Young People and Depression:

A Sociological Perspective.

By

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Introduction

Introduction.

Depression haunts the lives of many, especially our young people, this is becoming more and more apparent in Western countries. Depression is a common mental disorder characterized by sadness, loss of interest in activities and by decreased energy. Depression is no respecter of status, intelligence, class or race. It can strike anyone at any time. The severity of depression can range from mild to acute. At the most severe end of the continuum individuals can experience life threatening and profound feelings of despair and sadness. Depression is differentiated from normal mood changes by the extent of its severity, the symptoms and the duration of the disorder. The aim of my study is to look at young people's experience of depression. This will be done by using interviews with several suffers of depression. They will tell their stories of how they came to realize they were depressed, challenges which they faced with the medical profession, elements of stigma and in some cases the loss of hope. These are real people with real account of their experiences. It is important to realize that young people get depressed and that it is an important issue, which needs to be highlighted.

According to Bates (1999), one remarkably consistent finding in studies across different continents has been that women are about twice as likely to experience depression as men. There are many explanations for this, including increasing role strain for women, fragmentation of the community, changing expectations and feelings of needing to

compete with others to prove oneself worthy, knowledgeable and able. There is no doubt that Ireland has been going through a period of significant social change in recent years. The lack of integration and fundamental changes in spiritual values and rising rates of births outside of marriage have been associated with increase rate of depression. However, like many mental health issues, depression has been neglected globally and the increasing numbers of young people who suffer has focused long overdue attention to this problem. Mental illness, particularly depression has long been recognized as a major contributing factor to suicide.

Death among young people in Ireland is rare. However, AWARE (2003) argues that suicide is the principal cause of death for young people and is responsible for more deaths than car accidents and cancer. Dr Kelleher (1996) incriminated the increasing pressures of modern living, especially amongst young people, for the rise of depression and suicide. He has pointed to the disintegration of the family network and the diminishing influence of religion as a stabilizing and cohesive influence in society. The family presents an interesting challenge, as it was blamed for many centuries as the cause of many mental disorders. This will be looked at in depth in the literature review. The major cause of the stigma which surrounds mental illness are due to misconceptions, myths and negative stereotypes which are many held in societies. However, a very important point needs to be made is that mental disorders are usually less well tolerated than disorders which are visible. Because depression is not seen it is very often overlooked and therefore rarely talked about.

Throughout the history of the World Mental Health Programme, the attention dedicated to young people has not been proportionate to that dedicated to adults and the elderly. Mental health disorders and young people represent a key area of concern. WHO (2003) argues that the lack of attention to the mental health of young people may lead to health problems with long consequences. This is why although the extent of the association of depression and suicide remains open to confirmation on a general population basis it is nevertheless an important issue for the whole of society.

It has been suggested that depression may become the biggest medical disorder in this millennium. GP's play a pivotal and essential role in all aspects of health, from prevention to treatment and aftercare. Unfortunately, young people and young males in particular are less likely to attend their GP and therefore less willing to ask for help. Depression is an important psychiatric disorder in adolescence that increases in frequency with age, often coexisting with anxiety disorders and behaviour disorders and is associated with long-term morbidity and risk of suicide. Different people, with a range of types of depression benefit from various types of treatment. Some gain enormous benefits from medication and some from counselling, some gain benefits from both. However many people want to go beyond this and try to understand how they became depressed.

Depression is a feeling, which affects everyone in life. The nature and cause of depression and the extent of which it take hold of ones life varies and depends largely on the individual. Although it is commonly accredited that depression is a frequent emotion, it is important to recognize that for many in society depression is very much an illness

that affects their whole life. Depression can destroy every aspect of an individual's life. If not properly treated depression can lead to a person feeling they can no longer cope with life. In the case of severe depression, suicide can often be the end result. There are many different forms of depression and each can reveal itself in different ways. It is commonly acknowledged that there is no one cause of depression. Indeed the causes are very complex. Very often a combination of genetic, biological and environmental factor contribute to the onset of depression. In some cases depression will occur for no apparent reason. For young people college life imposes many new and exciting challenges but also many demands, which can cause considerable stresses. For example, greater academic demands, perhaps living away from home for the first time, financial responsibilities, and exposure to new people, ideas and temptations and maybe becoming aware of new sexual identity or orientation. A student's task is to become an independent individual. Those who are vulnerable with low self-esteem tend to be more prone to depression. Depression can also emerge at times of transition i.e. starting/ending college or starting working life. Setbacks or failures, whether real or imagined may compound their problems and subsequently lead to suicidal ideation. Often depression is caused by a combination of factors in ones life. Peer pressure and the aspiration to conform may result in adolescents concealing their problems or anxieties. Students may see seeking help as a form of weakness, which is in conflict with them gaining their independence.

According to Abercrombie N, Hill S and Turner B (2000), 'Madness' belongs to a collection of labels- witchcraft, vagrancy, hysteria and depression- by which deviance can be incarcerated. 'Madness' is a social label for classifying and controlling deviancy.

While there may be organic causes of insanity, insane behaviour breaches social norms and therefore treatment is seen as a form of social control. Although there have been studies on mental illness and depression, there is a lack of in-depth study in to young people and their experience with depression. This would be of huge value not just medically and sociologically but for the sufferers and their families. At a general level the ordinary public need to be re-educated about what depression is and that it could happen to anyone regardless of their family background, their qualification, race, religion or gender. More information needs to become available so people can approach their GP or a volunteer group for support. The families of the suffer, need to be aware of the situation and have a better understanding. Understanding of the problems by all who are affected can act as a bridge between those who feel isolated and those who are alienated by depression. Therefore the need and value for the research would be of great importance to both academia and the families and those who sufferer from depression. I hope that my research highlights that young people do suffer from depression and many do so in silence. Young people need to feel that they can talk about issues they have without being labelled or judge as different. Young people experience so many different feelings and emotions it is important for them to know that it is acceptable to talk about problems or worries.

Since the start of my research my eyes have been opened greatly; yes I too have been ignorant on a number of issues, which surround depression. I knew depression was out there on some level, but the extent of its reach was really unknown to me. I guess in some way like most people I had a vague notion of what a person who suffered from

depression was like. Perhaps someone who had lots a loved one and just was not strong enough to deal with it, maybe someone who was unemployed or who just lacks social support. For many some of those who suffer from depression these aspects may in some way play a part. But what about those who are young, who did well in school perhaps, are in college or working, come from a good family background, who appears on so many levels to be happy? It is these people we seldom hear about. Little did I know that after a few weeks of doing my research several people I knew well came forward and admitted that they suffer from depression. In some of the cases they had suffered alone for quite some time. It was their stories of silence that compelled me to look specifically at young people and their experience of depression. Each story is individual and has strength in its own right. It can often bring home to you what really is important when you hear of the private account of a person who from the outside looks 'normal' but carries a weigh of their problems on their own. Even those closets to the sufferer may not know what they are feeling. Very often those who suffer from depression fear the consequences of speaking about their experience because they fear the societal consequence of labeling.

Most who suffer from depression do so away from the blaze of publicity; it is usually a lonely, hidden affair. This dissertation is an attempt to address this problem in the context of Irish society. Depression and suicidal behaviour are both great drains on the individual, their family, the community and the nation as a whole. I am not going to try and find a cure for depression or to explain why certain people suffer while others do not. I do think it is important that we admit that it is a problem, which needs to be de-stigmatized and discussed openly. It is important that young people regardless of their

support network or qualification realize that depression can happen to anyone. Depression can be a very scary time for those who suffer from it; there experience can last many weeks, months and sometimes years before they get help. Although there has been much written from a psychological perspective little has been done to date on young people experience and their views and challenges, which they have tried to overcome.

Chapter 1

Review of Literature.

Literature Review.

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 2001:1)

The purpose of this study is to hear some of the accounts of young people and their experience of depression. It is important to highlight the need for more research in this area and to try and understand the challenges and stigma a sufferer faces. In order to get a better understanding of the general field of mental health in Irish society we must look at various pieces of literature, which has been done to date. This literature review will look at various research and a range of literature, which will help situate my research topic, young people and their experience with depression, in a sociological context. This will be looked at under a number of headings such as Health and Society, Mental Illness and Society, Power and Surveillance, the Establishment of the Asylum, the Family, Stigma and Depression, the links between Suicide and Depression, Media and Depression and finally various Studies which have been done specifically in the Irish context. Although there has been substantial research done on health, little has been done to date on young people and health especially in relation to mental illnesses such as depression. In considering the care for young people with mental illnesses like depression the importance of the contextual understanding and context of the disorders must be stressed. This contextual understanding places a special importance on the environment of the

young people that is the family and the community. Therefore in order to place this subject choice in a sociological context we will first look at Health and Society.

Health and Society.

Hardey (1998) maintains, that sociologists are interested in the how, the why and the when particular piece of knowledge became accepted. Furthermore, they are interested in how and to whom this knowledge is applied. While, medicine and psychology are essentially based on the individual, sociology takes a more collective approach, which include areas such as social psychology, history, philosophy and other disciplines. Reader and Goss (1959) states that sociology did not, develop out of attempts to explore conditions of health and disease as such. Like physiology, it arose in an effort to describe human functioning. Reader and Goss (1959) argue that sociology can contribute to medicine by means of studies, which relate specific social factors and processes to particular states of health and disease.

The political and ideological role of medicine is highlighted in the separation of early medical knowledge. Alternative or contemporary medicine is becoming increasingly popular and challenges both scientific basis of medicine and how it is practiced. This uncertainty can be linked to the evolving role of non- orthodox medicine and wider concerns about 'new plagues' that may threaten the existence of whole societies. Reader and Goss (1959) maintain that sociologists and other social scientists are making significant strides toward understanding numerous and varied types of social phenomena

in medicine. McCluskey (1997) maintains the definitions of health and illness, perceptions of their causes and accepted ways of maintaining and restoring health are socially constructed. The dominant prototype in modern societies for understanding and interpreting health and illness is described as the biomedical model, health is viewed simply as the absence of disease and disease or illness is reduced to a discrete biological abnormality inside the body.

Contemporary ideas about health and illness are embedded in the development of the biomedical model and the emergence of the natural science, which can be traced back to the Renaissance. People could intellectually disengage from the body and religion in a way that had not been possible previously. As Foucault (1976) argued, the 'medical gaze' is shorn of mysticism, magic and faith because the scientist or doctor is informed by nothing more than material facts. Foucault offered a systematic approach to medical institutions, governmentality and the human body.

> *"Foucault was concerned to examine the relationship between certain medical discourses and the exercise of power in society, that is the development of alliances between discourse, practice and professional group."* (Turner 1995:10)

The dominance of orthodox medicine makes it easy to forget that it has a comparatively short history of about 150 years. Previously there was a great diversity of beliefs about illness and potential treatment. There has been a move from the absolutism of the sick role, which accepted biomedical definitions of illness, to a range of approaches that prioritize lay people's understanding and experience of health and illness. This shift is

reflected in empirical research, which was preoccupied with problems identified by the medical professionals. There has been a shift from the 'top down' ideas about health, to a wider 'bottom up' focus on lay knowledge, and finally to general issues about the nature of society.

The standard history of medical sociology takes note of the fact that in the twentieth century the main theoretical contribution to the emergence of a specific sub- field came from Parsons (1951), through an analysis of the role of motivation in illness and the sick role. Through his interest in Freud, Parsons had become interested in the question of detachment and involvement in the doctor- patient relationship and this issue had been the focus of the concept of the sick role in his analysis of the social system. His early analyses of professionalism contributed in an important way to the development of an interest in the medical profession as a crucial element in the modern system of occupational hierarchies.

In *The Social System* (1951), Parsons gave medicine a central role in maintaining the stability of society. Within the Functionalist theoretical framework, health appeared as a major element in the social theory; it stemmed from Parsons earlier work on the profession of medicines. Parsons, from a Functionalist perspective looked to the healthy population and felt that if the healthy section of society could undertake various tasks that it would be fundamental to the smooth running of society. This refers to the basic needs of a society, which have to be met if it is to continue to survive as a functioning system. According to Elliot (1996), some functionalist writers depicted the nuclear family as

evolving to 'fit' with changes in other parts of the social system. Parsons (1951), the most notable of early family theorists, claimed that the modern conjugal family contributes both to the efficient organization of industrial economies and to the psychological needs of the individual. In Parsons (1951) view, this family form makes it possible for the economic system to operate unhampered by wide ranging kinship obligations and at the same time, provides family members with a stable relationship.

> *"At a very basic level Parsons viewed society as a system that contained mechanisms for shaping and controlling behavior. Parsons felt that, behavior which were of threat to the smooth running of society, must be identified and minimized."* (Hardey 1998:22).

However, the problem was to identify the processes that the sick received care and that the healthy fulfilled their roles in society. From Parsons perspective, illness was deviant in that sick people could not undertake their roles in society. Parsons felt that an inappropriate amount of illness could threaten the social fabric of society. According to Parsons (1951), the sick role governs the rights and obligations, as a right of the sick person he/she is exempted from normal social roles such as employment, domestic chores and so on. However, the obligations entailed that the person must seek treatment from a doctor and must cooperate with whatever treatment. Parsons doctor- patient relationship was seen as an encounter between the expert and the lay client, which was also seen as *"..an encounter of the powerful with the relatively powerless,"* (Hardey 1998:68).

