronger for it and my kids will be a stronger for it. And my kids are a lot more open-minded and hopefully, please God, none of them will suffer from this but if they do that they'll know that it's OK. It's alright to come to mom and say mom I think there's a problem or mom I've noticed it in one of my friends, she has the same issues as you used to have.'*

It is important to Laura that her children are empowered by her experience of PPD as well as herself. She envisages her role as a mother being improved due to her own personal experience of PPD. PPD has now become a symbol of strength and empowerment. More significantly, it becomes a symbol of becoming more maternal and approachable to her children. Throughout Laura's interview, it is clear that being a mother is an important part of her identity. Thus, this positive growth in her role as a mother is important to Laura as it restores her identity as a 'good' mother that was taken away from her by her PPD. There is a tinge of fear when Laura says *"please God, none of them will suffer"*. This is interpreted as Laura's fear of PPD as she remembers the devastating effect it had on her identity and relationships. It highlights that although she no longer internalises the stigma of PPD, the fear of PPD will remain a part of her for years to come, if not forever. Thus, the memories have both positive and negative aspects: they will serve to remind her how far she has come to reclaim her identity, but also will remind her how her identity was stripped of her and how vulnerable she felt. It is interpreted that this fear of PPD possibly reoccurring either with her or with her children leads Laura to actively distance herself from this identity. Laura does this by envisaging her stigmatised identity to be gone in years to come: *'used to have'*, highlighting the Laura's view of PPD as a transient experience and her resistance to PPD being a part of her future identity. As she distances herself from PPD, her old identity comes to the surface once more and she feels restored and like her old self: a 'good' mother.

**Reflective Box:**

It was uplifting to see how the participants viewed depression positively. It appeared to me that they had gone through a difficult journey and still struggled on occasion. It seemed at times during the interview they were trying to convince even themselves that they did not feel any negative feelings towards depression. It showed to me how difficult it can be to have a stigmatised identity and how stigma can make recovery from depression even more difficult. However, it did make me reflect on the strength and resilience of the participants.

### 4.5 Summary

The two superordinate themes *self-stigma as a threat to gender identity* and *resisting the threat to gender identity* originally identified in Table 4 answered the research question: how do men and women with depression experience, manage, and potentially resist, self-stigma? Gender was found to greatly affect how self-stigma was experienced, with a few minor exceptions. Men and women experienced self-stigma as a loss of gender roles, and a need to conceal. However, over time, participants were found to resist self-stigma and resist the threat of depression on their gender identity. Participants' achieved this by seeking help, disclosing to others about their depression, making sense of their depression as a normal reaction, and viewing their depression as an empowering experience. The findings in this section will now be discussed in relation to prior literature in the next chapter.

# Chapter Five: Discussion

## 5.1 Chapter Introduction

The present study sought to explore how men and women experience and manage, and possibly resist, self-stigma. This chapter will present a summary of the findings and discuss superordinate themes and their respective subordinate and minor themes in detail. References to the literature presented in the literature review will be now discussed in relation to the research findings. Strengths and limitations of the research are discussed along with the researcher's critical reflections on the research process. Implications of these findings for practice, education, policy and future research will be considered.

## 5.2 Summary of Findings

Two superordinate themes, six subordinate and minor themes emerged from the data. These themes emerged from the application of IPA. The first superordinate theme to be identified was *self-stigma: depression as a threat to gender identity*. The implications of this threat to identity was a loss of family roles, which included the loss of being male head of the household and the loss of being a good mother. The data reflected how men and women used different management strategies to conceal their identity. Men were more likely to socially withdraw whilst women described wearing a sociable 'mask'.

The second superordinate theme which was identified was *resisting the threat to gender identity*. Participants were found to resist stigma by a journey of seeking help and disclosing to others, normalising depression, and viewing depression as an empowering experience. The following sections will discuss these findings in relation to the literature.

## 5.3 Self-Stigma: Depression as a threat to gender identity

The present study supports Goffman's (1963) theory that stigma leads to a discredited social identity which for this research was seen to lead to a diminished gender identity. Nine participants spoke about self-stigma, with many interpreted to be describing self-stigma implicitly (Rusch et al., 2010). This study also supported Corrigan et al.'s (2002a; 2004; 2011) Socio-Cognitive model of self-stigma as participants made reference to the social cognitive perspective of self-stigma. In addition, participants spoke of negative attitudes and prejudices in society and towards themselves that led to loss of self-esteem. This study supported Corrigan et al.'s (2002a; 2004; 2011) model as participants internalised the stigma attached to depression which led to a decrease in self-esteem and increased self-discrimination. These results also extend our knowledge in the field of self-stigma as the results of this study suggest

that self-stigma can be a journey and can present itself differently depending on the context. As will be detailed below, findings suggest both men and women go through a journey of self-stigma and it is not as static as previous theoretical literature suggests (Corrigan & Watson, 2002a; Corrigan & Watson, 2002b). These findings contribute specifically to Corrigan et al.'s (2002a; 2004; 2011) Socio-Cognitive model and Corrigan and Watson's (2002b) Paradox of Self-Stigma models. According to these self-stigma models, a person either has self-stigma or resists self-stigma. However, this study's results suggest self-stigma can be context dependent and an individual can move from internalisation to resistance continuously. This suggests that self-stigma theories need to account for the varying experiences of individuals in relation to self-stigma of mental illness. Future theoretical research needs to be conducted in order to further explore these findings.

In addition, Corrigan et al.'s model (2002a; 2002b; 2004; 2011) does not account for different experiences in the context of gender. This study suggests that gender may be important to take into account when considering how self-stigma occurs. As gender has been shown to effect the experience of self-stigma, this adds to the self-stigma literature that gender is an important aspect to consider when studying self-stigma. This study's findings supported the view that gender is sociologically constructed through interactions (West & Zimmerman, 1987) as individuals discussed their experiences of self-stigma in relation to the appropriate ways in which men and women should behave. Participants were found to speak of gender in relation to societal norms and expectations. This adds to the literature base of the sociological perspective of gender as it highlights that men and women experiences of self-stigma of depression are affected by the societal expectations of their gender. As gender is socially constructed, as opposed to biologically constructed, how gender affects self-stigma is important to consider in future research in self-stigma.

Mackay et al.'s (2015) and Charmaz's (1991) findings were supported as participants were found to experience depression as a significant change in their identities which led to a need to reconstruct their identities. This research also supported Boysen et al.'s (2014) findings that there is an overlap between gender and mental illnesses as it found that gender affects the experience of depression, specifically regarding the self-stigma of depression.

This study added to the literature by exploring the lived experiences of depression in men and women and how their gender affects their experience of self-stigma. This is an important gap to fill given that previous research has highlighted the need to explore the effects

of differing social categories in order to explore the full experience of self-stigma (Livingston & Boyd, 2010). Similar to previous research (Chuick et al., 2009; Emslie et al., 2006; Johnson et al., 2012; Lafrance & Stoppard, 2006) men and women participating in this study were aware of societal norms and influenced by broader societal views of depression which informed their experiences and decisions. This research added to the literature by showing that these societal norms and views were also applied by participants to the experience of self-stigma.

The ways in which self-stigma was viewed as a threat to gender identity shall be outlined below.

### 5.3.1 Loss of Family Roles

#### *5.3.1.1 Loss of Male Head of Household*

The male head of household concept signifies a strong male providing financially and being strong for his family. In this study men's negative attitudes and prejudices related to the loss of male head of household, which led to them feeling sadness and shame. The fits with Link and Phelan's (2001) definition of the stigma of status loss. This concurs with prior research that providing financially for the family is linked with masculinity despite the changing view of men's roles (Bernard, 1981; Christiansen & Palkovitz, 2001; Levant, 2011). These findings also support Willott and Griffin (2004) who contend that being a financial provider is important to a man's gender identity given that in this study the loss of male head of household represented a weakness. This study showed that being the man of the house did not just signify financial provision but was also a sign of strength, with depression a sign of weakness. The current study shows how men's experiences of depression can be similar in relation to self-stigma of depression, highlighting the significance of gender in how it shapes self-stigma. One woman also discussed her job as an important part of her identity, highlighting both the changing gender roles and how men and women's experiences can be similar (Bernard, 1981; Emslie et al., 2007).

#### *5.3.1.2 Loss of Being a 'Good' Mother*

Women's experiences of self-stigma was closely related to their role as mothers and the experience of depression was considered a threat to their gender identity. Female gender identity was seen to be associated with the social expectations of care-taking, as previously described by Gilligan (1982). The women's views of motherhood in this study supported Lafrance and Stoppard's (2006) findings as women also viewed being a 'good' mother as being

selfless. Depression and PPD negatively affected the perception of being a 'good' mother and participants' experienced their depression and PPD identities as incompatible with this 'good' mother identity, supporting previous literature (Staneva et al., 2015). Depression was seen as an identity that resulted in an inability to cope effectively with the requirements of motherhood and participants viewed this as being selfish, and described how others viewed it as being selfish, which supports previous research (Lafrance & Stoppard, 2006).

Expanding on McLoughlin's (2013) findings of PPD this study also found that both depression alongside PPD were viewed as a sign of a character weakness as women felt personally responsible for their illness. Depression was seen as something that is within their control and was their responsibility supporting Danielsson et al. (2009), and this study found that this perception affected how women experienced self-stigma. Due to this view, some participants were found to defend their pregnancies as both beyond their control or actively separate their depressed identities from their pregnancy. In addition, this study expands on previous research as it showed that women before during and after pregnancy and women with older children all experience the loss of being a 'good' mother. These findings highlight that the experience of motherhood at any stage is experienced similarly by women with depression and PPD. These findings also suggest that the experiences of self-stigma of both depression and PPD are similar for women with children.

Due to depression being incompatible with a 'good' mother identity, women's self-stigma of depression included the view that depression is self-indulgent owing to the social expectations of care-giving. This was reflected in both the women's own views and in their experiences of public judgment. These findings highlighted how depression and gender identity, specifically in relation to motherhood, affects how women self-stigmatise. Women were concerned about their female identity being threatened due to the social expectation of females as care-taking which supports the previous qualitative research on women with self-stigma of depression (Oakley et al., 2011). As Oakley et al. (2011) conducted just one focus group, this study's use of IPA and semi-structured interviews provided a more in-depth account of women's lived experience of self-stigma of depression and how it affected their experiences of motherhood.

This study found differing results amongst participants as some women were found to resist self-stigma by becoming angry which supports Corrigan and Watson's (2002b) Paradox of Self-Stigma model. Interestingly, although one participant attempted to challenge the stigma

she experienced, this approach was not seen as effective which contrasts to Thoits' (2011) findings that challenging stigma can be an effective stigma management strategy. Although one participant did effectively resist self-stigma in relation to her 'good' mother identity, she was found to experience self-stigma of depression in relation to gender norms of women being sociable and friendly. These results suggest possibly different experiences of self-stigma in relation to different types of gender norms. In addition, other participants described both internalising and resisting stigma depending on differing contexts. These findings support the literature that self-stigma can vary depending on the context the individual finds themselves encountering (Corrigan & Watson, 2002b). Thus, this experience reflects the literature as self-stigma appears to be a state as opposed to a trait (Corrigan & Watson, 2002b). However, as these results are found in only a few participants, there is limited generalisability but it is an interesting finding that is worth exploring further in future research.

This study was able to contrast the experiences of women and men which allowed for a fuller exploration of gendered differences in relation to family roles. Oliffe et al.'s (2011) findings were supported in this study which highlighted that men's gender identities as provider and protectors affected how some men experienced depression and prevented them from dying by suicide. These findings support the literature that these gender identities give men a purpose to stop the thoughts about self-harm and suicide that occur frequently when experiencing depression (Oliffe et al., 2011). This study also highlighted the different experiences of women and men and found that some men can experience less pressure of societal expectations as care-takers of children.

### 5.3.2 A Need to Conceal

#### *5.3.2.1 Social Withdrawal*

Stigma management strategies have been explored using quantitative methodologies (Ilic et al., 2012; Ilic et al., 2014). This study adds to the literature base as it allowed for and in-depth exploration of how participants managed their self-stigma. Social withdrawal was seen to be an ineffective defensive management strategy which is similar to Ilic et al.'s (2014) findings of stigma experiences. Withdrawal was discovered to be employed more by men. This strategy was defensive and was used to protect the individual from negative attitudes and discrimination of others as in previous literature (Goffman, 1963; Ilic et al., 2012; Link et al., 1989; Link et al., 1991). It also supports Corrigan and Rao's (2012) stages of disclosure which states social withdrawal is used due to the shame of depression. This study supported this

finding as participants exercised social withdrawal which can be utilised in order to cope with their self-stigma of depression. This is in contrast to Camp et al.'s (2002) who suggested that withdrawal may not be due to individuals applying stigma to themselves. This present study provides new findings that suggests that men use the stigma management strategy of withdrawing when experiencing self-stigma. This study found men wanted to socially withdraw due to their diminished self-esteem, which supported similar findings of men wanting to keep a low profile due to their self-esteem being threatened (Mahalik & Rochlen, 2006).

These results concurs with Oliffe et al. (2013) who reported that men with depression socially withdraw as they worry about further judgement due to depression. Men were conscious of their vulnerability and wanted to protect this vulnerability which is similar to findings in the help-seeking literature (Johnson et al., 2012). The current study's findings add to the literature by suggesting that men's experiences of self-stigma can lead them to feel vulnerable and withdraw in order to protect their gender identity. As it was seen to be more common in men, it was interpreted that stigma management strategies can be affected by gender. However, due to the small number of participants in this study, these findings need to be further explored in order to generalise these findings. Social withdrawal was seen to be used by one of the women in the study, highlighting how experiences of self-stigma can be similar in men and women. This supports previous findings of similar experiences of depression (Emslie et al. 2007).

#### *5.3.2.2 Wearing a Sociable 'Mask'*

Similar to how men managed the stigma of depression, women's gender identity affected how they managed their self-stigma of depression. As this study was qualitative, it was able to explore the full range of management strategies associated with self-stigma unlike previous quantitative research (Ilic et al., 2012; Ilic et al., 2014). The present study discovered a different management strategy that was common amongst the experiences of women's self-stigma. Wearing a sociable 'mask' is a different stigma management strategy to the ones studied quantitatively by Ilic et al. (2012; 2014). Ilic et al. (2012; 2014) studied management strategies such as educating others, humour, and information seeking, or disclosure. This differing result is possibly due to management strategies not being studied in the context of self-stigma. In this current study, women utilised this strategy due to the pressures of their gender identity and to protect themselves from a diminished gender identity. While depression is typically a female mental illness, women in this study did not feel it was socially acceptable

to show their depression. This suggests that while depression is compatible with femininity, women did not want to be associated with that particular type of femininity. The participants wanted to have the female identity of being pleasing, sociable, and friendly (Prentice & Carranza, 2002) and not the female identity of being emotionally expressive (Broverman et al., 1972). These findings also suggest that although gender stereotypes of depression suggest women are relational and emotionally orientated (Bengs et al., 2008; Broverman et al., 1972), the self-stigma of depression stopped women from wanting others to view them as this particular type of woman.

This 'mask' was experienced by the woman as self-sacrificing. This ties in with research regarding women and depression that suggested women prioritise their relationships over their own needs in an attempt to fit into the identity of 'good' woman (Jack, 1991). The 'mask' was also used to protect both personal and professional relationships and was seen as an achievement. The 'mask' was a way to self-silence their own needs for the needs of others, which reflect previous research highlighting that women are expected to be self-silencing (Beauboeuf-Lafontant, 2007). This study also supported the findings of Schreiber and Hartick (2002) as women in this study also spoke of an internal sense of shame about their depression as they felt depression separated them from the female societal values of being cheerful.

While one man discussed his strategy of wearing a 'mask', this study found that wearing a 'mask' appeared to be more common with women. Previous research has reported that men can also wear a 'mask' to protect their vulnerability (Oliffe et al., 2010). As the current study's sample was relatively small, it may be that the particular men recruited did not use this strategy. Overall, the findings draw attention to the possibility that both men and women can employ similar stigma management strategies as evident from the results of this study where a woman socially withdrew and a man spoke about his experience of wearing of a 'mask.' This highlights how experiences of stigma management strategies can be similar in both men and women. These findings add to Emslie et al.'s (2007) previously mentioned study which shows that men and women can have similar experiences of depression. Further similarities are highlighted next in the superordinate theme: resisting the threat to gender identity.

### 5.4 Resisting the Threat to Gender Identity

The findings of this superordinate theme show how men and women's experiences of depression can be similar, supporting Emslie et al. (2007). The present study provides a detailed experience of participants' self-stigma of depression and found that very often these

similar experiences can be affected by an individual's gender. Participants were found to resist stigma over time, with this resistance seen as participants fighting for their threatened identity by reframing their self-stigma. This finding support the mental illness literature which documents that people can eventually come to terms with their stigmatised identities (Michalak et al., 2011).