There has been widespread criticism of Parsons' conceptualization of the sick role and the functionalist project in general. Based on the assumption of social cohesiveness and consensus, the functionalist approach largely failed to find an adequate explanation for social conflict and change.

Mental Illness and Society.

Annadale (1998) maintains that mainstream sociological theories grew out of the Enlightenment, an eighteenth century movement based on notions of progress through the application of reason and rationality. Durkheim's intention was to distinguish sociology from biology and psychology. Durkheim was concerned with consensus and seeing society as a system. He was keen to demonstrate the workings of what he called 'social facts', that is ways of acting, thinking and feeling which are external to the individual. Durkheim's (1952) most famous work was on the study of *Suicide*. He took this seemingly individual act of ending one's life to see if there were any social patterns or forces at work. By comparing statistics from different societies, Durkheim showed that there are regularities in the patterns of suicide, which demand attention. Notably, Catholic societies had a lower rate of suicide than Protestant- the explanation being the strength of community and the anti- individualism of Catholicism. Durkheim was seeking to draw out the empirical correlations he had established between social integration and the rate of suicide. Durkheim talks about 'social currents', which pushes an individual towards a particular action. According to Craib (1997) it can best be described as the form and strength of the social integration in a society.

"Moreover, it was a subject which, though restricted, was directly related to the institutions and the general features of the wider society (in particular marriage, widowhood, family life and religion)" (Lukes 1973:192)

There are strong collective forces operating in society causing some people to take their own life. What distinguishes a social fact is that it is imposed upon us from the outside. Lukes (1973) argues that Durkheim's statistical and interpretative work on variations in the suicide rate multiplied in France, Belgium, Germany and Italy. A number of statistical associations were established and hypotheses advanced relating differential suicide rates to social factors such as occupations, urbanization, religion and the rate of social change to non- social factors such as heredity, race and climate.

Keohane and Chambers (2002) offer a sociological interpretation of Irish suicide, one that collects the medical and psychological discourses in terms of a broader historical and cultural explanation. The explanation is based on a number of case studies complied by Irish coroners, which were interpreted by Keohane and Chambers (2002) within a sociological framework on the transformation in Irish society. Keohane and Chambers (2002) argue that the causes, which underpin the increases in suicide, stem from historical experiences of cultural 'collisions'. Collisions between the vestiges of traditional community and accelerated modern society, between the rural and the urban and the local and the global. Durkheim, identified four types of suicide, 'altruistic', 'fatalistic', 'egoistic' and 'anomic' which are the most characteristic of modern society especially in the Irish context. In modern societies people lead highly individualized lives

and as a result they may be insufficiently integrated into normal collective lives. Excessive individualization may lead to egoistic suicide such as high profile suicides. More mundane and sadly very familiar examples of egoistic suicide may be suicides related to pressures and anxiety generated by expectations of examinations and career performances. Keane (1991) insists, that similarly, in many cases that lack of statistical evidence prevented any clear-cut statements or analyses to be made on the prevalence of certain disorders in the Irish context.

Erving Goffman is another sociologists who played an important role in the study of mental illness especially in relation to his work done on the Asylum. Goffman (1961) claims that the inmates of the Total Institutions, in a prison or a mental asylum, are subjected to a series of abasements, degradations and humiliations and withdraw from the physical world and from the social supports that once sustained them. Goffman (1961) points out that the inmates practice secondary adjustments; they did not directly challenge the staff but did seek forbidden satisfactions. While all total institutions attack the self in the course of attempting to reconstruct it, Goffman feels that only the psychiatric institutions leaves no possibility of the expression of the self. Goffman argues that no matter how crazy a person has been, to strip the self from the person without allowing some expressed distance is unjustified.

According to Lefley (1996), historical eras and cultural systems have varied widely to define what mental illness is, yet throughout history there have been individuals in every society who have been identified as manifesting thoughts and behaviors that deviated

from the normative behaviour in that culture. In most societies certain behavior was clearly merited with the label of mental disorder and assigned derogatory terms such as loony, madness, insane etc. According to Schwartz H and Jacobs J (1979) sociologists have been concerned with identifications primarily in connections with stigmatizing labels such as 'criminal' or 'crazy'. There identifications are treated as tags, which once assigned to people have various social consequences. The main focus is on the process by which tags get pinned on individuals. All social groups make rules and attempt to enforce them at some point. The social rules define situations and the kinds of behaviour, which is appropriate. When an individual breaks a rule, the group may feel the person cannot be trusted and is therefore labeled an *Outsider*. Becker (1963) defines a deviant as anyone whom others successfully label deviant.

> "*Deviance is not a quality of the act the person commits but rather a consequence of the application by others of rules and sanctions to an 'offender'*" (Becker 1963:9)

According to Gove (1975) once a person is stigmatized by being labelled a deviant, a self- fulfilling prophecy is initiated, with others perceiving and responding to the person as a deviant, they are usually forced into a group of like minded people for example an asylum or some sort of care. This forms a type of sub-culture; they tend to have a common fate as they face the same problems. Becker (1963) argues that the simplest view of deviance is essentially statistical, defining as deviant anything that varies too widely from the average. A less simple but much more common sense view is that it is identified as something which is a disease- this rest mainly with a medical analogy. The

human organism, when working efficiently is said to be healthy, but when not efficiently, a disease is present. Sometimes people mean this analogy in a strict sense and therefore think of deviance as a product of mental disorder. Becker (1963) maintains that deviance is not a quality that lies in behaviour itself, but in the interaction between the person who commits an act and those who respond to it. Gove (1975) maintains that the traditional view was that a person is labelled deviant primarily because he/she either acts in a deviant manner or has characteristics that makes him/her deviant for example he/she is labelled mentally ill because he/she is mentally ill. The societal reaction view is that a person is labelled as a deviant primarily as a consequence of power and resource or the social distance or the tolerance level. The attribute, which has received by far the most attention in the literature, is the resource and power. Gove (1975) argues that persons with few resources and little power are the ones most likely to have a deviant label imposed upon them. In the next section the power struggle, which the medical profession has had over the individual will be discussed.

Power and Surveillance.

Hardey (1991) states that medicine in the early eighteenth century placed an emphasis on the classical learning and status of the doctor. Until the eighteenth century, medical diagnosis was based largely on the patient's own observations and feelings, so much so that diagnosis could be made through letters.

> *"The knowledge held by the patient was therefore fundamental to comprehending illness"* (Hardey 1998: 6).

Foucault (1976) described how, in the eighteenth century, attempts to understand disease moved away from observation of the symptoms experienced by sufferers to the traces left in the dead bodies. Reader and Goss (1959) suggested that medical research started with a simple observation of events and of recurring associations of events. With the growth of technology, the patient became increasingly marginalized from the diagnosis process, developments such as the laryngoscopes for examining the throat and the microscope for identifying cellular pathology.

> *"Modern medicine developed around the hospital and it remains the seat of power and status within the healthcare system"* (Hardey 1998: 57)

Turner (1995) was particularly concerned with the relationship between knowledge and power in the social distribution of health and illness and as the basis for professional management of socially deviant individuals. Turner's (1995) argument was concerned with the role of medical discourse as the foundations of medical power. Sociology also draws awareness to the role of social and natural constraints in the distribution and experience of health and illness. Turner (1995) comments that this type of medical sociology is a crucial analysis of the history of medical discourse as legislation of medical power and practice. Medical sociology is concerned with the character of the social construction of disease entities in the power relations of society.

> *"A theoretically informed medical sociology would address itself to the broader issues of social order and inequality by considering the role of medical values and institutions in the regulation of disease and disorder. Such an enquiry is concerned with the structural differentiation of religion, law and medicine as*

institutional forms of social control for the management of deviance and disorder in social groups" (Turner 1995:45)

Sociology also involves an investigation into the inequalities of power and wealth in human societies. Health may be regarded as resources, which produces hierarchical distribution if illness is present within a community. In Turner "Medical Power and Social Knowledge" (1995), the social construction of disease is categorized whereby individuals are classified and regulated by professional groups. The emergence of institutions with a special responsibility for the sick and the deviant (such as asylums, hospitals, clinic) is explored. The power behind the diagnosis is very important. The power relations, which the doctors have, and the acceptance of the patient are of great consequence. Analysis concerns the societal organization of the health care system, their relationship to the state and the economy and the problems of the social inequality both within and between societies.

"In an important sense medicine is (or ought to be) a form of applied sociology, since to understand the illness of a patient it is important to locate the patient in a social and personal environment. One major problem with technological medicine is the fact that it divorces the patient from this social context". (Turner 1995:5)

Hardey (1991) argues that it was the medical profession that gate-kept legitimate entry and exit to the sick role. Reader and Goss (1959) suggest that there has been a considerable amount of research on nurses and their relationships to patients, doctors and

other nurses. But considerably less has been reported about doctors. Something is known of the sorts of behavior, which medical personnel expect of patients but less information seems to be available concerning the types of behavior, which patients expect of medical personnel. The doctor embodied the development of rational neutral science. Essentially, medicine was thought to be a mechanism of social control. Patients were relatively powerless in the face of medical expertise.

The hospital replaced the bedside medicine of the eighteenth century, which changed the nature of the doctor- patient relationship by placing the former firmly in charge of the latter. According to Hardey (1991), the patients in the clinics were the poor who had access to the 'modern' healthcare at the cost of their passive collaboration in the medical process. This is what Foucault (1976) termed surveillance, regulation and discipline of the bodies. Foucault (1967) claimed that the asylum was part of the same system as the workhouse and the prison, they were places where those who's behavior threatened the social order could be gathered together and controlled. Hardey (1991) maintains, that the medical encounter is a supreme form of surveillance where the doctor probes the patient, he investigates, asks questions, touches the exposed flesh, while the patient acquiesces and confesses with little knowledge of why the procedures are really being carried out. These professional and medical discourses evolved in relation to the growth of the surveillance of societies through the exercise of discipline over the body and the population. Foucault (1976) was interested in tracing the development of surveillance through the clinic, the asylum and the prison. Foucault (1976) wanted to observe a very close relationship between power and knowledge:

> *"The clinical gaze enabled medical men to assume considerable social power in defining reality and hence in identifying deviance and social order."* (Turner 1995:12).

Today, in Western societies, Donnelly (2002), maintains that most people simply want to make the most appropriate healthcare decision for their circumstances and in order to do this they wish to be informed of their options and consulted on the most suitable procedure. Bates (1999) argues that many people want to go beyond the medication and try to understand how they became depressed and more importantly what they can do to help themselves. There needs to be movement away from medical diagnosis to practical understanding and the power relations which Foucault talks about needs to be re-evaluated. Informed consent in this regard is merely a manifestation of the basic requirement for communication between doctor and patient, but with the added recognition that it is the patient who is making the decision. Sociology of medicine has traditionally been concerned with the nature of medicine as a profession and embodies a shift away from the doctor's perspective on illness towards the client's view of their condition.

The Establishment of the Asylum.

Hardey (1991) stated that the idea about the nature of the mental health was changing at the turn of the twentieth century. Following the post war era cost escalated for the state for the running of institutional care. Due to this the state reverted from institutional care back to community care. The early mental hospital in both its architecture and its locality

is a dramatically different institution from the general hospital. The asylum was located in a remote location in the countryside. By the mid- nineteenth century virtually no aspect of the traditional asylum remained the 'insane' were moved out from the community into these asylums. The patients found themselves

> *"Incarcerated in a specialized, bureaucratically organized, state- supported asylum system which isolated them both physically and symbolically from the larger society"* (Scull A.T 1992:31)

Clare (1991) argues, that the Irish, when compared to virtually any of the other European neighbors are prone to experiencing marked and pathological swings of mood otherwise known as manic- depressive illness. According to Bracken et al (1998), there is now considerable evidence that of all the ethnic minorities in Britain, the Irish have the poorest record of both physical and mental health. In spite of this little research has been focused on the health needs of this community- Irish born people make up approximately 1.5% of Britain's population. When people of Irish parentage are included the size of the community is raised to 2.5% making the Irish people in Britain the largest migrant minority in Western Europe. Irish people were over- represented in most diagnostic categories especially figures for depression and alcohol related disorders. According to Bracken et al (1998) suggests a number of factors which have been identified as important including a relatively large provision of psychiatric hospital beds, few out patient services (especially in rural areas), rural poverty, unemployment, isolation and a large percentage of elderly men and women.

According to Daly and Walsh (2001) there were 4,321 patients resident in Irish psychiatric hospitals and units on 31st March 2001 on that particular night. On the night of the census 17% of the patients had a diagnosis of depressive disorder. According to Health Research board 2001, overall admissions for that year was 24,446, depressive disorders accounted for 31% of admissions in 2001. This is a 78% reduction in resident patients over the 38-year period from 1963 to 2001. The Health Research Board (2001) argues that this reduction is due to the death of older long- stay patients and their non-replacement by new long-stay patients. The table below presents diagnostics groups and gender for All Admissions for 2001, the three main diagnoses accounted for two- thirds of all admissions. Admissions for depressive disorders were highest across all age groups compared to all other diagnostic groups

Table 1: Diagnostic groups and Gender.

	Male	Female
Depressive Disorder	235.9	325.9
Schizophrenia	223.4	135.5
Alcoholic Disorder	231.7	94.9

All admissions. Selected Diagnostics groups and gender. Ireland 2001. Rates per 100,000-population aged 16 years and over. (Daly A 2001)

According to McKeon (1991), over 10,000 admissions to psychiatric hospital each year are diagnosed as having a depressive illness. McKeon (1991) suggests that depression is a

normal experience, it is in a sense of mind's equivalent of what the body calls pain or hurt, so too have normal range of mood swings within which we can experience the everyday ups and downs. However, when the moods change and the person is unable to cope then the depression is considered to have moved into the realms of an abnormal depression (they have to rely on the person's ability to recognize the shift from normality). Most do recognize the shift, as they find it harder to deal with everyday life. However for some the fact that depression, except in severe forms, can be hidden from all except from those with whom the person lives with and even then it can be disguised for a time, that is usually the most difficult part of accepting it on the sufferer part.

> *"The silent majority, largely composed of the nine out of ten who do not have treatment, carry their burden in private and as such their experience never becomes incorporated into the publics perception of what depression is. As a result, the dividing line between having and not having a depressive illness is going to be perceived by the public as a very stark one, being as they are unaware of the different graduations of depression."* (Keane 1991:91)

Hardy (1991) argues that major tranquillizers helped alleviate symptoms of patients and evolving ideas about psychiatric rehabilitation helped them to leave institutional care. Hardey (1991) comments that the pharmaceutical companies advertised heavily the use of certain drugs in the 1980's as creating a route from hospital to the community. The retention of drugs as the basis for mental healthcare was central to the continued involvement and the status of psychiatry as only doctors could prescribe. The decline of the institutions posed a threat to the profession's established power base, although during

the 1980's, physical treatment and biomedical theories of mental health remained significant in medical care. According to Hardey (1991), it has also argued that psychiatrists overstated the effectiveness of the new drug treatment as part of this professional strategy to retain control over the area of medicine.

It is the average GP who sees the bulk of depression, anxiety, panics and phobias and other stress related disorders, perhaps as many as one in seven people attending their GP are due to psychiatric reasons. According to Clare (1991), GP are usually dismissive of psychological factors, while the patient is nervous of any suggestion of psychological involvement in his/her illness. People have always been anxious about mental illness; after all it implies a loss of control. Also mental illness is also associated with the mental hospital, which is hidden away behind high walls and few people return from behind them once inside.

In recent study carried out by the IPA (Irish Psychiatric Association) entitled "The Stark Facts" (2003), demonstrates the regional comparison of clinical resources and affluence and specialist services. The study indicated that clinical resources in mental health are over stretched. However not only are they over stretched but also they are concentrated not in places where social deprivation is at is highest but concentrated mainly in affluent areas. The study also highlighted that there has been an absence of an up to date national mental health strategy for service development and this is one of the causes of the inequalities The study also highlight that adolescent psychiatric services were not available to 88% of the population. Specialist services dedicated to young people are very

important, as the late teen time tends to be when mental health problems arise and also rates of suicide among young males soar.

The Family and Mental illness.

It is not only the actual behavior of families but perhaps even more importantly, it is also the ideas and assumptions about 'the family' that have been such critical features of the environment which has shaped not just the policies and practices that are aimed at mental illnesses, but our very definitions of sanity and madness. The role of the families and familial ideologies are notable factors that have largely been neglected. In order to understand developments there is a need to look towards the wider social processes involved in shaping our construction of insanity. Jones (2002) maintains that by understanding the perception of families we are reaching a better understanding of the 'problem' of mental illness. Jones (2002) maintains that some historical perspective is required for understanding why the relationship between ideas of mental illness and the family are so entwined. These ideas have evolved together over the last few centuries in the Western society, because they are both institutions in which it is hoped people's emotional lives might be contained and controlled. If people became insane the answer was to remove them from the family and place them in institutions that could provide a setting in which people could learn a self- regulating discipline.

> *"They were actively encouraging the proliferation of the asylums by using them to place their relatives who they felt were 'mentally ill'. All this suggests that if we are to reach a better understanding of the contemporary world of serious mental*

illness, attention needs to be turned towards the families themselves" (Jones 2002: 21)

Jones (2002) argues also that during the 20th century, the view that families were responsible for fostering sane conduct became explicit as 'dysfunctional' families were directly blamed for causing mental illness by a number of psychological models. According to Jones (2002), family genes have been implicated, their behaviour assessed and their communication styles analyzed by those who have assumed that the origins of mental illness lie somewhere within the family background of the sufferer. It was also reported by Lefley (1996), that depressive illness was associated with a greater degree of family strain and impairment than in schizophrenia and other psychiatric conditions.

There has been a great deal of debate put forward about the changing structure and functions of the family. The increasing rates of divorce, separation and single parenthood are sometimes put forward as representing the demise of the family. According to Elliot (1996), in contemporary Western societies, debates about the family have taken on a significant and new direction that is markedly different from that of the 1960's and the 1970's. The 1960's and 1970's was characterized by the emergence of wide ranging critiques of the modern conjugal family as an 'oppressive and bankrupt institution'. This ideology was underpinned by the decline in religious belief, collectivist values and moral absolutes.

Jones (2002) looks at the experiences of people whose relatives suffer from severe mental health problems. Jones (2002) maintains that it is also about the families struggle for meaning in the face of what appears to be the breakdown. An important theme in the book is that many of the family's experiences and their understanding of those experiences cannot be shared with many people around them. According to Jones (2002), families are not just passive objects being pushed around by professional bodies or ideological forces.

According to WHO (2001), there are two kinds of added burdens which families must deal with, they are the undefined and hidden burdens of mental illness. The undefined burdens refer to the economic and social burden families and communities must deal with. They include lost production due to premature death resulting from suicide, lost production from people with mental illness who are unable to work, and lost production from family members caring for the mentally ill. Secondly, there are the hidden burdens, associated with stigma and violations of human rights and freedoms:

> *"Stigma can be defined as a mark of shame, disgrace or disapproval which results in an individual being shunned or rejected by others"*. (WHO 2001:2)

The stigma associated with mental illness is strong but generally increases the more the individual differs from the 'norm'.

Stigma and Depression

According to Jones (2002), there is a degree of isolation and stigmatization experienced by families caused in part by social attitudes that stigmatize mental illness and in part by

the attitudes of the professionals who have often blamed the families. Lefley (1996), maintains that there are stressful effects on the family's own mental and physical health, feelings of stigmatization, inability to make or fulfill personal plans, empathic suffering for the pain of a loved one and worries of the ageing parent about the future of their child who will surely out live them. Goffman (1963) has noted that the effects of stigma are not confined to those who are directly marked by difference but reach those associated with that person, referring to this as 'courtesy stigma'. It is very likely that families involved in mental illness will experience stigma. It is the families themselves who will benefit if the mental health professionals had a better understanding of their (families and patient) experiences. Jones (2002) suggests that it is the attitudes and beliefs of the relatives, which, are effectively helping to shape the world in which mental illnesses are defined and understood. It is the economic strain, real and attributed stigma, isolation, burnout feelings and need for respite, which are widely prevalent aspects of the burden of mental illness in the family, which need to be addressed and focused on by society:

> *"The result of public fear, ignorance, prejudice and withdrawal is stigma: the mentally ill are marked and branded as fearsome, evil, inferior, weak, dangerous, unpredictable, unreliable and by the particularly ignorant, contagious"* (Clare 1991: 3)

Clare (1991) argues that de-stigmatization could be accelerated by the replacement of the mental hospital by a system of psychiatric care composed of smaller psychiatric units attached to general hospitals and supported by a variety of facilities in the community such as hostels, shelters, workshops, day hospitals and day care and a variety of skilled

professionals including social workers, occupational therapists and nurses. Clare (1991) maintains that failure to develop an appropriate system of hospital and community care system would merely mean replacing one deficient system of diagnosis and treatment by another.

Links between Depression and Suicide.

> *"40% of illness seen by our general practitioners has a sizeable psychological component……one out of ten people will at some point in their lives suffer from a psychiatric disorder"* (Keane 1991:1)

Keane (1991) insists that almost every Irish family has had some experience first hand of mental illness. World Health Organization (2001) scientists have noticed this very dramatic increase, one of which recently characterized Ireland as the *'nation most at risk'* for the accelerating suicide of its young people. Dr McKeon (1991) spoke of the 200,000 and more who suffer from depression, of which the majority carry their pain in private. And what about those who commit suicide? In Ireland, Fahy (1991) tells us that at least one funeral a day takes place of a person who has taken his/her own life. Almost 20,000 have lost a loved one through suicide in the last ten years. According to Fahy (1991), contrary to popular belief, the suicidal state of mind is not something, which persists over weeks or days; the impulse comes suddenly and does not last that long.

> *"Severe depressive illness brings with it psychological effects which distort perception. Very depressed people feel worthless and alone even in the midst of family and friends. The illness can cause extreme anguish and in this setting successful suicide becomes almost understandable"* (Fahy 1991: 23)

According to AWARE (1998), the link between physical illness and suicide may be due to several factors including pain, depression, and alcohol abuse among other things. AWARE (1998) suggests that in Community Studies 10-20% of adolescents get major depression. Could the increase in suicide rates among young people be associated with depressive disorders? AWARE (1998) suggests that there is evidence to prove that depression has increased in young people. According to the National Youth Council of Ireland (1998), the scale of suicide and depression is widespread and it has become increasingly important not only in terms of understanding and dealing with the problem, but as well as with its causes and consequences:

> *"Successive cohorts of young people studied since 1945 show an increase in the rate of mild to moderate depression, rather than the more severe and probably more genetically determined depressions. This increase in environmentally determined mood disorders suggests that social change may be relevant."* (AWARE 1998:8)

The public discourse which surrounds suicide in Ireland has been mostly informed by medical and psychological explanations, which analyze the epidemiology of suicide in terms of 'risk factors' linking suicide with alcohol and substance abuse and with the rise of stress associated with transition to adulthood and role adaptation. Keohane and Chambers (2002) maintain while such an approach is useful in understanding individual cases it has not contributed significantly to our understanding of why the overall pattern of death by suicide in Ireland has changed over the past twenty years or so. Because the

act of suicide is surround by so much intense emotion, it is not surprising that society has constantly looked for a scapegoat. According to Kelleher (1996) the blame was first attributed to sin, and then to crime and then to society and by the twentieth century shifted again, this time in the direction of mental illness. Suicide was now a public problem.

> *"Most are not psychotic... Yet in dying, they throw away the miracle of individual existence that can never be recreated, no matter how many more billions of people are born- often the death is to use a catchphrase, a permanent solution to a temporary problem"* (Kelleher 1996: 13)

According to Fahy (1991) the peaking of suicide and depression in spring and early summer may have something to do with as yet poorly understood alterations in the biological rhythms of body chemistry. However, modern medical studies of suicide usually find evidence of severe depression preceding the act. Fahy (1991) suggests that it has always puzzled psychiatrists that only a small minority of mentally ill persons even those at greatest risk, actually takes their own lives. Very recently it has been found that the brains of suicide victims are depleted of an important chemical messenger. This substance is called serotonin; it is one of the most important neurotransmitters in the nervous system. It has for some times been suspected that the lack of serotonin is one of the main reasons behind the development of severe depressive illness with its attendant risk of suicide. The findings that successful treatment restores the supplies of serotonin to the brain have strengthened this suspicion. Attitudes have turned full circle, from a crime against the state, then a crime against God, then society's crime against the person, we

come to the twentieth century notion of suicide as a public health problem and finally to serotonin.

GP's play a pivotal and essential role in all aspects of health, from prevention to treatment and aftercare. Unfortunately, young people, young males in particular, are less likely to attend their GP and are therefore, less susceptible to help. According to the North Eastern Health Board (2001), depression is an important psychiatric disorder in adolescence that increases in frequency with age, it often coexists with anxiety disorders and behaviour disorders and is associated with long-term morbidity and risk to suicide. In the study carried out by the Health Board (2001), females were more likely than males to have attended the mental health services. Irish males have been slow to seek help and this is an area that needs to be addressed, perhaps in the broader context of the overall men's health debate. The North Eastern Health Board (2001) suggests that depression could become the single biggest medical disorder in this millennium. The large number of patients taking nervous system drugs, particularly antidepressants again demonstrates the high level of morbidity in these patients as a result of mental illness.

Young People and Depression.

AWARE is a voluntary organization in Ireland; it was formed in 1985 by a group of interested patients, relatives and mental health professionals. AWARE's aim was to assist areas of the population who were affected by depression. AWARE has several support services which include a support group meeting, a help-line counselling service, a 'beat the blues campaign' (sufferers of depression organize talks in second levels schools, it

has proven to be highly successive in increasing awareness and understanding), information service, mail order book services, aware magazine and a charity shop. AWARE maintains that, depression is a very common disorder and it affects 10% of the population directly at some stage in their live.

Forms of Depression.