### 5.4.1 Seeking Help: From a Threat to Recovery

Although the self-stigma of help-seeking was outside the scope of this study, it was a significant experience for participants in this study and so was highlighted as a subordinate theme. The current study indicates that help-seeking appears to be an important part of the overall experience of self-stigma. Participants were found to avoid seeking help in order to avoid a label, supporting Corrigan's (2016) construct of label avoidance. It was interpreted that this was related to their self-stigma of seeking help (Tucker et al., 2013).

Within this study, participants discussed differing experiences and so it appeared that both self-stigma of seeking help and the self-stigma of mental illness were related to seeking help in this study. However, given the small sample size, this study is unable to draw firm theoretical conclusions and limits the generalisability of these findings. As there is conflicting research on how the self-stigma of mental illness is related to seeking help (Tucker et al., 2013; Lannin et al., 2015; Clement et al., 2015), the constructs of self-stigma of mental illness and help-seeking need to be explored further. This study did find that seeking help was a significant part of the depression experience of participants, however, this may be due to the fact that all participants attended a day service and had been recruited through this day service for this study.

Farmer, Farrand & O'Mahen (2012) argue that identity conflict was the reason for delaying help-seeking. This study had similar findings with identity threat being a more pertinent aspect of delayed help-seeking. Participants were found to avoid seeking help in order to reduce perceived threat to their identity. In contrast to Farmer et al. (2012), in this present study help-seeking led to participants reaching a point of acceptance, as opposed to participants obtaining a position of acceptance before seeking help. This study's findings support the previous literature that there can be a relationship between rejecting stigma, and ignoring what others think and seeking help (Clement et al., 2015).

Seeking help was also found to be affected by gender identity. Men and women were found to experience seeking help in relation to their gender. This study concurs with Levant

et al.'s (2013) and Pederson and Vogel's (2007) theories that self-stigma affects the relationship between male gender role conflict and traditional masculinity ideology and willingness to seek counselling. Men in this study were found to resist seeking help due to their need to be self-reliant and have emotional control, similar to Johnson et al. (2012), Addis and Mahalik (2003), and Emslie et al. (2006). This need to be self-reliant and have emotional control resulted in men finding it difficult to seek help and also to engage in help. These masculine gender norms were associated with self-stigmatisation similar to Latalova et al.'s (2014) findings.

However, this study found that over time seeking help was no longer viewed as an emasculating experience and men resisted the threat to their gender identity. They viewed it in a positive light and an important part of their recovery. This supports previous findings where men were found to cope with depression by reframing masculine norms in the context of depression (Spendelow, 2015). In this study, men reframed masculine norms by reframing their views of seeking help to viewing it as responsible action, similar to Johnson et al.'s (2012) findings. This was interpreted as reclaiming their masculinity and resisting self-stigma.

This study adds to the research in exploring how seeking help can affect women's identities and how they reframe their attitudes and prejudices in relation to seeking help. Women were found to worry about other people's views about depression as opposed to how seeking help affected their own identity. This was interpreted to be connected to the minor theme of wearing a 'mask' as it highlighted how important it is to women how they are perceived by others. By seeking help, there was a chance that their diminished gender identity behind the 'mask' will be undermined, which was threatening to their identity. This is supported by literature that states that women are expected to be pleasing and self-sacrificing (Lafrance & Stoppard, 2006) and that depression goes against the 'good' woman identity. However, women were able to resist the negative connotation of taking care of themselves and viewed it as an important part of their recovery which supports previous literature (Lafrance & Stoppard, 2006). One participant was found to struggle with the self-stigma of seeking help within their discourse, highlighting how fully resisting stigma can be difficult and can be a varying state (Corrigan & Watson, 2002b). This is in line with previous qualitative research studying self-stigma, as with Mackay et al. (2015), some participants were found to experience self-stigma and stigma resistance simultaneously.

### 5.4.2 Disclosure: From shame to opportunity

The self-stigma of their mental illness led participants to view disclosure of their depression as something that could be harmful to them. They protected their shame by keeping their diagnosis a secret. These findings support the self-stigma literature of disclosure (Corrigan & Rao, 2012). This study found that men were worried about being viewed as weak and so did not disclose, similar to Ridge and Ziebland's (2002) study. These results highlight that it is not just help-seeking but disclosure itself that threatens a man's masculinity in concurrence with previous theories (Levant et al., 2013; Pederson & Vogel, 2007). Women were found to be concerned about their credibility due to their management strategy of wearing a sociable 'mask'. This highlights how men and women can be concerned about different aspects of disclosure, suggesting a gendered experience. These findings add to the literature by exploring how disclosure is affected by gender identities.

As in Ridge and Ziebland (2012), over time participants challenged the stigma and disclosed their illness. The findings of this study also highlighted that participants can dismiss the negative consequences of disclosure and use disclosure as an opportunity to educate others about depression which supports the stigma management literature (Corrigan & Rao, 2012; Ilic et al., 2014). Disclosure was found to reduce self-stigma in these participants and allowed for a sense of empowerment. This study supports the idea that certain stigma management strategies can be empowering and not be a draining experience for the individual as reported by Thoits (2011). This empowerment construct is supported by previous qualitative research on bipolar disorder by Michalak et al. (2011) who, as in this study, found disclosure can be experienced very differently by the participants; from anxiety-provoking to empowering. The present study also supported the literature that educating others can be seen as an empowering experience and a way to regain control of a person's experience of depression (Corrigan & Watson, 2002b; Corrigan & Rao, 2012; Ilic et al., 2014). However, disclosure as an empowerment strategy was not seen to have gender differences, suggesting that experiences of educating others may not be affected by gender. As the results in this study are from a small sample size, further research is important to ascertain whether empowerment is affected by gender or is experienced similarly by men and women.

Righteous anger was found to be a reaction to stigma by two of the participants, however, one participant was interpreted to resist stigma, whilst another internalised stigma despite feeling anger towards public stigma. This suggests that anger may not always lead to

successful resistance of stigma, which is dissimilar to theoretical literature on resisting self-stigma (Corrigan & Watson, 2002b). However, as this contrasting finding only concerned one participant, no firm conclusions can be drawn and further research needs to be carried out to further explore this interesting finding.

### 5.4.3 Normalising

Ilic et al. (2014) discussed normalising as emphasising the similarity between physical and mental illness. This study was able to explore normalising in-depth and found it is a much broader experience than comparing mental illness to physical illness. Participants also discussed normalising in relation to financial stresses and normalising low mood. The literature is unclear whether normalising can reduce stigma (Ilic et al., 2014), however, it was found in this study that participants used normalising to reduce self-stigma. These findings call for more research regarding how normalising affects stigma and self-stigma.

Normalising was found to help both men and women resist the stigma of depression. It was found that being normal was important for their self-esteem as they wanted to reclaim their threatened gender identity. This is similar to previous findings that feeling normal was important to people with depression in order to comply with gender norms (Danielsson et al., 2011). The findings are also similar to Ridge and Ziebland (2012) who found how people can accept their depression identity by viewing their depression as normal and common.

Both genders described differing reasons for why depression was normal with a few exceptions. These findings are similar to Johansson et al. (2009) who found women and men described different reasons for experiencing depression. Similar to Johansson et al. (2009) findings in this study men spoke about how environmental reasons can cause depression. These findings suggest that men use this strategy to normalise their depression in order to resist the threat to their gender identity. Men's normalising of depression was found to relate to how it was out of their control, which is similar to Danielsson et al.'s (2009) study. As being a provider is an important part of men's identity (Bernard, 1981; Levant, 2011; Willott and Griffin, 2004) normalising depression using financial reasons as the cause of their depression were used to help protect their diminished gender identity. One woman describing financial reasons for depression supports previous research that there are changing gender roles within society (Bernard, 1981).

In this study, women normalised low mood possibly because depression is a gendered mood disorder (Boysen et al., 2014). In this way they are resisting the stigma of being

emotionally expressive (Broverman et al., 1972). They were found to be normalising low mood in order to resist the social pressure of needing to be cheerful and pleasing all the time (Schreiber & Hartick, 2002).

### 5.4.4 An Empowering Experience

Both men and women in this study described depression as an empowering experience. By viewing their experience in a more positive light, this was interpreted as a rejection of the negative view of themselves that they had when they first experienced depression and, thus, resisting self-stigma. Participants spoke about how they now saw depression as an empowering, learning experience as opposed to an integral part of their identity, thus restoring their self-concept. As participants felt they had a sense of power and control, this was viewed as participants experiencing empowerment (Rappaport, 1987). The participants experienced rejecting the common negative view of depression and described how they overcame their depression and promoted their recovery from their illness (Corrigan & Garman, 1997).

The results supported Corrigan and Watson's (2002b) Paradox of Self-Stigma model that participants can resist self-stigma and find this experience empowering. Participants experienced resisting self-stigma as a journey that they were able to achieve over time. This study's findings supported Michalak et al.'s (2011) aforementioned results regarding people with bipolar disorder. Participants in this study were also found to have a gradual coming to terms with depression and become empowered by their experience of depression. Although participants in this study did not directly discuss overcoming public stigma as an empowering experience as Shih (2004) previously reported, participants did describe depression itself as a learning curve where they have realised their strength. Depression was no longer seen as a draining process which is how stigma has been previously described (Link et al., 1991), but an educational experience that allowed them to gain control. This finding suggests mental illness itself can be an empowering experience, which, in turn, can help people resist self-stigma. As the sample size of this study limits the generalisability of these findings, future research is needed to fully explore this relationship between empowerment and mental illness.

There is a dearth of **r**esearch on how stigma resistance can be affected by gender identity. In this study, men and women described their stigma resistance and empowerment in a gendered way. Men and women were found to relate their empowering experience to gender identity, highlighting how entrenched gender identity can be in everyday social interactions (West & Zimmerman, 1987). Men described how the experience of depression

allowed them to become mature, independent, and self-reliant, thus reclaiming their masculinity. Women discussed how empowering it was for their relationships, which ties in with previous literature that documents how women feel a greater concern for relationships when experiencing depression (Danielsson et al., 2009). Thus, women resisted self-stigma by describing how empowered they felt in relation to their relationships. The construct of being a 'good' mother was also described in relation to empowerment, thus, reclaiming the diminished 'good' mother identity (Mickelson et al., 2015; Staneva et al., 2015). Women were found to highlight the journey and learning experience they had encountered through their depression, which increased their self-esteem, reflecting previous literature (Staneva et al., 2015).

## 5.5 Strengths and Limitations

While this research has added to the literature regarding the gendered experience of self-stigma, it is important to reflect on the quality of the findings. There are strengths and limitations of this study which emerged throughout the process of the research which are discussed below.

### 5.5.1 Strengths

The present study provided an important insight into the experience of self-stigma in people with depression in the context of their gender. It gave a voice to people with depression to express their views of their experiences. This allowed for insight into the self-stigma construct which has rarely been researched in relation to gender and thus adds to the knowledge base regarding self-stigma. The findings of this study have useful implications for practice, research, policy, and service development.

The use of qualitative methodology, specifically semi-structured interviews, benefited this study. It allowed in-depth access to the experiences of people with depression. The semi-structured interviews enabled participants to have time to talk about their experiences at length. It also provided them the opportunity to bring up experiences that were important to them that the researcher had not specifically asked or considered. This allowed topics to be explored that may not have featured in quantitative methods or structured interviews.

The mix of both male and female participants was a strength of this study as it allowed the examination of both genders' experiences of self-stigma. This allowed the researcher to fully explore the gendered experience of self-stigma and be able to report the similarities and differences between men and women in the analysis of data. This provides insight into the

gendered experience of self-stigma that would not have been possible by studying only one gender.

Participants were of different ages and backgrounds. One participant had Peri-Partum Depression (PPD). Some of the participants regarded themselves in recovery and so were doing relatively well than the other participants who were currently experiencing depression. While this heterogeneity may be seen as a weakness in quantitative research, it is seen as a strength in qualitative research as it allows the researcher to explore more fully the varying and wide-ranging experiences of self-stigma of depression. Including a participant with PPD allowed the researcher to explore the participants' gendered experience of various types of depression. Although this study does not claim general representation of experiences of depression and self-stigma, the sample does reveal a broad range of experience and complexities about the gendered experience of self-stigma of depression. This study highlights how complex and varied the experience can be for individuals.

### 5.5.2 Limitations

This study interviewed people who were willing to talk about stigma and depression, so the sample was limited to exploring experiences of people who might possibly be less stigmatised and more able to resist stigma. People who do not want to talk about their depression could arguably be more stigmatised and it is a limitation that these individuals were not represented in the sample. All participants were engaged in mental health services, this engagement in help-seeking may have allowed them to be more comfortable talking to a researcher about their depression. The inclusion of people who attend services infrequently or not at all may have revealed different results.

The study of self-stigma of depression can be difficult due to low self-esteem and self-efficacy being a symptom of depression. In addition, stigma involves many different constructs that can interlink with each other, e.g., self-stigma vs. anticipated stigma. Individuals themselves may not be aware of their self-stigma as it can be implicit (Rusch et al., 2010). Thus, for these reasons, there may be overlap of constructs and it may be difficult to discern exactly which construct is being researched. To address this, the questions were tailored in order to concentrate on self-stigma by first asking participants' opinions on public stigma and asking participants their opinions of this stigma and how it made them feel about themselves. The conversation was then explored from this starting point to ensure the concept of self-stigma was explored. Although it is acknowledged that there may be still overlap due to the

similarities of the constructs, it was controlled for as much as possible. While a self-report measure may have increased the validity of the findings, self-report measures do not capture possible implicit self-stigma (Rusch et al., 2010). In addition, given that self-stigma is a varying state dependant on context (Corrigan & Watson, 2002b) self-report measures would not capture possible past experience of self-stigma or differing contexts in which the level of self-stigma varies. These methodological limitations are an important area to be considered for future research studying self-stigma.

The use of Interpretive Phenomenological Analysis (IPA) may have also in itself been a limitation as this can be a subjective methodology as it asks the researcher to provide their own interpretation. However, IPA advocates that the researcher be aware of this throughout the process. The researcher should reflect upon their own assumptions and biases that may have influenced the data. In order to ensure the researcher self-reflected throughout this study, the researcher completed a reflective worksheet after every interview. Reflective boxes of the researcher's thoughts were included in the results section. This allowed the reader insight into how the study many have been influenced.

Other limitations to be considered are the interview schedule being too structured for an IPA study. Thus, the questions within the interviews may have been too leading. Also, due to the interviewer's personal experience, which is detailed below in Critical Reflection, the interviews were more structured than semi-structured in the early stages of the project. This may have affected the answers the participants provided, which in turn, would affect the data collected. As the staff at the day hospital recruited participants, there was a sample bias due to staff choosing participants they deemed suitable. The use of the word "resist" in the study's research question may have also been leading and biased the findings.

### 5.6 Critical Reflection

IPA stresses the importance of the researcher critically reflecting on their impact of the process and interpretation of the interviews (Smith et al., 2009). This section will outline the researcher's assumptions, challenges, insights and experiences throughout the study.

My motivations to explore this area was due to my experience of clients I worked with exhibiting signs of self-stigma of their mental illness. I began to wonder what the experience is like for them and how, if at all, they could resist this internalisation of stigma. As these clients who expressed self-stigma happened to be all men, I wondered whether gender affected

the experience of self-stigma and whether a woman who had self-stigma would go through similar experiences.

I found the use of semi-structured interviews helpful in allowing participants to speak about their experience of self-stigma. In the initial interviews I found I was anxious about ensuring I asked all the questions I had on my interview sheet. I felt this ended up prohibiting participants from discussing a subject they wanted to at length and the data from the initial interviews was not as detailed as I would have hoped for. I found once I spoke as little as possible and used reflective listening skills more than asking questions, this allowed for the interviewee to talk about what was important to them. I found this allowed me to gain a deeper understanding of the participants' experiences.

The fact that I had previously worked in the day hospital where I was recruiting participants proved to be beneficial. I had built up a relationship with the staff that I believe helped them to be more open to recruiting participants for my study. However, I was concerned that participants being recruited through staff at the day hospital may lead participants to feel pressurised to agree to be interviewed. I found that this was not a problem as staff ensured participants knew of the voluntary aspect of the study. Participants reported being happy to 'give back' to the day hospital and were happy to talk about their experiences. There was also a sense that the participants were happy for their voices to be heard. I also wondered what the dynamic would be like with a woman asking men about how their experience of depression made them feel in their male role. While it appeared the men felt comfortable talking to a woman, I did feel they may have expressed themselves differently if I had been a man due to them possibly being more comfortable with the same gender.

The analysis of the data was challenging as it was my first analysis of data using IPA. I used Smith et al.'s (2009) detailed description of IPA to guide me through the analysis. The openness of analysis and lack of set criteria to interpret the data made it challenging to decide how much interpretation was needed. I found my data was more descriptive than interpretive as I felt I was concerned that my interpretation was not quite right or did not reflect the experience of the participant. To address this, I continually studied the transcripts and the themes during analysis in order to ensure there was a balance of themes reflecting the participants' experience and my interpretations. I also brought these difficulties to the attention of my supervisor to ensure my analysis was both interpretive and reflected participants' accounts.