According to AWARE (2003), it has been generally accepted by experts that there are many different types of depression, which can be distinguished by looking at the signs and symptoms. Various brain waves recordings and hormonal tests also help to identify the particular type of depression the person has. AWARE outline five forms of depression. Firstly there is reactive depression. When a person experiences an unexpected loss or bereavement; this type of depression is not thought to be severe. It is the most frequently encountered form of depression. Secondly, there is Neurotic depression those who experience problems of everyday life in an emotionally efficient manner will experience repeated episodes of reactive depression and these moods are referred to neurotic depression. Thirdly there is endogenous depression; it means depression coming from within. The patient is unable to point to any particular event, which may have been upsetting. Although this is primarily a chemical or biological type of depression, traumatic events in a person's life will often have acted as provoking agents bringing the depression to the fore. These depressions can be totally out of the blue or are precipitated by relatively minor mishaps. They are frequently found to run in families to be more severe than the reactive forms. They are usually at a major risk from suicide. Next there is manic- depression, the patient experiences unique spells of elation or mania. Some one

percent of the population will develop this disorder at some stage in their life and typically it occurs between the teenage years and the early forties. Lastly, there is secondary depression, where the mood changes are due to some underlying medical or other psychiatric disorder. The different types of depression have different causes and in most instances depression results from a combination of factors coming together at one point to produce the mood change.

According to McKeon (1991), studies indicate that over 40% of people hospitalized with depression could not identify any distressing life event that might account for their mood disturbance. A bout of depression, which is solely determined by a major loss, is best treated with counselling whereas a recurring endogenous or manic-depressive illness is highly unlikely to benefit from any treatment other than antidepressant medication or mood stabilizing drugs.

AWARE (1999), carried out a study on the "Prevalence of Depression in Third Level Students: a National Survey". They surveyed 1,531 students in Irish Third-Level colleges. A representative sample of students was requested to complete a self rating depression questionnaire using Zung scale and provide details of previous history of depression, of treatment sought, their attitudes to the treatment of depression in general practice and information on who they were residing with. The main findings were that one in thirteen students at the time of the study were depressed, while 38% reported having had a period of depression in the past. Of those who were depressed at the time of the study, 77% reported that they had previous history of depression and 34% had

received treatment. 93% of the students felt that depression needs to be treated. While two-thirds of the students were registered with a G.P. 55% of those at the time of the study, stated they had not gone to their G.P. because they could not afford it. Twice as many females' students were depressed at the time of the study than compared to males. This investigation also sought to explore the relationship between living alone and being depressed. The findings were that students living on campus were twice as likely and those living alone were three times more likely to be depressed than those living with a group of people or with their families. The report recommended that given the high rates of suicide among young men and their reluctance to contact a G.P. when emotionally distressed, the consideration was that students be given greater access to G.P's, that depression awareness and recognition campaign of an on-going nature is needed in third level colleges and that students particularly those living away from home for the first time should be discouraged from living alone.

The Union of Students in Ireland have just recently carried out a study on depression in higher education institutions, which emerged after a motion was passed at USI congress 2002 calling for more research into welfare related topics. According to the USI (2003) it was evident that the issue of depression and mental health among students was a topic, which had not been addressed since the AWARE study in 1991. It was for these reasons coupled with the growing concern over mental illness amongst young people in Irish society, which prompted the study. The research seeks to examine the causes and affects of depression on students studying in third level education. The study included four third level colleges. The sample size included 501 students studying at colleges in the Northern

Ireland and the Republic of Ireland. When students were asked what they thought the cause of depression was; stress accounted for 19%, difficult childhood accounted for 20% and bereavement accounted for again 20%.

A significant and positive finding was that 68% of the respondents said depression could be successfully treated. Another interesting finding was that 24% would approach a friend or family member if they were feeling depressed. However, a worrying factor was that 4% would not disclose it to anybody. A key finding was that 6% mentioned their GP as a source of treatment for depression, citing instead counselling as the preferred source of treatment. This finding indicated that students viewed therapy as a more preferential form of treatment. In relation to stigma 75% of respondents consider depression to have a social stigma. The USI (2003) argues that sadly the stigma of depression is prevalent not only on college campuses but in the wider community. USI (2003) believes that in order to lessen the extent of the negative image of depression and mental health among student body and the whole community is to invest in education and awareness campaign.

Table 2: The Causes of Depression

	Frequency	**Percent**	**Valid Percent**
Stress/ family/work pressures	93	18.6	19
Financial Difficulties	70	14	14
Bereavement	98	19.6	20
Inherited	50	10	10
Difficult childhood experience/past problems	102	20.4	20
Chemical imbalance	61	12.2	12
Don't know	15	3	3
Other	12	2.4	2
Total	**501**		**100**

(USI 2003:42)

The North Eastern Health Board (2001) study on Suicide found that the most common presenting complaint for both males and females was classified as "complaints relating to psychological symptoms". This category involved mental health complaints. A diagnosis of a depressive episode accounted for more than a quarter of all the diagnosis. Almost

half of the study groups were referred by their GP's to a consultant psychiatrist at some time and there was a high attendance rate by those who had been referred. Males and females who were less than 30 year were more likely to have attended than their older counterparts. Of those who were referred to the consultant psychiatrics two-thirds were treated as in-patients. Again the most common diagnosis was depression. The North Eastern Health Board (2001) insists that mental health disorders especially depression, remain the highest risk factor for suicide. A history of deliberate self-harm is also a significant risk factor, with almost a quarter of the study population having a known history of this behaviour.

> *"There is no doubt that Ireland has been going through a period of significant social change in recent years. The lack of integration and fundamental changes in spiritual values and rising rates of births outside of marriage have been suggested as being associated with an increased rate of suicide."* (North Eastern Health Board 2001:58)

The Public Perception of Depression.

As McKeon (1991) insists, it is the silent majority- the employed, the unemployed, the workers, the teachers and the nurses, the mechanics and the designers, the young and the elderly- who hold the missing pieces of the jigsaw to complete the pictures of what depression truly is. According to McKeon (1991), there are many misconceptions, which surround the cause of depression. For example in a research study carried out by AWARE (1991), the survey found that one half (1395 were surveyed in total) of the sample considered people with depression to be neither feeling sorry for themselves, nor

to be of weak character. There was little evidence to show that the association of unemployment and depression are linked. Stress in interpersonal relationships and pressure in work ranked top as the causes of depression by the public. Bereavement was the next mentioned as a cause. More particularly farmers, rural dwellers and the elderly ranked genetic factors third. This may reflect the fact that they live in a more stable environment with few, if any, changes of family residence for decades or even centuries. As a result they have a unique chance to observe inherited genetic characteristics through generations. Difficult childhood experiences were the fourth most frequently mentioned cause in the survey. Finally, 1 % cited loneliness, bad health, post- natal depression or drink problems as relevant causes.

> *"The public's perception of the different causes of clinical depression are surprisingly accurate. Depression seen by the general practitioner is more likely to result from distressing life event, be they bereavement, relationship problems or career disappointments. Personality factors are also of relevance here, in the some less robust individuals will be less able to tolerate loss and distress in life than others*" (McKeon 1991:92/93)

When the respondents were asked about the treatment of depression, only 10% were of the opinion that one must live with it, while 60% felt that depression could be treated successfully. More interviewee expressed the need to have depression treated and people were twice as likely to be of the opinion that their G.P. was the person to consult. When asked if they suffered from depression would they consult their G.P., 84% said that they would consult their G.P. In general, the public in 1999, (as compared to 1989 when the

first survey was commissioned to carry out the first national survey of public attitudes to depression) had a more clear cut understanding of the link between depression and suicide, with 74% of those interviewed agreeing that those who died by suicide are usually depressed. However, 22% regarded suicide victims as being psychologically well.

The AWARE's (1991) report concluded that additional and more thorough public educational campaigns are needed. These should target those segments of the population that the report identified as having less well informed attitudes to depression, particularly single young male, those over 65 and people from farming communities. As these groups have also been identified as having a higher than average suicide rate and given the strong causative link between depression and suicide a focused public educational campaign should heighten public awareness and recognition of depression and encourage early treatment.

In 1989, AWARE carried out a public attitudes survey of depression, a similar study was carried out in 1999, negative and stigmatizing attitudes remain and although these are less deep-rooted than ten years ago, certain sections of the population, most particularly young single men, those over the age of 65 years and people from farming communities need more realistic understanding of depression, it's causes and treatment if the high suicide rate in these segments of the population is to lessen.

Jodelet (1991) states that although much has been written on the mentally ill not a lot is known about the fate reserved for these people by the public. According to Jodelet

(1991), social representations of mental illness have attracted little study. It is important that social representations should be accorded the central position. Researchers have been interested in the perception of and attitudes towards the mentally ill for more than twenty years and yet the results of their studies are neither conclusive nor coherent. According to Jodelet (1991), in fact, most research into attitudes towards the mentally ill has gathered increasing amounts of evidence of public prejudice, its ability to reject and its resistance to information campaigns.

> "*The transformations made in psychiatric practice with the opening of hospitals and the development of a community therapy sector, are responsible for a change of perspective which is however, fails to focus on the real problem of the relationship with the mentally ill. That is the problem of the representation of their illness and their condition and their social status are constructed.*" (Jodelet 1991:4).

Jodelet (1991) maintains that the change of perceptions goes beyond merely recording the consequences of a new policy, which returns the mentally ill to the fabric of society. It corresponds to a change of paradigm to the study of inter-group relations. Attention is shifted away from attitudes and towards behaviour, partly as a result of the failure of researchers to demonstrate the effects of the former on the latter. In the last twenty years the quality of knowledge of mental illness and the accuracy of their appreciation of symptoms have improved, then the image of the mentally ill is simultaneously becoming increasingly associated with danger. Equally, at the same time as the expression of social distancing is diminishing, we are witnessing a growing tendency to avoid contact with the

mentally ill. Attempts to reintegrate 'de-institutionalized' patients into society reveal that communities develop a high degree of resistance as soon as the numbers of such patients grow too large. Rapid saturation of the social environment leads to their concentration in reserved or increasingly isolated areas.

The Media and Depression.

The media plays a mixed role in relation to depression. The media plays a negative role by way of linking violence and mental illness- thereby reinforcing the public's flawed view of the mentally ill as a group practically predisposed to anti-social and especially violent behaviour.

> *"The result of public fear, ignorance, prejudice, unreliable and by the particularly ignorant, contagious...One consequence is that some patients would almost prefer a diagnosis of an untreatable, fatal physical disease than of a treatable psychiatric disorder on account of a vague feeling that mental illness is not 'true illness'.* (Keane 1991:12/13)

According to Clare (1991), such notions are slowing starting to change as people become more educated and better informed. However, the media has taken some responsibility in educating the public by showing documentaries and soap operas which have highlighted the issue of mental illness such as depression. Also magazines also play an important role with interviews and real life stories of people who suffer from mental health problems. Clare (1991) maintains that the media are now trying to redirect public attention and resources towards a neglected area.

Again in relation to the media Philo (1996) insists that the television and the press are clearly very important sources of information and can generate strong motional responses in viewers and readers. Philo (1996) maintains that some of the messages about violence and mental illness exploit deep anxieties about the unknown and unpredictable in what is seen as a very frightening world.

> *"At the same time other images can relate to and develop quite different responses to the need for care and sympathy for people who are seen as helpless victims. It is quite possible for both of these cultural elements to co- exist in people's consciousness. But the depth of anxiety is so great in this area that some media accounts can evidently exert great power."* (Philo1996: XIV)

I have tried in my literature review to draw together important research, which has been carried out, not only on depression but also on health and society. In doing so I have used various theorists to locate mental illness in a sociological perspective. I have tried to locate depression a within a number of categories such as stigma. Stigma has been highlighted as an important factor, which has many consequences. Stigma has in many situations prevented many from coming forward and to seek help. This is not just in relation to depression but to a great many of issues from drinking to drug use and so on. I reviewed many studies, which have been carried out by various organizations. AWARE has been prominent in this research area. They have highlighted that public opinion towards depression has changed slowly since the 1980's. USI also has carried out various important studies with particular attention to third level institutions in Ireland. Although

there has been research done on the area of depression little has been done on a young persons experience in a social context.

Chapter 2

Theoretical Framework.

Theoretical Framework.

When looking at the study of young people and their experience of depression in a sociological context, a number of theories will be used to conceptualize the subject. No classical sociologist was overtly interested in health and illness, no real theoretical groundwork for medical sociology was established with the foundation of the discipline as a whole. The principal exception of this argument may be Durkheim's study of *Suicide* in 1897. By using Durkheim's study of Suicide it can give use a useful insight into depression. Many of the themes involved in the study of suicide can be appropriated to the study of depression. There are a number of theorists, which will be looked at throughout this theoretical framework. Firstly I will look at Durkheim and Keohane and Chambers, Becker's theory on Labelling, Goffman's study on inmates in a Total Institution and finally Foucault's Power and Surveillance by the Medical Profession.

It is certainly the case that Durkheim's view of the importance of social integration and regulation in relation to suicide rates in European societies created the theoretical basis for subsequent studies of suicidal behaviour and these studies came to provide a framework for the modern sociological analysis of depression. Durkheim, looking from a realist perspective believed that one could only comprehend suicide and depression by examining the society in which an individual lives. Society reveals itself through social facts. Durkheim described suicide as

"All cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result" (Durkheim 1952:44)

Durkehim's *Suicide* is part of an extensive investigation of the social transformation of the 19th century, the emergence of the industrial society and the tension between the pre-modern and the modern. Durkheim differentiated between the modern and the pre-modern. In the traditional community there is an undifferentiated division of labour, whereas there is a high division of labour in modern society. There is a high degree of occupational specialization. Traditional community is integrated by the principle of mechanical solidarity, the individuals in the community resembles the other members in the community. This is not just in relation to occupation and labour but they also share same beliefs, values and sentiment; a collective conscience. By contrast, modern societies are integrated by organic solidarity. The person in modern society has an individual conscience that is differentiated and flexible. He/ she is responsible for their actions.