## 5.7 Implications for Practice

Although the use of qualitative methods limits broad generalisations, commonalities across accounts have provided useful insights into how clinicians can work with people with self-stigma.

The significance of seeking help at first should be noted by clinicians and steps should be taken to ensure the person seeking help feels as comfortable as possible at their initial appointment. Normalising reluctance to seek help in initial phone conversations or letters may prevent people who would refuse seeking help to make contact. As gender has a factor in help-seeking, clinicians should be cognisant of this when working with clients. For example, clinicians should reframe help-seeking as a positive experience, including how it can be an important independent action to men and an important part of recovery to women.

Clinicians working with men and women with depression who have self-stigma should tailor their interventions of self-stigma and adopt a gendered approach. Clinicians exploring how men and women feel about their gender identity will allow for the clinician to gain access to the clients' gendered experience of self-stigma, or even lack of self-stigma. This will then allow for discussion and reassurance by clinicians. It would also allow for the intervention to be focused on rebuilding a client's diminished gender identity. This is similar to Mackay et al.'s (2015) recommendation of focusing on working on identity-based work in order to assist clients with reducing self-stigma. Tailoring to gender would add another important feature and make the interventions more effective in decreasing self-stigma in men and women, and, in turn, promote recovery. For example, including gendered aspects to psychoeducation on mental illness and narration work often used in self-stigma interventions (Yanos et al., 2015) would be beneficial as it will allow individuals to become empowered in their lives.

Clinicians normalising their experience of depression in relation to gender norms may help clients resist the stigma of depression. Discussing the positive experience of depression with clients may have a therapeutic effect and help clients resist stigma. By empowering clients to reclaim their gender identity, for example, teaching clients that depression does not mean they have lost their gender identity as a man or as a woman, clinicians can help clients resist self-stigma.

### 5.8 Implications for Education

This study has discovered factors about self-stigma of depression that are specific to each gender. Health professionals would benefit from being made aware as part of their education of the specific issues of self-stigma and how self-stigma can be gendered. This would allow health professionals to plan services with self-stigma in mind which, in turn, would help with service engagement as people with self-stigma would feel understood.

The findings of this study show that self-stigma can be experienced in people with depression, even in those who attend mental health services. Seeing depression as a threat to a gender identity impacts on people's recovery from depression and makes them reluctant to seek help or disclose their depression to others. This suggests the need to provide educational campaigns related to the stigma of depression and gender identity to people with depression. Educational campaigns should focus on men and women separately, given the different experiences of self-stigma. These education programmes should focus on normalising depression in relation to gender, normalising seeking help, addressing the difficulties each gender has due to social norms of how men and women should be and how men and women can empower themselves to overcome these. Participants in this study spoke about their concern for other people's negative views, illustrating that self-stigma is interlinked with public stigma. Thus, it is important that education is provided at a community level also in order to address public stigma. These community level educational campaigns should also target each gender individually.

### 5.9 Implications for Policy

The World Health Organisation (2012) has acknowledged that overcoming stigma has been identified as one of the main challenges facing people with mental illnesses. Yet, despite many anti-stigma campaigns, studies still show there is a high rate of stigma towards people with mental illnesses as well as a significant amount of self-stigma in people with depression (Brohan et al., 2011; St. Patrick's Mental Health Services, 2014). This suggests that these campaigns are not targeting stigma effectively. The current mental health policy should also differentiate between public stigma and self-stigma. This will allow for polices to target each stigma more effectively. National anti-stigma campaigns and policies aimed at people with mental illnesses should tailor their campaigns to specific gender concerns. Acknowledging gendered differences in self-stigma will increase the effectiveness of campaigns. National campaigns and policies should understand how people with depression have overcome stigma

and ensure policies are put in place so that all people with depression have the opportunities to overcome stigma.

### 5.10 Implications for Future Research

As this research specifically looked at depression, future research on other mental illnesses, such as anxiety or bipolar disorder, would be useful to explore how self-stigma is experienced and managed in relation to gender. Specifically exploring a more masculine illness, such as substance misuse, would be of benefit to ascertain how gender identity is affected in disorders that are viewed as masculine and also are more stigmatised.

As this study focused specifically on self-stigma, future research should focus on exploring how other types of stigma of depression is gendered, such as public stigma, experience stigma, or structural stigma. This could be conducted on members of the public exploring their views of depression. Further research is needed to fully explore the constructs of self-stigma, label avoidance, and self-stigma of seeking help on people with depression. Research on these differing constructs and how they are experienced in people with depression would further the knowledge within the self-stigma literature.

The use of IPA methodology allowed the perspectives of people with depression to be heard. This gave a valuable source of rich and in-depth data. This suggests there is value in further research using qualitative methods to highlight the voices and perspectives of this population. Further research could look at self-stigma longitudinally by interviewing people with depression at different stages of their journey, for example, at diagnosis and then at six months into treatment. This would explore the journey of self-stigma and the possible development of stigma resistance over time.

Previous research on non-clinical male participants has found that self-stigma partially mediates the relationships between male gender role conflict and traditional masculinity ideology, and willingness to seek counselling (Levant et al., 2013; Pederson & Vogel, 2007). It would be beneficial for future research to use quantitative methods to investigate the relationship of gender role conflict and also gender role attitudes with self-stigma in a clinical population. This research should be extended out to studying women's gender role conflicts and their experience of self-stigma. Future research should also study other mental illnesses to explore if there are differences in each mental illness.

## 5.12 Study Conclusion

The aim of the present study was to explore how men and women experience, manage, and potentially resist self-stigma and in particular how gender affects the way in which people experience self-stigma. The literature review identified a significant gap in the literature in that there was no research on how gender affects the self-stigma experience of depression. Furthermore, there was no research on how gender can affect the management and resistance of stigma. Self-stigma was deemed to be an important construct to study as it has significant negative effects on people with depression.

The current study has made an important and significant contribution towards addressing the above gaps and in understanding how self-stigma is experienced by people with depression. This study has given men and women with depression an opportunity to tell their story of self-stigma. The current study gave important insights into how men and women experience, manage and resist self-stigma. As a result, this study has important implications for practice, education, policy, and future research.

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# Appendices

## Appendix A: Interview Questions

| | |
|---|---|
| Stigma | What do you think others think about depression?<br><br>Do you think there is a common stereotype of a person with depression? If so, what is it?<br><br>How do you think others perceive or behave around you because of your depression?<br><br>Have you experienced discrimination/stigma as a result of having depression? Can you tell me a story of a time you feel you've been treated differently because of having depression? How did that make you feel? |
| Self-stigma | Do you feel you fit into the stereotype of depression? Why/why not?<br><br>How does having depression make you feel about yourself? As a woman/man?<br><br>When you've encountered situations where you feel you've been treated differently because of your depression, how did you deal with it?<br><br>Did these encounters bring up any feelings for you? Can you describe them? How did you manage these feelings?<br><br>How has your life changed since you were diagnosed with depression? (relationships with others in family, friends, work; interactions, quality of relationships) |

**Appendix B: Information Sheet at Recruitment Stage**

**INFORMATION SHEET**
**PLEASE KEEP THIS PAGE FOR YOUR INFORMATION**

My name is Rachel Parkinson and I am currently conducting a doctoral research project in the Department of Psychology in University of Limerick under the supervision of Dr Barry Couglan (Ph: 061-245345) and Dr. Ronni Greenwood (Ph: 061 234618). You are being invited to participate in my study. Thank you for taking time to read this information leaflet.

**WHAT ARE THE OBJECTIVES OF THIS STUDY?** The aim of the study is to explore what men and women with a primary diagnosis of depression think about stigma, and any possible self-stigma that may occur.

**WHAT IS SELF-STIGMA?** Self-stigma or 'internalised stigma' is when someone who has experienced discrimination and stigma because of their depression, starts to have negative feelings towards their depression themselves. However, this does not always occur and you do not have to feel you experience self-stigma to partake in this study.

**WHAT DOES THE STUDY ENTAIL?** The study will involve partaking in an interview with the researcher, Rachel Parkinson, at a time and location that is convenient for you. The interview will explore your experiences and beliefs of stigma, how you manage and respond to stigma and possible self-stigma.

**HOW DO I SIGN UP?** If you would like to partake in the interview, please tear off and fill out the contact details form attached to this form. Please note, you may not be asked to participate in the study due to time constraints.

**CAN I PARTAKE IN THE STUDY?** If you attend XXXX Day Hospital, have a primary diagnosis of depression, are over the age of 18 and do not have current substance misuse or psychotic symptoms, you are eligible to participate in this research.

**WHAT WILL HAPPEN IF I VOLUNTEER?** Your participation is entirely voluntary. If you initially decide to take part you can subsequently change your mind and withdraw from the study without difficulty. This will not affect your care or services with XXXX Day Hospital. If you agree to participate you will be requested to provide contact details information. You may then be contacted by the researcher to be asked to attend an audio-recorded interview, which will involve exploring your experiences and perceptions of both stigma and self-stigma, and also how you manage stigma and self-stigma. Although the researcher will have a few set questions, the interview itself will be informal and flexible. The field researcher may access your file at XXXX Day Hospital to clarify your diagnosis of depression.

**RIGHT TO WITHDRAW:** You can withdraw from the study at any point in the study, including during and after the interview. If you decide afterwards that you do not want your interview to be used in this study, you can contact the researcher and your interview will be withdrawn and deleted. Only when the results have been written up and sent for publication, will we be unable to withdraw your data.

**ARE THERE ANY BENEFITS FROM MY PARTICPATION?** While there will be no direct benefit from participation, studies like these may improve our understanding of stigma and self-stigma in people with depression. As such, the findings from this study may be presented at national and international conferences and may be submitted for publication in peer-reviewed journals. However no individual participant will be identified in any publication or presentation.

**ARE THERE ANY RISKS INVOLVED IN PARTICIPATING?** There are some risks associated with participation, which relate to the possible inconvenience of attending an interview and the sensitivity of the topics addressed. Any inconvenience involved in taking part will be limited. Stigma may be a sensitive subject for some participants and so distress may be caused. Helplines and contact details will be provided at the interview.

**WHAT HAPPENS IF I DO NOT AGREE TO PARTICIPATE?** Whether you decide to participate or not, your care and services at XXXX Day Hospital will **not** be affected in any way.

**WHAT HAPPENS TO MY DATA?** Contact detail forms will be removed from XXXX Day Hospital in a locked box to the Field Researcher's office. They will be kept in a locked drawer. After the interview, the recorded interview will be transported securely to a locked drawer, it will be transferred to an encrypted USB key and the data will be pseudo-anonymised. Only the Field Researcher, Rachel Parkinson, and co-investigators, Dr. Barry Coughlan, and Dr. Ronni Greenwood, will have access to your data. Rachel Parkinson will transcribe the data.
Identifiable data will be destroyed as soon as its purpose has been fulfilled (when interview has been conducted and results have been sent out to participants). Pseudo-anonymised data will be kept for one year after academic qualification.

**WHAT ABOUT CONFIDENTIALITY?** All individual information collected as part of the study will remain confidential. What is discussed in interviews will be kept confidential, including from mental health professionals working at XXXX Day Hospital. Any incidental findings that occur during the interview will be discussed with you. Limits on confidentiality will only occur if harm to you or harm to others is disclosed in the interview. Rachel Parkinson will discuss this with you in the interview and inform a mental health professional at XXXX Day Hospital.

**CONTACT DETAILS** If you have any further questions about the research you can contact:
FIELD RESEARCHER: Rachel Parkinson EMAIL: 12021628@studentmail.ul.ie
PRINCIPAL INVESTIGATOR: Dr. Barry Coughlan EMAIL: barry.coughlan@ul.ie
PHONE: 061-234345

**IF YOU ARE AFFECTED BY ANY ISSUES RAISED IN THIS STUDY, PLEASE CONTACT:**

XXXX Day Hospital: (XXXXXXX) (9AM – 5PM)
Dept. of Acute Psychiatry, XXXX General Hospital: XXXXXXX (24 Hours)
Samaritans: 116 123 (24 Hours)

**Appendix C: Consent Form at Recruitment Stage**

# CONSENT FORM

Chief Investigator: Dr. Barry Coughlan, Assistant Director of the Doctorate Programme in Clinical Psychology, University of Limerick. Phone: 061 234345

Joint Supervisor: Dr. Ronni Greenwood, Lecturer in Psychology, University of Limerick. Phone: 061 234618.

Field Researcher: Rachel Parkinson, Psychologist in Clinical Training
Email: 12021628@studentmail.ul.ie

You are being asked to participate in a research study. In order to decide whether or not you want to be a part of this research study, you should understand enough about its risks and benefits to make an informed judgment. This process is known as informed consent.

The information sheet gives detailed information about the research. Once you understand the study, you will be asked to sign this form if you wish to participate.

Your participation is voluntary and you may withdraw your consent at any time. Your decision not to participate or to withdraw will not restrict my access to health care services normally available to you.

You have opportunity to ask questions concerning any and all aspects of the project and any procedures involved.

Confidentiality of records concerning your involvement in this project will be maintained in an appropriate manner. The Field Researcher, Rachel Parkinson, will be accessing your records at XXXX Day Hospital to confirm your primary diagnosis of depression. When required by law, the records of this research may be reviewed by government agencies of the research.

If you have no further questions about giving consent, please sign below. Please also fill out the contact details form.

Participant's Signature: _____
Date: _____

**Appendix D: Contact Details Form**

Contact Details Form

Please read the information sheet and sign the consent form before providing contact details. Please keep the information sheet.

If you would like to partake in this study and be contacted for an interview, please leave your name and contact details below.

Name: _____

Contact Phone Number(s):_____

Address:_____

_____

_____

**Appendix E: Consent Form at Interview Stage**

Chief Investigator: Dr. Barry Coughlan, Assistant Director of the Doctorate Programme in Clinical Psychology, University of Limerick.
Phone: 061 234345

Joint Supervisor: Dr. Ronni Greenwood, Lecturer in Psychology
Phone: 061 234618

Field Researcher: Rachel Parkinson, Psychologist in Clinical Training
Email: 12021628@studentmail.ul.ie

You are being asked to participate in a research study. In order to decide whether or not you want to be a part of this research study, you should understand enough about its risks and benefits to make an informed judgment. This process is known as informed consent. This sheet gives detailed information about the research study, which will also be discussed with you. Once you understand the study, you will be asked to sign this form if you wish to participate.

The interview will involve the researcher, Rachel Parkinson, asking you a number of questions. These questions will be about stigma, self-stigma and your experiences and beliefs of these issues as an individual with a diagnosis of depression. Although there are set questions, these are more like a guide and so you have space to direct the conversation as you wish. The interview will last up to 60 minutes and will be audio-recorded.

Your participation is voluntary and you may withdraw your consent at any time. Your decision not to participate or to withdraw will not restrict my access to health care services normally available to you. You have opportunity to ask questions concerning any and all aspects of the project and any procedures involved.

Confidentiality of records concerning your involvement in this project will be maintained in an appropriate manner and will not be discussed with anyone other than researchers involved in the project: Dr. Barry Coughlan, Dr. Ronni Greenwood and Rachel Parkinson. However, if you disclose that you may harm yourself or harm others, a mental health professional at XXXX Day Hospital will need to be informed of this specific issue. You will be informed of this before a third party becomes involved. If this occurs, all other information spoken about in the interview will still remain confidential. If you have no further questions about giving consent, please sign below:

Participant's Signature: _____
Date: _____

Field Researcher's Signature:_____
Date:_____

**Appendix F: Information Sheet at Interview Stage**

## PLEASE KEEP THIS PAGE FOR YOUR INFORMATION

Thank you for giving up your time to take part in this study, it is very much appreciated.

**WHAT HAPPENS NOW?**
Your participation in the study has now finished. Your recorded interview will now be transported securely from the location of the interview to the field researcher's office. The data will be transferred onto an encrypted USB key and the interview will be pseudo-anonymised (e.g., you will be given a pseudo-name). The anonymised data will then be analysed. It will be written up for a doctoral thesis and submitted in April 2016.

**WHAT IF I CHANGE MY MIND?**
You have the right to withdraw your data at any time up until the time the results have been written up, which will be approximately February 2016. If you wish to withdraw, please contact Rachel Parkinson on the contact details below or discuss this with your key worker at XXXX Day Hospital. Your key worker can then contact Rachel Parkinson who will withdraw you data.

**CAN I SEE THE RESULTS?**
Rachel Parkinson can send on the overall results of the study in a journal article format (approx. 4000 words) if you so wish. If you agree to this, your contact details will be kept in a sealed locker in the principal investigator, Dr. Barry Coughlan's, office until then. Rachel Parkinson will be in contact with XXXX Day Hospital who will verify your current address. The results will then be sent to you in the post. If you do not want the results of the study sent to you, your contact details will be shredded immediately after interview.