Durkheim believed suicide to be the most personal, desperate, lonely act and could only be explained by looking at the society in which it belongs. Those who suffer from it too have also described depression as the loneliness and most isolating experience. Therefore he believed the degree to which one is integrated or regulated into society played an important role in committing suicide. Integration and regulation represents equilibrium and if there were deviance from either, this would be reflected in the suicide rate, which is what concerned Durkheim as opposed to individual suicides. Durkheim identified four

types of suicide- 'Fatalistic', 'Altruistic', 'Anomic' and 'Egoistic'. 'Fatalistic' and 'Altruistic' suicide were associated with pre-modern, traditional community. While 'Egoistic' and ''Anomic' suicide are more characteristic of modern societies.

Egoistic and Anomic are particularly useful in developing a sociological explanation of suicide in an Irish context. In modern society people lead very individualized lives and as a result they may be insufficiently integrated into normal collective life. As mentioned in the literature review excessive individualization may lead to egoistic suicide. Sadly, very familiar examples of egoistic suicide may be suicide related to pressures and anxiety generated by expectations such as in examinations and career performance. This can be related to the literature review and especially to the research carried out by AWARE.

Anomic suicide is also linked with the organization of modern society. Anomic suicide is most likely to occur in times of moral confusion due to rapid social change, when moral and regulatory frameworks and institutions are unstable. In Ireland, anomic suicide is related not only to the boom but also to the decline of Catholicism as a unifying moral framework, fundamental transformations of gender roles and family life.

The increase in the Irish suicide rate and also the rise those suffering from depression over the recent years illustrates Durkheim's general thesis, that the social form within which modern suicide rates can be interpreted and understood is anomie and egoism. Anomie points to the loss of a central stable normative framework, the expansion of material and moral horizons and intensification of desires that in contexts of limitlessness

are insatiable. Egoism is related to the disintegration of traditional social bonds of family, kinship and community, which have all been dealt with in the literature review. To grasp and understand what in the traumatic experience of living in contemporary Ireland is conducive to mental health issues especially depression and suicide. We must focus more closely to specific circumstances which will be looked later in the discussion section.

> *"The tragic drama played out in the life worlds of individuals constitutes a microcosm of the larger drama of collision culture in contemporary Ireland."*
>
> (Keohane and Chambers 2002:33)

The underlying premise of Durkheim's theory is that the less associated one feels with the society in which they live the more likely one is to commit suicide and in this study more likely to suffer from depression. Keohane and Chamber (2002) hope to offer a sociological explanation for the rise in suicide and perhaps the rise in depression. They frame the medical and psychological discourses in terms of a broader historical and cultural explanation. Keohane and Chambers looked at a number of case studies collected from the coroners, which were then interpreted within a sociological framework of the transformation in Irish society. Keohane and Chambers acknowledge that these increases stems from the historical experience of cultural 'collisions', these collisions are between the rural traditional and the urban global.

Becker's theory is of great importance for those who suffer from depression in that once they are identified as being different they are categorized and made to feel abnormal. Becker's theory offers a useful insight to what happens when an individual has been diagnosed with depression and the societal consequence of that labelling, for example the

stigma that is associated with depression. According to Becker (1963), all social groups make rules and attempt, at some time and under some circumstances to enforce them. Social rules define situations and the kind of behaviour appropriate to them, specifying some action as 'right' and forbidding others as 'wrong'. When a rule is enforced, the person who is supposed to have broken it may be seen as a special kind of person, one who cannot be trusted to live by the rules agreed on by the others in the group. He/she is regarded as an outsider. To the labeling theorists, deviance is not quality of an act but instead is produced in the interaction between a person who commits an act and those who respond to it. The outsider- the deviant from the group, has been the subject of much speculation, theorizing and scientific study. Scientific research has tried to find answers to these questions. In doing so it has accepted the common sense premise that there is something inherently deviant about acts that break the social rules. Rules may be of a great many kinds. They may be formally enacted into law. In other cases, they represent informal agreements, newly arrived at or encrusted with the sanction of age and tradition; rules of this kind are enforced by informal sanctions of various kinds. Whether the rules are formal or informal they must be enforced by a specialized body such as the police or a committee or on the other hand it may be everyone's job to ensure the rules are not broken. Becker (1963) argues just how far 'outside' one is, some rule breakers do not think they have been unjustly judged. Alcoholics are often ambivalent, sometimes feeling that those who judge them do not understand them and at other times agreeing that compulsive drinking is a bad thing. At the extreme, some deviants (homosexuals and drug addicts) develop full-blown ideologies explaining why they are right and why those who disapprove of and punish them are wrong.

Once a person is stigmatized by being labeled a deviant, a self fulfilling prophecy is initiated, with others perceiving and responding to the person as a deviant The person is usually forced into a group of like minded people, this creates a kind of sub- culture. They tend to have a common fate, as they face the same problems. Labelling theory indeed has value in studying the effects of social stigma. The idea of stigma and depression has been reviewed at length in the literature review. Sociologists have been concerned with identifications primarily in connections with stigmatizing labels such as 'criminal' and 'crazy'. Here identifications are treated as tags, which once assigned to people have various social consequences. Labelling theories and sociological studies of the asylum (Goffman 1961) have had a distinct influence on accelerating the closing of state hospitals.

> *"Conceptualizing mental illness as deviance rather than disease is allied with rejection of psychotropic medications and other somatic therapies as well as opposition to involuntary commitment for crisis stabilization and hospitalization during acute psychotic episodes."* (Lefley 1996: 44)

Goffman was an important figure in the categorization of stigma in the asylum. Goffman carried out his research from autumn 1954 to the end of 1957 in the National Institutes of Mental Health in Maryland. He wanted to study the ward behaviour of the inmates. According to Goffman (1961) a total institution may be defined as a place of residence and work where a large number of like situated individuals, are cut off from the wider society for a considerable period of time, together lead an enclosed form of lives. The main focus of Goffman's book is on the Mental Asylum and on the world of the inmate

and not the staff. Goffman's chief concern is to develop a sociological version of the structure of the self.

The handling of many human needs by the bureaucratic organization of a whole block of people whether or not this is necessary or effective means of social organization is a key factor of the Total Institution. Goffman (1961) argues that when persons are moved in blocks they can be supervised by personnel whose chief activity is not guidance or inspection but surveillance- this can be linked to Foucault's 'Medical Gaze'. Inmates typically live in institutions and have restricted contact with the world outside the walls while the staff operate an eight- hour day and are integrated socially into the outside world. Each grouping usually conceives of the other in terms of narrow hostile stereotypes.

Foucault was concerned to understand the rise of discipline and the regulation of the individual in his study of psychiatry in *Madness and Civilization* and medicine in *The Birth of the Clinic.* Foucault attacked the official view of the history of psychiatry that interprets the professional growth of psychiatry as a triumph of reason over madness. Foucault's research gave rise to a distinctive notion of power, in which he emphasized the importance the role of professional knowledge. Foucault's concerns have centered around how knowledge is produced and utilized in a society and how power and discourse are linked to knowledge. Foucault's view of power has an emphasis on the importance of knowledge and information in modern means of surveillance. Exercise of power whether at the level of the state, the organization or between individuals involves

surveillance. As Foucault (1963) points out, in contemporary societies power is exercised by administration. This surveillance system provides a precise kind of supervision, which effectively prevents infractions of rules. Surveillance can be very detailed and very powerful. Consistent and massive discipline and supervision often led to some imagined Utopia of a perfectly governed city but the rural applications were found in the asylums. Constant surveillance was supposed to induce a permanent awareness that they were being watched. Thus the power was to be seen as automatic and impersonal. Knowledge was to follow the power to observe and to normalize.

Turner (1995) was particularly concerned with the relationship between knowledge and power in the social distribution of health and illness and as the basis for professional management of socially deviant individuals. Foucault's enquiry into knowledge/power was organized around an enquiry into the body (of individuals) and bodies (of the populations). These professional and medical discourses evolved in relation to the growth of the surveillance of societies through the exercise of discipline over the body and populations.

One important function of the medical dominance is to preserve and extend the medical access to its clientele by limiting and subordinating adjacent occupations. The possession of a knowledge base and access to patients as clients leads in the work place to considerable privileges in the form of occupational autonomy and control over the process by which the service is delivered. In various dimensions, the medical profession has been relatively successful in maintaining its position within the class structure and the

professional hierarchy over the last 100 years by regulating and controlling access to healthcare delivery. The development of various bodies of knowledge, which permit sufficient scope for interpretation, has resulted in the patient remaining relatively ignorant and subordinated.

In conclusion, although there is no direct theory related to the rise of depression and the experience of young people the above theories have provided useful insights into this field. There has been much work done on the study of Suicide especially by Durkheim and Keohane and Chambers. Although, Durkheim, Keohane and Chambers deal with suicide there are many elements which can be interpreted as being important and may overlap in the study of depression. Their insight into suicide has many themes, which can be appropriate to the study of depression. Becker's theory on Labelling showed the process by which individuals get categorized and labelled deviant and so on. This is important when dealing with the stigma attached to depression. In the most part once a person is tagged with a label the correlation by in large is negative i.e. when a person is diagnosed with depression people in general may be suspicious and skeptical. The labelling theory may prove essential in illustrating that stigma is very much an important element involved in depression and the negative stereotype could be the reason why so few people talk openly about their experience with depression. Foucault tried to illustrate the power, which the medical profession had and still does have over the individual. For the medical profession the possession of certain knowledge leads to a form of access privilege, thereby the profession can control who has access and who does not. I hope to

prove that this subordination is largely still in operation in the medical profession although there may be some exceptions.

Chapter 3

Methodology.

Methodology

This section is a brief overview of the methodology used to collect data for this study. In order to gain a deeper knowledge of young people and their experience of depression it was necessary to carry out primary research. Due to the sensitive nature of the topic under investigation it was evident that qualitative research was the most appropriate methodology to explore this area. The initial focus was a comprehensive review of the existing literature in the area of mental illness. As depression is such a delicate topic, I felt that the best way of obtaining the information was to take part in personal interviews with a semi- structured questionnaire.

Although the qualitative research formed the basis of the study and provided a great understanding of the key issues affecting young people suffering from depression, it was evident that more research, particularly in the area of young people and their experience was needed on a national scale.

Qualitative Research.

A particular strength associated with qualitative research is that the descriptions and theories are grounded in reality. Although, this does not mean that reality is depicted in some simplistic sense. According to Denscombe (2001) it does suggest that the data and the analysis have their roots in the conditions of social existence.

> *"The in-depth study of relatively focused areas, the tendency towards small scale research and the generation of 'thick descriptions' means that qualitative*

research scores well in terms of the way it deals with complex social situations"

(Denscombe 2001:220)

Some techniques are more effective than others especially when addressing specific kinds of questions or topics. According to Neuman (2000) qualitative data whether words or images are the product of a process of interpretations. Qualitative research can be used as part of an information gathering exercise, where the information is produced by ways of interpretation. Obtaining the data can be done in a variety of forms: field notes, interview transcripts, text and so on. Lastly, the use of qualitative analysis draws on the interpretive skills of the researcher, this opens the possibility of more than one explanations, it allows for the possibility that different researchers might reach different conclusions, despite using broadly the same methods.

In order to gain an insight to the experience of depression amongst young people, an interview offered a more in-depth and personal approach. The main data collection process, which I used, was personal interviews. Interviews involve a set of assumptions and understandings about the situation, which are not normally associated with a casual conversation. The semi –structured questionnaire allowed for the greatest control. Therefore, I could ask the questions in order of which the topics arose. Questions are normally specified but the interviewer is free to probe.

"With semi-structured interviews, the interviewer still has a clear list of issues to be addressed and questions to be answered. However, with semi- structured interview the interviewer is prepared to be flexible in terms of the order in which the topics are considered and perhaps more significantly to let the interviewee

develop ideas and speak more widely on the issues raised by the researcher. The answers are open ended and there is more emphasis on the interviewee elaborating points of interest." (Denscombe M 1998:113)

With personal interviews I was able to build up a rapport with the respondents. I am of the opinion that this is of the utmost importance as trust develops between the interviewer and the interviewee. This is an element that I was eager to maintain throughout the interviews as it allows for a better flow of information if the respondent recognizes this element of trust. Neuman (2000) maintains that face-to-face interviews have the highest response rates and permits the longest questioning. The face- to- face interviews helps motivate the interviewee to answer fully and accurately.

Gaining Access.

It proved extremely difficult to gain people's trust and allow them to talk to me about issues that some people could not even tell their families or close friends about. It also proved testing to actually locate people who suffer from depression, to make contact was extremely challenging. Unfortunately I was unable to make contact with any male who were willing to have their experience recorder or to talk openly to me about it. This element proved obvious from the onset. Females are more willing to come forward and admit they suffer from depression than there male counterparts.

In an effort to accommodate both the respondents and myself more than one attempt was made to set up the interviews required. Another important element, which was mentioned

early, was in relation to making contact with those who suffer from depression. Therefore as depression is a very sensitive topic I informed those that they could change names and specific details at request. I also informed the interviewees that they could turn off the tape recorder at any stage during the interview. Also travel time and cost were time consuming.