If any topics that came up at the interview have caused you distress, it is advised that you contact your key worker at XXXX Day Hospital or contact the numbers below:

XXXX Day Hospital: (XXXXXXX) (9AM – 5PM)

Dept of Acute Psychiatry, XXXX General Hospital: XXXXXXXX (24 Hours)

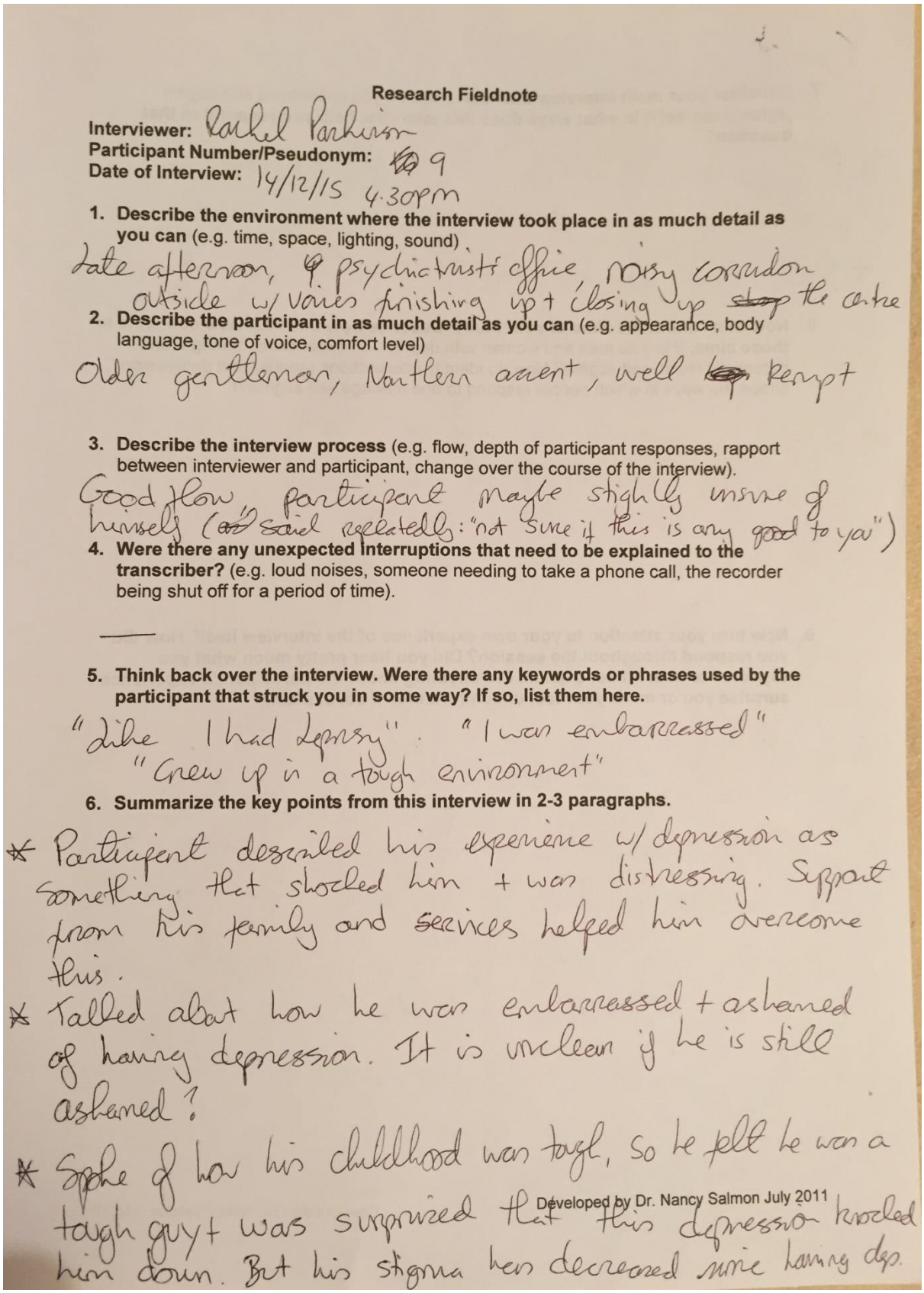
Samaritans: 116 123 (24 Hours)

If you have any further questions about the research you can contact:

FIELD RESEARCHER: Rachel Parkinson EMAIL: 12021628@studentmail.ul.ie
PRINCIPAL INVESTIGATOR: Dr. Barry Coughlan EMAIL: barry.coughlan@ul.ie
PHONE: 061-234345

Thank you again for taking the time to partake in this study.

**Appendix G: Example of a Research Fieldnote**



**Research Fieldnote**

**Interviewer:** Rachel Parkinson
**Participant Number/Pseudonym:** ~~10~~ 9
**Date of Interview:** 14/12/15 4.30pm

1. **Describe the environment where the interview took place in as much detail as you can** (e.g. time, space, lighting, sound).

late afternoon, ~~9~~ psychiatrists office, noisy corridor outside w/ voices finishing up + closing up ~~stop~~ the centre

2. **Describe the participant in as much detail as you can** (e.g. appearance, body language, tone of voice, comfort level)

Older gentleman, Northern accent, well ~~kept~~ kempt

3. **Describe the interview process** (e.g. flow, depth of participant responses, rapport between interviewer and participant, change over the course of the interview).

Good flow, participant maybe slightly unsure of himself (~~and~~ said repeatedly: "not sure if this is any ~~good~~ to ya")

4. **Were there any unexpected interruptions that need to be explained to the transcriber?** (e.g. loud noises, someone needing to take a phone call, the recorder being shut off for a period of time).

---

5. **Think back over the interview. Were there any keywords or phrases used by the participant that struck you in some way? If so, list them here.**

"like I had leprosy". "I was embarrassed"
"Grew up in a tough environment"

6. **Summarize the key points from this interview in 2-3 paragraphs.**

* Participant described his experience w/ depression as something that shocked him + was distressing. Support from his family and services helped him overcome this.
* Talked about how he was embarrassed + ashamed of having depression. It is unclear if he is still ashamed?
* Spoke of how his childhood was tough, so he felt he was a tough guy + was surprised that this depression knocked him down. But his stigma has decreased since having dep.

Developed by Dr. Nancy Salmon July 2011

7. **Consider your main interview question** (How do you experience self-stigma [agree/disagree]?) **In what ways does this interview help you respond to that question?**

* Participant spoke about feeling ~~self~~-stigma so limited disclosure, was in shock at first diagnosis
* ~~Spoke~~ spoke about how he agreed w/ stigma but doesn't anymore.

8. **Now think about the aims of your study. Describe how this interview connects to those aims.** (How do men and women with depression experience, manage, and potentially resist, self-stigma? How do identity intersections (gender and depression) shape the ways in which people respond to and manage self-stigma?)

* Interview connects as participant spoke of experience w/ depression, how he dealt w/ stigma (not-disclosing).
* He also spoke of how depression changed his identity and how he dealt with it.

9. **Now turn your attention to your own experience of the interview itself. How did you respond throughout the session? Did you hear pretty much what you expected to hear? If so, explain. Did anything about the participant's experience surprise you or make your feel uncomfortable? If so, explain.**

* ~~&~~ Heard what I expected to hear. Talked about childhood which was surprising.
* I felt anxious at ~~the~~ end, felt preoccupied with the fact that it was nearing 5pm and the centre was closing up. Worried that I would be left alone so finished interview early. Couldn't explore as much as I would've liked.

Developed by Dr. Nancy Salmon July 2011

## Appendix H: Ethical Approval

Ospidéil OL
UL Hospitals

**Ospidéal na hOllscoile, Luimneach**
**University Hospital Limerick**

Quality & Patient Safety Department,
University Hospital Limerick
Dooradoyle
Limerick.

Tel: 061 482519
Fax: 061 482920

11th June, 2015.

Ms. Rachel Parkinson,
Psychologist in Clinical Training,
Clinical Psychology,
Department of Psychology,
University of Limerick,
Limerick.

**Re: Protocol Title**
**Exploring Self-Stigma in People with Depression.**
**REC Ref: 71/15**

Dear Ms. Parkinson,

I am in receipt of your proposal as above submitted for review by our Research Ethics Committee. I have reviewed the contents of same.

I wish to advise that I have given your study Chairperson ethical approval.

You should note that your study cannot commence until you also receive AON approval which will issue from the Quality and Patient Safety Department shortly. You are obliged to inform us as soon as your study is completed or if it terminates early for any reason.

Should you wish to avail of statistical advice/assistance regarding this study you may contact Dr. Jean Saunders, Statistician, University of Limerick who is a member of our Research Ethics Committee.

I wish you every success with your study

**Yours sincerely,**

**Pat Dillon,**
**Consultant Anaesthetist,**
**Chairperson, Research Ethics Committee.**

ULH
Caring, Courteous and Professional

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Ospidéil OL
UL Hospitals

**Ospidéal na hOllscoile, Luimneach**
**University Hospital Limerick**

Quality & Patient Safety Department,
University Hospital Limerick
Dooradoyle
Limerick.

Tel: 061 482519
Fax: 061 482920

9th July, 2015.

**Ms. Rachel Parkinson,**
**Psychologist in Clinical Training,**
**Clinical Psychology,**
**Department of Psychology,**
**University of Limerick,**
**Limerick.**

Re/ **Protocol Title**
**Exploring Self-Stigma in People with Depression.**

Dear Ms. Parkinson,

The Research Ethics Committee at the University Hospital Limerick has received a submission for ethical approval for the above study.

The following documents were reviewed and approved by the Research Ethics Committee:

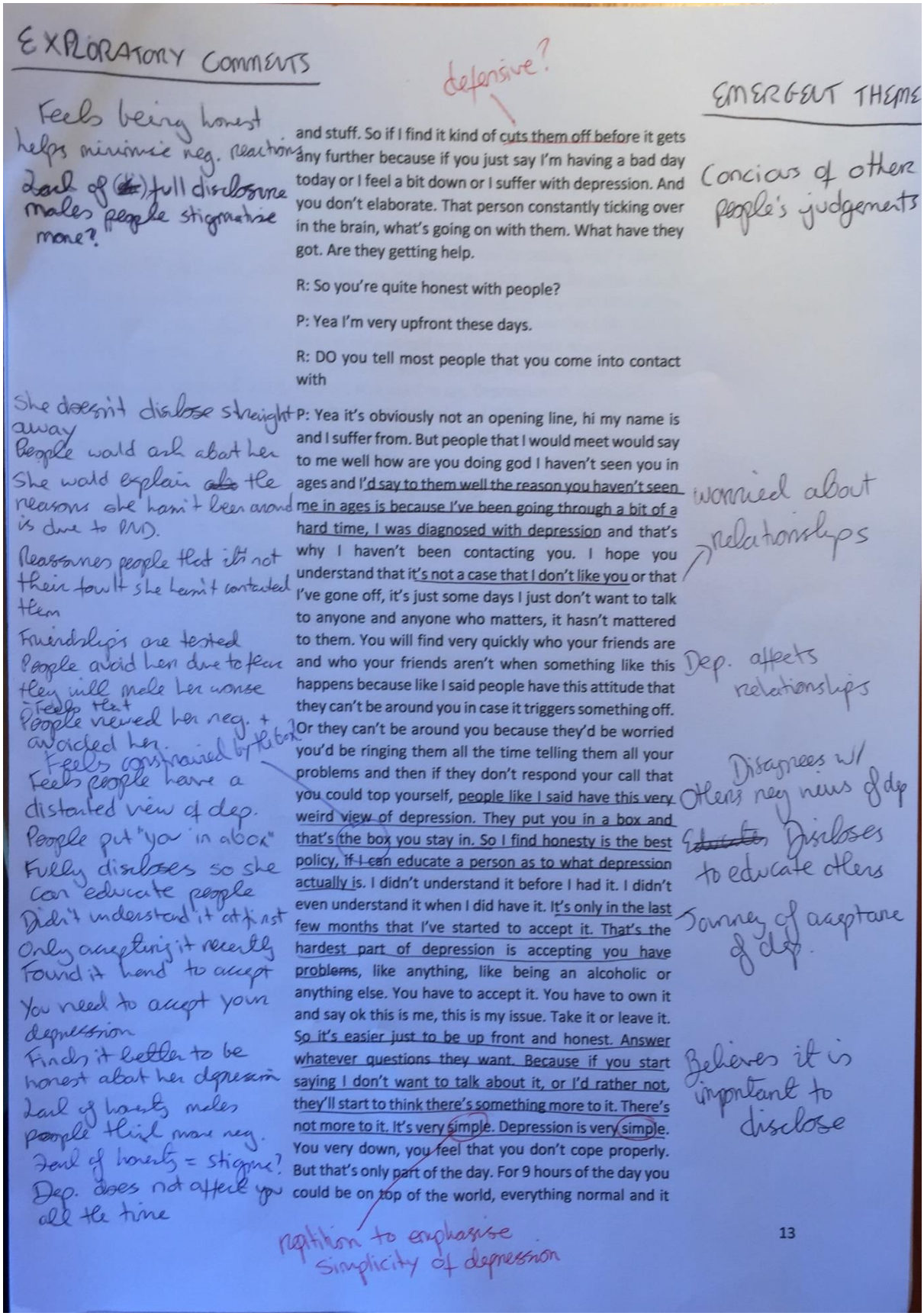
| | |
|---|---|
| **Application to the Research Ethics Committee** | **Approved** |
| **Information Sheet** | **Approved** |
| **Consent Form** | **Approved** |
| **Contact Details Form** | **Approved** |
| **Interview Questions** | **Approved** |
| **Sample Letter to Participant who was not selected** | **Approved** |
| **Consent Form at Interview Stage** | **Approved** |
| **Information Sheet at Interview Stage** | **Approved** |
| **Sample Letter to Participant of Results of Study** | **Approved** |

From an insurance perspective, please note that cover does not extend to those parties not employed by the Health Service Executive (HSE), or non-HSE Institutions.

**Yours sincerely,**

**Brian McKeon,**
**Planning, Performance & Business Information Manager.**
**(For and on behalf of the Research Ethics Committee & the QPS Department).**

## Appendix I: Extract of Initial Noting



EXPLORATORY COMMENTS

Feels being honest helps minimise neg. reaction

Lack of (~~full~~) full disclosure makes people stigmatise more?

defensive?

and stuff. So if I find it kind of cuts them off before it gets any further because if you just say I'm having a bad day today or I feel a bit down or I suffer with depression. And you don't elaborate. That person constantly ticking over in the brain, what's going on with them. What have they got. Are they getting help.

R: So you're quite honest with people?

P: Yea I'm very upfront these days.

R: DO you tell most people that you come into contact with

She doesn't disclose straight away
People would ask about her
She would explain ~~also~~ the reasons she hasn't been around is due to BPD.
Reasonses people that it's not their fault she hasn't contacted them
Friendships are tested
People avoid her due to fear they will make her worse
Feels that People viewed her neg. + avoided her.
Feels constrained by the box
Feels people have a distorted view of dep.
People put "you" in a box"
Fully discloses so she can educate people
Didn't understand it at first
Only accepting it recently
Found it hard to accept
You need to accept your depression
Finds it better to be honest about her depression
Lack of honesty makes people think more neg.
Lack of honesty = stigma?
Dep. does not affect you all the time

P: Yea it's obviously not an opening line, hi my name is and I suffer from. But people that I would meet would say to me well how are you doing god I haven't seen you in ages and I'd say to them well the reason you haven't seen me in ages is because I've been going through a bit of a hard time, I was diagnosed with depression and that's why I haven't been contacting you. I hope you understand that it's not a case that I don't like you or that I've gone off, it's just some days I just don't want to talk to anyone and anyone who matters, it hasn't mattered to them. You will find very quickly who your friends are and who your friends aren't when something like this happens because like I said people have this attitude that they can't be around you in case it triggers something off. Or they can't be around you because they'd be worried you'd be ringing them all the time telling them all your problems and then if they don't respond your call that you could top yourself, people like I said have this very weird view of depression. They put you in a box and that's the box you stay in. So I find honesty is the best policy, if I can educate a person as to what depression actually is. I didn't understand it before I had it. I didn't even understand it when I did have it. It's only in the last few months that I've started to accept it. That's the hardest part of depression is accepting you have problems, like anything, like being an alcoholic or anything else. You have to accept it. You have to own it and say ok this is me, this is my issue. Take it or leave it. So it's easier just to be up front and honest. Answer whatever questions they want. Because if you start saying I don't want to talk about it, or I'd rather not, they'll start to think there's something more to it. There's not more to it. It's very simple. Depression is very simple. You very down, you feel that you don't cope properly. But that's only part of the day. For 9 hours of the day you could be on top of the world, everything normal and it

repition to emphasise simplicity of depression

13

EMERGENT THEME

Concious of other people's judgements

worried about relationships

Dep. affects relationships

Disagrees w/ others neg views of dep

~~Educates~~ Discloses to educate others

Journey of acceptance of dep.

Believes it is important to disclose

## Appendix J: Visual Overview of Themes