In relation to my study I carried out seven interviews, six of which were with young females who suffer from depression. I also interviewed a male student Welfare Officer. One of the suffers was a member of an organization called AWARE, she ran a 'Beat the Blues' campaign, which targets second level school and tries to make the young people become more aware of depression. The interviews took place in various locations most of those who were sharing their experience had a preference for the interview to take place in their own homes. I interviewed Julie (she ran the 'Beat the Blues Campaign) in the AWARE office and the Student Welfare Officer in his office. The most effective form of making contact with people who suffer from depression was by way of snowball sampling. Abercrombie, Hill and Turner (2000 4th edition) maintain that snowball sampling begins with a group of known subjects. They grow in size as the first participant adds names to the list and these in turn identify more subjects. It is important to appreciate that, because snowball sampling is not random, the research results cannot be taken as representative of the wider population. Prior to the main data collection phase of my research topic, I pre-tested my research design, including the techniques of data collection, on a small scale, pilot study. The pilot study took place with one of the respondents. The pilot study allowed me to modify my questions or techniques. During

my interviews I used a tape recorder, I then transcribed the interviews and after completing all the interviews I went on to analyze the qualitative data to produce my findings.

Data from other sources were also used such as national statistics and various organizations were only too happy to send out information on request. AWARE, USI and Trinity College have all carried out surveys in the past few years all of which I received copies of and reviewed in my literature review. The vast qualitative material helped me gain a deeper understanding of depression in Ireland.

Limitations of the Study.

Originally I had hoped to organize a focus group; the focus group is a special kind of interview situation that is largely non- quantitative.

> *"In focus group, a researcher gathers together 6 to 12 people in a room with a moderator to discuss one or more issues for one or two hours.....the moderator introduces issues and ensures that no one person dominates" (Neuman 2000:274)*

Focus group interviewing is particularly suited for obtaining several perspectives about the same topic. The benefits of focus group research include gaining insights into different people's opinions, understandings and perspectives. Unfortunately, due to the sensitivity of the topic, it proved difficult to form a focus group for this study, as the interviewees were not comfortable with the group interview idea. Therefore, the face-to-face interviews were the best option for all those concerned. After much consideration I

decided for the alterative and that was semi- structured interviews with young people who suffer from depression.

In conclusion, the methodology consisted of using qualitative methods in the form of semi-structured interviews. I carried out seven interviews over the course of several weeks. The interviews gave an insight into the lives of those who suffer from depression and the challenges they face. In conjunction with the interviews I also used various pieces of literature and surveys and other studies which have been undertaken over the years During the course of the interviews I learnt a very important lesson that listening emphatically was more important than talking.

Chapter 4

Young people and Depression: A Sociological Perspective.

Discussion and Findings.

The aim of this study was to highlight a subject, which has been largely neglected by sociology. This is the area of young people and depression in a social context. The research hoped to acknowledge that it is a serious topic, which needs to be brought into the public arena for discussion The case studies are tremendously significant in terms of giving the reader insight into how depression can affect an individual. In many of the case studies it is apparent that the sufferers of depression did so in silence. Very often those who suffer fear the consequence of speaking out about their experience, as they are fearful of the societal consequence of labeling them depressed. In recent months the USI has carried out research on depression in higher education:

> *"Because there is so much stigma attached to mental health and that it isn't regard with the same compassion as other diseases or other illnesses would be...If someone is suffering from depression you can't see it, it's not something you know, like your not going to know who suffers and who doesn't suffer from depression. It's a very secret and silent illness and it's not something people openly talk about."* (Student Welfare Officer)

The Student Welfare Officer, that I interviewed, felt that there was a lack of up to date information on the attitudes and opinions of Irish students in general on depression. The role of the USI Student Welfare Officer is to have a mandate to organize a Mental Health Campaign with each college; they also source funding and help coordinate the campaign. One of the aims of the study was to re-educate people on mental health, how to get treatment and to know the signs and symptoms. They also hold press conferences. The

Welfare Officer felt that it was important to eliminate the age old view of depression as the;

> *".ad on TV of the old lady sitting in the dark and the voice over saying that there is light at the end of the tunnel, that is what most people would traditionally have associated with depression, someone old and sullen, but that is not what depression is, it's the people you meet everyday of the week, they could have depression to some degree, you just don't necessarily know."* (Student Welfare Officer)

Depression has many knock on effects which filter into people's social lives to their academic life and family life. This is when it becomes a problem.

> *"....You have to nip it in the bud, at the start and let people know that depression isn't something to be ashamed of."* (Student Welfare Officer)

For this reason I will examine the interviews around the main themes which arose. These will range from the meaning which the individuals give to depression, history of depression in their family, the reason behind their depression, the role of the medical profession, stigma associated with depression, suicide and depression and their family involvement. Firstly I will give a brief introduction to the individuals who participated in my study, all of whom I really appreciate and admire.

Julie work's with AWARE and is currently involved in a programme call 'Beat the Blues' which targets secondary schools and discusses what depression is, how it can be treated and the signs and symptoms of depression. The program targets hundreds of schools nationwide and is very effective and valuable. Julie was twelve when she became depressed.

> *"It seemed almost overnight I became and felt very unwell, it felt like the flu but it never passed off and I had no energy and I would sleep all the time, I was so miserable, I was always crying."* (Julie)

Julie is now in her twenties and she had a relapse in 2001, she spent three months in St Patrick's psychiatric hospital.

> *"I have been trying to build myself up from that since. I'm on medication and now I'm pretty well, I still have bad days but generally I'm ok."* (Julie)

Aoife is a 21-year-old student from Dublin. She started experiencing problems when she was in school, but she can't say when for certain when it all started happening.

> *"It seemed to take me twice as long to grasp everything and I used to get really angry with myself, I felt like I was always playing catch up."* (Aoife)

She was thought to believe that everyone goes through bad patches and that it was all part of growing up and that eventually she would grow out of it.

"*My mum always said that I was just growing up and everyone has problems but that I would grow out of them. And I believed her.*" (Aoife)

Michelle is a 24-year-old living in Galway. For Michelle she felt her depression started when she was in second year in college. She had the financial burden of paying back a loan after going to America for the summer, but she failed her first year exams and had to come home early. Her social circle changed dramatically that year also, her close friend dropped out of college and she was under increasing pressure from her family to achieve great things in college.

"*Everyday became a struggle. I had a huge bank loan to pay back, so I worked every weekend and rarely went back to Galway.....Most days I couldn't get out of bed. I wanted to hide away...I had distanced myself from so many people that I doubt at that point anyone noticed I was gone (she had gone home for Christmas)*" (Michelle)

Claire is a 22-year-old single mum and student. She became depressed shortly after she found out that she was pregnant but the depression climaxed when she gave her son up for foster care. She was in complete shock and disbelief; she had no money, no degree and no real support. It was only when she decided to give her baby up for fostering that she realized the extent of her depression.

"I didn't really think about anything apart from what am I going to do, I wasn't thinking god I'm sitting here every night crying, all that was going through my mind was what am I going to do" (Claire)

Sarah is a twenty two year old from Dublin; she has just finished college and is currently working. It was after Christmas in 2001 when she became very anxious about her weight, she began binge eating.

"I was just one of those people who a lot had happened to them over the years and eventually it had to come bursting out sometime.... I was someone who was always bullied in school....I don't think I have an eating disorder, my eating was of consequence of how I was feeling". (Sarah)

Sinead is in her late twenties and works full time. Sinead was not diagnosed with depression until she was in her twenties but she became depressed in her early teens. Sinead is also an alcoholic and is bi-polar.

"I drank a lot...I was self-medicating for the down and the ups with the bi-polar...I became suicidal and I attempted suicide I was crying before I went to sleep I was hoping I would die and I would cry in the morning because I didn't die in my sleep." (Sinead)

Sinead felt that she was mad and for that reason she could not tell anyone she was experiencing problems. She did not know she was depressed. She believed that she was one hundred and one percent sure she was mad. She felt she could not love herself and because she could not love herself how could she expect anyone else to love her.

Each account is very different and heartbreaking. All of the individuals found the strength to deal in some way with their situation. Although no two stories are the same they found a way through it and were able to talk about it so in order to prevent other young people going through what they experienced. Their experiences although very different share similar themes. These themes will be discussed under various heading, which I mentioned early. Also as I stated in the methodology place name and actual names have been changed at the request of the interviewees in order to protect their privacy.

The Meaning of Depression.

> "*When I, well before I got into this (being a welfare officer), depression was something that was suffered by girls.....because they didn't get their own way so they got the hump. It isn't that at all....Like you do through education I suppose is the only way to gain a proper understanding of what it is and you grow out of the misunderstandings of depression. Depression is an illness, which can affect anyone. And it's not just specific to girls or to boys, it doesn't discriminate*" (Student Welfare Officer)

For many it invokes feelings of loneliness, isolation, hopelessness and unhappiness. Sinead described her meaning of depression as complete and utter hopelessness.

> *"It's a black hole that you just can't get out of".* (Sinead)

For Aoife it was something that was never really discussed in her family, depression was something that happened to others and not 'them'. It brought with it shame and disgrace to the whole family. Depression is the most heartbreaking of illnesses because it is not something you see but you know it's there. For some the meaning of depression has changed especially over the last few years. For Aoife it was a word rarely spoken, it was a word surrounded by secrecy and disgrace. For Aoife, although the silence and secrecy is still their, depression for her is much more personal.

> "*It was something that didn't happen to you it happened to someone else. Now my opinion is that it means isolation, loneliness and frustration.*" (Aoife)

For Sarah too her opinion has changed, it was only when it affected her that she realized that depression does not happen to the extreme individual but it could be an ordinary person.

> "*I think it is an illness but if you asked me years ago I would have said that they were people who were a bit lala"* (Sarah)

When asked about history of depression in their family, few had little knowledge of depression among immediate members of their family.

> *"Oh, eh I don't think so well if there was no one talked about it openly. So I guess it's hard to know. Because my family doesn't know about me and my depression*" (Aoife)

For Sarah and Sinead that was a belief that there was depression in their families. For Sarah it was evident on her father side of the family but yet it did not surprise her that there was depression in her family. For Sinead there was many cases of depression, it was not specific to certain generations or sex. Her grandmother, her aunt and her two cousins all suffer from depression.

When Julie was admitted into St Patrick's Hospital after trying to take her own life, she met several people who were in similar situations. Julie found this very helpful meeting others who understood what she was going through and she knew she did not have to explain what was going on to them.

> *"I keep a journal and I always remember the first night I was in St Patrick's hospital I wrote, "I can't believe I'm in here with all these mad people" and about five days later I had written, "I have just realized that I am one of these mad people". And that is totally what it is you release that these people are just like me that everyone is normal in here and you can talk more openly with people who are patients because you know they are not going to judge you....i felt that it was a really important part of being in hospital".* (Julie)

Contributing Factors to Depression.

For Julie, her depression was a chemical imbalance which was medically diagnosed, it would have occurred at some point in her life.

> *"There was nothing really going on in my life that would have triggered it, some doctors thought that it was the start of puberty and hormones playing up and*

whatever. And the changes in my body triggered it but it would have happened at some stage" (Julie)

In the study by the USI (2003), 12.2% of the respondents felt that chemical imbalance was the overall cause of depression.

For others especially in the case of Claire, Michelle and Aoife, strain and stress appeared to be their underlying cause of their depression. The USI found that 18.6% of the respondents felt that stresses/ family/work pressures were the cause of depression. In the case of Aoife, her financial difficulty, the pressure from her parents to do well in college and her isolation meant that a combination of problems were the cause of her depression.

Durkheim attributed this type of pressure and strain to egoistic suicide. Although Durkheim talked about suicide, there are many elements to his theory that can be applied to the study of depression. Durkheim was looking from a realist perspective and believed that one could only comprehend suicide by examining the society in which an individual lives. Therefore he believed the degree to which one is integrated or regulated into society played an important role in depression and suicide. As mentioned early in the literature review and theoretical framework excessive individualization may lead to egoistic suicide and depression. Sadly, very familiar examples of egotism are related to pressures and anxiety generated from expectations such as examination and career performance.

"*In each lecture there were hundreds of people, some days you would be talking to someone really nice before the lecture and than you might never see them again. It was very hard to make friends. It was so impersonal. I was getting lost in lectures and I found the work piling on.....The pressure at college was heating up and I was so far behind..*" (Michelle)

For Sarah, her eating disorder was a consequence of suffering from depression. Although, it was not actually her weight she had the problem with it was a way of venting her frustration of feeling this way. She also cut herself in order to find a way and reason to visit her GP in the hope that he would realize that she had a problem. Sarah could remember specific times in her childhood which would affect her still and had a lasting effect on her. She recalls being bullied and never really fitting in at school. In the USI (2003) study, difficult childhood experience and past problems were attributed to the cause of depression, this accounted for the highest categories of responses, which was 20.4%.

In relation to the public opinion which surrounds this topic, the AWARE's study in 1991, showed that stress in interpersonal relationships and pressures in work again ranked top as the causes of depression. Mckeon (1991) argues that there are many misconceptions, which surround the cause of depression. It is these misconception, which prolong the silence and prevent young people coming forward to share their problems. McKeon (1991) insists that it is the silent majority- the employed, the unemployed, the workers, the teachers and the nurses, the young and all the other groups are those which

make up our society who hold the missing pieces to the jigsaw to complete the pictures of what depression genuinely is.

Again AWARE was involved in two studies relating to this, one was in 1989 and the other was in 1999. The 1999 study was a follow up to 1989 to see if changes in opinion had occurred. Negative and stigmatizing attitudes remain, although they were less deep-rooted then ten years ago. It is those over the age of 65 years and young single males who need more realistic understanding of depression, it's causes and treatment if the high suicide and depression rates in these segments of the population are to lessen. Sarah felt that it was the generation gap, which prevented her parents from accepting her illness. Her mother was of the view that Sarah would be kept in a psychiatric ward and that she cannot see it as an illness and that Sarah should and would snap out of it.

A very difficult and daunting phase was realizing and confronting their depression. Michelle had not realized how isolated she had became from friends in college and she did not want to bring up her problems over the phone with her parents.

> "*In the back of my mind I thought it was but I so hoped that I was just imaging it. Mum would always say that if I ever had a problem to come to her but I just couldn't explain what was going on in my own mind let alone trying to explain it to someone else*" (Michelle)

It was not until one night when Michelle felt she had hit rock bottom that she could not go on anymore.

"I remember sitting on the floor in my bedroom and I thought about ending it all. I just, I don't know, it felt like my only option. The pressure had got too much, I was so lost in college; there was nobody to talk to or check to see if you are doing alright.... My mobile rang ...it was my mum....I just couldn't stop crying at the thought of never seeing her again.....the next morning before mum arrived I went to the doctor" (Michelle)

For Claire she did not realize she was depressed until she decided to give up her baby for foster care.

"I'd say when he went into foster care, I knew I wanted to keep him but I think it was a turning point, I just didn't know how things would sort out." (Claire)

For Sarah, it was her weight, which brought her to the doctor in the first place; she had no idea that she was depressed. For Sinead it was not until she was diagnosed as being an alcoholic and admitted into hospital that she was told that she was depressed.

The next step for the interviewees was in some cases to seek medical advice and for others confiding in a close friend. The process of labeling does not just apply in the case of stigma. Seeking help for many was a way of acknowledging they suffer from a mental illness. Becker (1963) insisted that all social groups make rules and attempt, at some point and under certain circumstance to enforce them. The labeling of a mental illness is no different.

The Role of the Medical Profession.

For Julie the medical profession brought mixed feeling. It took many years and many visits to GP' and specialist to confirm she suffered from depression. None of the doctor's whom she visited could find anything wrong with her, on one occasion she visited her GP but there was locum, Julie broke down and after much investigation she was diagnosed with depression.

> "*They said that I was a different person, literally over night...they were so frustrated....bring me from doctor to doctor and basically that they had been told that they were indulging me too much*" (Julie)

Julie felt that in her opinion although there were changes in the medical profession attitudes from the 1987/88 towards young people and their experience with depression there is still a long way to go. On reflection Julie felt that because of her young age when she began experience problems and that a lot of different doctors had carried out several tests and found nothing physically wrong with her, she felt as though they dismissed her. They told her that it was exam stress and so on. But she had been like that for five and half years. She felt that they became very dismissive.

For Sarah, her experience was similar. She attended her GP first, who could see nothing wrong with her, and she was referred to a dietician and then back to her GP. It was her dietician who suggested to her GP to refer her to psychiatrist. After visiting many psychiatrists who basically told her that nothing was wrong, she cut herself in order to give herself a reason to visit her GP. She was at breaking point and wanted to know why

she was feeling like this. She felt that she was brushed off by her GP, who did not seem to know much about depression and where to refer her.

> *"In my mind it was the case that if I'm fine why am I sitting here in front of you....there was no sense of continuity (between the different doctors) and when I tried pointing this out I was brushed aside.....in my head I felt I wasn't good enough to be helped...Going to see all those doctors made me feel very isolated, they were going to help me and that it was it but they didn't"* (Sarah)

Sarah did not feel angry with the medical profession but became more upset as;

> "*These people were supposed to help me express how I was feeling...I have huge issues with my first psychiatrist, I would go so far to say she was negligent...but I couldn't prove I was depressed*" (Sarah)

In the context of power struggle, Foucault wanted to observe the very close relationship which existed between power and knowledge. The medical encounter is the supreme form of surveillance in which the doctor probes the patient. This is what Foucault (1967) termed surveillance, regulation and discipline of the bodies. Julie's experience of the medical profession was that;

> *" 'We know best, we're the experts and you're only a child' and that was basically it. I think in that area things have improved a lot but certainly back in the late 80's it wasn't good" (Julie)*
>
> *"I think most doctor are very well meaning and that they genuinely want to help and they want to listen but as with everything you will get the occasional doctor that just doesn't listen. But from own experience I think it was hard cos I was so*

young, they felt that maybe I was a typical teenager....but I was very unfortunate with the doctors I met" (Julie)

Turner (1995) argued that the social construction of disease is categorized whereby individuals are classified and regulated by professional groups. The power, which the medical profession has over diagnosis, is very important. The power relations, which the doctors have and the acceptance of the patient are of great consequence. If the medical profession exercises support as well as power it can be of benefit to the patient. In the case of Julie, she took an overdose and ended up in St Patrick Psychiatric Hospital.

"When I went into hospital I actually went even lower because I felt safe in there I felt relieved, and I could see how ill I really was and they were very encouraging but they were also very strong and you have to do part of the work in getting yourself out of this. They were very much aware of the fact that I was sick but I suppose they encouraged me to take part in my own recovery and not just to depend on the doctors to it." (Julie)

Aoife too went to the doctor; the doctor in Aoife's case was also very dismissive. The doctor asked Aoife a series of questions about socializing and having friends and how was her study going.

"Then she said, well she can't see anything wrong with me, it's probably something to do with my periods and hormones. Then I was dismissed". (Aoife)

Aoife did not return to a doctor for help instead she opened up to a close friend.

"*It felt great to finally talk to someone who listened, who didn't question or judge. She is a very special person.*" (Aoife)

There needs to be movement away from the medical diagnosis to practical understanding and the power relations which Foucault talks about needs to be re-evaluated. Informed consent in this regard is merely a manifestation of the basic requirement for communications between doctor and patient, but with the added recognition that it is the patient who is making the decision.

Although Michelle was never hospitalized she too attended a doctor on a college campus. Michelle was afraid she would be judged and thought of as crazy, these thoughts prevented her from going to the doctor earlier.

"*The doctor was very nice and made me feel very relaxed....when I finally told her I suddenly realized how bad things had got...all that stress and strain had finally got to me.....after talking to the doctor for nearly an hour and a half she asked me what I wanted to do...I would try counselling....it was all very overwhelming and relieving, I had taken the first step*" (Michelle)

In Claire's situation she too confided in a close friend for support when she was pregnant. She didn't really want to talk to a stranger and she was afraid like Aoife of being judged. She also talked to her social worker about her situation. Although, a few weeks after her baby was born she was given a new social worker.

"I did talk to a social worker, the first women was really nice and was so helpful but a few weeks after my baby was born I got a new social worker, it was just the luck of the draw, the first one was great but the second one was terrible" (Claire)

The Role of the Family.

It is not only the actual behaviour of families but perhaps even more importantly, it is also the ideas and assumptions about 'the family' that have been such crucial features of the environment which has shaped not just the policies and practices that are aimed at mental illnesses. These assumptions also shape our very definitions of sanity and madness. The family for many of the interviewees was an arena that was rarely entertained, few felt it was easy to approach a parent and for those who did the reaction was frequently negative. For many, the family was the last place to find sanctuary. For Aoife's family depression was something that could not and would not happen to them. Aoife tried several times to communicate her problem with her mother; her mother response was that,

"I was a typical teenager just growing up, but I was really crying inside for help"

(Aoife)

Jones (2002) argued that in the 20th century the family was seen as an institution, which fostered sane conduct, and the dysfunctional family was seen as the prime cause for insane conduct. This could be the possible reason for many families denial of depression. Many people would prefer to turn a blind eye then admit their child or other family member had a mental illness. For Sarah, her father still denies that his daughter has a psychological illness, it is never talked about. Aoife's mum tried on some level to find

the source of the problem but would ask Aoife what was wrong but never listen to the answer

> "*I think whenever there was a problem at home she always felt that people saw it as her fault. And I think with something like depression in her mind she would have seen it as a poor reflection on her parenting skills. She would have felt it was her fault but with something like depression it's nobodies fault it's just something that just happens.*" (Aoife)

In Michelle's case it was her father who found her situation hard to handle.

> "*He thought things like that don't happen to people like us, I think he thought that if you work hard and you were a good person you couldn't possibly be depressed*". (Michelle)

Sarah's mother although she does acknowledge Sarah has a problem she finds it hard to come to terms with the fact it is an illness. Her mother feels she "must snap out of it". Michelle's mum reactions was much more positive. Michelle felt that telling her mum was the first encouraging step. She wonders what would have happened if her mother did ring her that night

> "*She helped me so much, I don't know what I would do without her support.*" (Michelle)

In relation to Claire's account the difficultly which surround her story lay in the generation gap. Also at the time when Claire had her baby a lot of her close friends were about to sit their final exams. Claire managed to keep her pregnancy a secret from everyone even her parents, as her pregnancy was not visible. Also Claire worked right up

until two weeks before she gave birth. Not being able to talk to anyone about her feeling put a huge strain on her mentally and emotionally. Also her baby was black, she felt that her parent may not accept her son, again she reflected that this was due to them coming from an older generation who were not willing to change there views.

> *"They are from a complete different generation, they have a very different set of believes, like they don't beliefs in sex before marriage and as well my baby's dad is black so there was a slight bit of racism in there. As well I just didn't want to hurt them."* (Claire)

Even when Claire put her baby into foster care she had not mentioned a word of her baby to her family or friends. At that point her depression and feelings of lowness were at it's worst. But she did confide in her best friend, Alex.

> "*Sometimes at night I would get really upset, I would sit in my bedroom and cry. In all my life I have never felt so alone as I did in those months when I was pregnant. Alex would ring me at night to see how I was; he would talk for hours and try and calm me down. Any time I needed him he was there.*" (Claire)

Claire admitted that she wished she had done things differently then maybe she would not have been depressed. When Claire eventually told her parents of her baby their initial reaction was complete shock.

> *"They adore him now and I know I made the right choice by keeping him. I guess I was afraid that they wouldn't accept him that's why I didn't tell my family. It's*

easy to say now like if I had done this or said that. I would have like to have done things differently looking back but that's easy to say." (Claire)

An interesting finding by the USI (2003) study was that 24% stated that they would approach a family member or close friend if they were feeling depressed. A worrying finding was that 4% of those surveyed stated that they would not disclose their condition or discuss how they were feeling with anyone. Jones (2002) maintains that by understanding the perception of families we are reaching a better understanding of the problem of mental illnesses on a general level. By understanding the complex nature of the family we will have some indication how in certain circumstance some people can and will tell there family of their depression and others will not disclose their account and remain to carry their secret in silence.

Julie's story is of a positive reaction by her family, it was her family who become aware of her change in behavior. Because of Julie's young age perhaps her family had more interaction with her then if she was in college or working.

"*They said that I became a different person, literally over night, having been really confident, I became chronically shy even with my own family*" (Julie)

In her case it was her family who brought her to the doctor initially. Julie talked about her family as being a strong unit of support for each other. However, for her family and especially her mum, it was particularly painful.

"*I think it is an in creditably painful thing to look at anyone going through depression but to see your child going through it and they have no idea what was*

going on. My mum said that I became a skeleton of the person once had been.... It was very painful but particularly the hospital experience really brought us all together. They would come and visit me without fail, I was there for three months and it was then I realized how lucky I was." (Julie)

Jones (2002) highlights the experiences of the relatives of sufferer of depression. Jones maintains that many family's experiences and their understanding of those experiences cannot be shared with many people around them. The stigma associated with mental illness is strong but generally increases the more the individual differs from the 'norm'.

Stigma and Depression.

Jones (2002) argues that there is a degree of isolation and stigmatization experienced by families caused in part by social attitudes that stigmatize mental illness and in part by the attitudes of the professionals who have often blamed the families. For Julie's family, the medical profession attributed her unknown illness at the time to them overindulging her. Julie's felt that to some extent that the medical profession and people in the community blamed her for her condition.

"*Well when you look at it if a person doesn't get a diagnosis for years and no doctor can ever find answers for them people are going to start thinking come on really it is a case of snap out of it and get yourself together and I think to a certain degree people were thinking that at certain times.*" (Julie)

According to Clare (1991) it is the public fear, ignorance, prejudice and withdrawal, which contribute to stigma. It is this stigma, which brands the person as fearsome, evil, a danger, unreliable and infectious by the particularly ignorant.

> *"I think It comes from all sorts of things, it comes from ignorance and from people thinking that we all feel blue sometimes, we feel down sometimes but there is much more to depression than just feeling like that but people very often don't realize that and we have a long way to go. However, things have improved an awful lot. AWARE did research I think about twelve years ago and then two years ago and I know the numbers of people who said that they would go to their doctors if they were feeling depressed was hugely increased.....so I do think people are becoming more willing to help themselves and admit the problem"* (Julie)

AWARE's study in 1999, proved that public opinion is changing and perhaps so is the area of stigma which surround depression. The level of knowledge of the cause of depression has improved since the first study in 1989. There has been improvement in the public attitudes and there is a greater willingness to seek treatment and people are becoming aware of the broader factors involved in depression. However, AWARE (1999) insists that negative and stigmatizing attitudes still remain and although these are less deep-rooted than ten years ago there are still certain sections of the population who hold negative opinions, these include mainly young males, those over the age of 65 years of age and those from farming communities.

In some cases families find it hard to accept because they are fearful of the stigma, which is associated with depression and other mental illnesses. For Michelle, her father found it particularly hard to come to terms with it.

> "*He thought things like that don't happen to people like us, I think he thought that if you work hard and you were a good person you couldn't possibly be depressed....Also I don't think he wanted people to act different around me. People act funny sometimes when they think you're not like them. Stigma is a big thing it's like that with anything in Ireland, people don't talk openly about things*" (Michelle)

Michelle noted that once people find out that a person is depressed they are labelled and therefore treated differently. This is can be related to what Becker talked about in his labelling theory. Social rules define situations and the kind of behaviour appropriate to them. When a rule is enforced, the person who is supposed to have broken it is labelled an outsider. Once a person is stigmatized by being labelled as a deviant, a self-fulfilling prophecy is initiated, with others perceiving and responding to the person as a deviant. This was the case for Claire

> "*Well I remember the first few days when I had him (my baby) back with me, walking down the street people would look and stare, because that see a young girl with a pram and they judge and especially because I look a lot younger for my age, it was really hard, that did upset me*" (Claire)

Aoife is of the same opinion that if you are different from everyone else people treat you as an outsider or abnormal.

"*I think something different scares people, they think the moral fabric of society may be damaged. It's like you become the black sheep...they just don't understand*" (Aoife)

Aoife would like someday to tell her family of her depression but fears that her family would be treated differently and would be judged. She feels that by not telling her family of her illness she is protecting them from the misconceptions, which surround depression.

"*People can be horrible and can judge others when they don't know the full facts of the matter. People occasionally have presumptions about issues and can be very stubborn about changing their believe or ideas about topics*" (Aoife)

For Sinead, the stigma, which surrounds depression, does not bother her, although she is very much aware of it.

"*I think people think that manic-depressive people are completely mad and off the wall where at least now there is bi-polar and people don't really know what it is, they don't have a clue. Yes there is stigma but not so much among our age group but older groups, say my parents age group there would be. But it doesn't bother me, I don't mind telling people I'm depressed and if that shocked them or offended them in any way so what.*" (Sinead)

Clare (1991) argues that de-stigmatizations could be accelerated by the replacement of the mental hospital by a system of psychiatric care composed of smaller psychiatric units.

"Like in some colleges the standard of some counselling services are fantastic, some are really, really good but the fact of the matter is that there is not enough to meet the demand." (Student Welfare Officer)

However, on many college campus the counselling facilities prove hard to locate and many student do not want to ask where they are.

"Well that's on purpose because well the fact of the matter is that you don't want to be going into the counsellor and in the middle of the hallway and meet your math's class coming out of the room beside the counsellor and also it is hidden away for the fact that if everyone knew where they were everyone would be using them and they would be completely run over with students, they wouldn't be able to cope with the demand, well that's why I think they are harder to find." (Student Welfare Officer)

The Welfare Officer felt that it does stop people from using the service but it is a catch twenty-two situation. He felt that there needs to be more awareness about the services available to the student population. The USI (2003) study found that stigma prevented many students from disclosing their condition and getting help. The USI (2003) argued that many students were weary of attending the Welfare Office as they would be anxious that others might see them going to the Welfare Officer and therefore draw their own conclusion. Sadly this stigma is not only present on student campus but in society. The USI feels the best way forward is educating people about mental health in general with particular emphasis on depression.

The Role of Education and the Government.

The role of the government is essential with any service. The main way that the government can help not only colleges but also the whole community is by investing in educating people of all ages on depression. Julie runs the 'Beat the Blues' campaign, which targets second level education; they hope to increase the level of awareness among young people. It is important for young people to see depression as an illness and that it is nothing to be ashamed about to feel guilty about. They also provide session after each meeting for students to come forward and talk on a one on one basis, so that if the person is a little shy to talk in front of the whole class they can have a chat after with one of the spokesperson. This system can be applied to third level education also.

> *"Educating people about depression is about helping them see that they are not just people feeling sorry for themselves and getting people to open up and talk about their emotions and I always say in the schools that I'm not asking you all to sit around and cry at lunchtime but if something is going on and you feel you need to say it someone...it's about educating people and opening up."* (Julie)

The government's role as I have mentioned is in relation to the provision of funding for services;

> *"The best thing is to provide the money, put it where it will be used efficiently where better then a college, for the young people are the future of this country."* (Aoife)
>
> *"I suppose giving more funding really, there are so many groups out there AWARE is just one group of many who are trying to do good and help people who*

are affected by illnesses like depression.....we get about 10% of our funding from the government and everything else is voluntary donated." (Julie)

For Claire, she too felt that the government needs to provide more financial aid for services especially for people like herself who want to go back to education and are single parents. Even though there are so many people out there who want to go back to education and have children unfortunately some do not qualify for back to education grants even if they follow the guidelines required. Claire also felt that there needs to be more counselling provided by the health system for people who are in a similar situation to her.

"*I found that the counselling services was very inadequate, like I wasn't offered any counselling when I gave up my baby for foster care and I think it is then when people really need the help....there is no post adoption counselling at all they just expect you to give up your baby and then visit you social worker a few times."* (Claire)

Sinead also found that the government needs to do more to increase awareness about mental illnesses. She thought that people in Irish society rarely talk about issues, which affect the mind as they feel it implies they are unable to cope.

"*If you don't have contact with someone who sufferers from depression you won't know about it...But even in the soap operas Zoë in Emerdale is a schizophrenic and they have her burning down church and off the wall some kind of mad women and she's perfectly better but they didn't show her going through the process of getting better, they don't show the struggle or how hard it is. I don't think there is enough education.*" (Sinead)

The Student Welfare Officer felt that the government only has a limited budget for locating funding to each organization that each group wants "A piece of the pie" (Student Welfare Officer)

Links between Depression and Suicide.

AWARE (1998) argued that the link between physical illness and suicide may be due to several factors including pain, depression and alcohol abuse among other things. The more acute forms of depression carry a major suicidal risk as the sufferer sees little hope for the future. According to AWARE (2003) if this form of depression is left untreated the risk of suicide is higher, some of 15% take their own life through suicide. Fahy (1991) suggested that the peaking of suicide and depression in spring and early summer may have something to do with alterations in the biological rhythms of the body's chemistry. However, modern medical studies usually found evidence of severe depression preceding the act. Julie suffered for many years with a chemical imbalance. It was many years after herself and her family realized that she suffered from depression that she tried to take her own life,

> "*Something just clicked, certainly I had contemplated suicide countless times over the years but that particular day I had a lot of other things going on in my life and I guess that day I hit my breaking point*" (Julie)

Sinead too tried to commit suicide; she felt there was a strong correlation between suicide and depression. There is a lot more pressure and strain put on young people.

"*A lot of these kids who commit suicide, after they are died they end up having got all A's in their leaving cert. A lot of the time they are putting themselves under a lot of the stress it's not even the parent....in school there is too much focus on the academic so there isn't much for the others who are not academic.*" (Sinead)

One night Michelle too had hit rock bottom, she felt she could not go on anymore and the only way out was to end it but fortunately a phone call from her mother saved her from actually going through with it.

"*There is, many people who are affected by depression get suicidal feeling that doesn't necessarily mean they want to die or that they are actually going to go through with the attempt on their life but certainly they would have fleeting thoughts of suicide and if you think of the symptoms of depression and living with them and in someway who can understand. I was at a conference a few months ago and someone summed it up as a 'permanent solution to a temporary problem'. And I sat there and I thought that is so true, and that is why it is so sad for those who actually go through with it".* (Julie)

Durkheim's theory on suicide rates was developed by looking at different societies and the amounts of deaths by suicide. Durkheim concluded that a society which was more individualized had the highest suicide rates. Durkheim believed that the degree to which a person is integrated and regulated into society played an important role in those committing suicide. Keohane and Chambers (2002) also offered an explanation for the rise in suicide. In the Irish context, they examined the medical and psychological

discourses in terms of a broader historical and cultural explanation. They argued that the rise of suicide and depression stemmed from cultural 'collisions'. In modern societies people led highly individualized lives and as a result they may be insufficiently integrated into normal collective lives.

> *"Nowadays people are really hustling and bustling and I think it is the pace of today's society rather than the decline of religion.....even years ago if you committed suicide you couldn't be buried on hallow ground....but I don't think that would scare someone from killing himself or herself. I think if someone is adamant about taking their own life I don't think the redeemer will change their mind. There are hundreds of other things in their lives that they will be thinking about like family, friends and I think God really comes very low on that list."* (Welfare Officer)

Conforming to the 'Norms' of Society.

This section will firstly look at the role of the media and depression. Then I will discuss the pressures on young people such as financial and pressures to look and dress in certain ways. The media plays a mixed role in relation to depression. An article in the Irish Times (2003), reported that pressures to conform to certain styles and looks could add to the triggers of depression and the rise in suicide. Many of the respondents in my study reflected this;

> *"Certainly I don't know how magazines and TV etc can have a positive impact when you have to be a size 8 and 6 foot tall to be seen as beautiful or whatever, those things are not realistic or obtainable for most people."* (Julie)

"That's a hard one because there are so many issues involved in depression. I suppose distorted self-image plays a role in depression it could be a secondary factor, a way of venting the anger like they think of himself or herself as overweight or something. But I do get angry with magazines all the models are very skinny and lets face it none of us well I know myself could ever be that skinny and still be able to have a full complete life." (Aoife)

"I think well especially in my class because it was mixed the girls were putting huge pressure on themselves to get high points say for medicine and so on. If someone aims really high and they don't get it, it's so disappointing. For someone who is seventeen that is very young. The CAO system puts too much pressure on young people and I think the English system is better where it is done on interviews and academic results" (Sarah).

However, the media has taken some responsibility for educating the public by showing documentaries and soap operas, which highlight the issue of mental illness. Magazines also play an important role with interviews and real life stories of people who suffer from depression. Clare (1991) maintained that the media are trying to redirect public attention to a neglected area.

"Although, some magazines are covering stories of issues which were often neglected like suicide and mental illnesses. I think this is a positive step forward

in showing that there are problems and although they may not have been mentioned but very much alive." (Aoife)

There are also many other burdens placed on young people especially academically and financially. In the study by the USI (2003), 14% of the respondents felt financial burdens were the cause of depression

"*The financial burden is huge like you could be talking about well over hundred euro for a pair of jeans, some people feel that they need them in order to fit in or something. Especially in say UCD, it's like a fashion parade it looks so stupid...they must have to get up at the crack of dawn to get ready for college. But I can see sometimes why people could feel the pressures to be a certain way"* (Claire)

"Styles and trends seemed some how to get into the colleges and they have no place in the colleges, I don't know how they came about in the colleges. Universities were traditionally places where you went to rebel and find yourself and you joined some odd religion and you started not washing your hair and learn some new stuff but now it's gone the other extreme" (Student Welfare Officer)

The casual factors of depression among those interviewed for this study were varied and ranged from anxiety over exams and academic performance to feelings of failure, unhappiness and chemical imbalance. Virtually all the interviewees spoke of how depression took a toll on their academic performance.

"I think academically there is huge pressure put on young people, sometimes it feels like a rat race everyone is always competing no wonder so many people turn to drink and drugs for escape." (Michelle)

"I think everyone at some point feels the strain.... especially for people who say have to take out a loan to pay for college that are relying on their exams to get a job and pay it off ...the pressure is huge and I can understand why some people crack under that strain...especially if you are moving away from home and looking for accommodation in Dublin." (Claire)

In the public's attitudes survey done by AWARE (1999) stress, family work/academic pressures accounted for 58% of the perceived causes of depression. In relation to student's themselves 18.9% felt that stress in academia was the cause of depression.

"*There is a lot more people being put under this stress.... up until free education was introduced like take working class they wouldn't have traditionally gone to university and would have just worked but now you need a degree to do pretty much any job. So now there is a situation that people who wouldn't never have gone to college are in a situation that they have to go to college.... That would have an impact on people's health and it is a huge amount of stress especially if you're 17 or 18 years old moving away from home for the first time...like you have to sink or swim. It 's a huge shock especially for the first few months until you find your feet.*" (Student Welfare Officer)

In conclusion, the accounts discussed are only a small piece of the puzzle, which surrounds depression. There are countless other stories in society which may be left untold. It is the job of the government through the education system to increase the awareness of not only depression but all mental illnesses. It is important for the government to acknowledge and admit that the level of depression reaches all age group and socio-economic groups. Depression does not discriminate. It is important that this awareness grips every age group and race not only in Irish society but in every community in the world. If the information is available it is hoped that the stigma and ignorance, which surrounds depression, will lessen in time so no more young people have to suffer in silence.

Chapter 5

Conclusions.

Conclusions.

"Depressive illness is not just the 'blues' or the 'ups and downs' of everyday life. It is an overpowering feeling which dulls thinking, mood and concentration, saps energy and disrupts sleep". (AWARE 2001: 2)

Depression is an illness which is shrouded by silence and ignorance. For young people who suffer from depression in our society, this is particularly evident. The aim of this study was not to find a cure, or to get to the root of the causes of depression, but to gain a deeper understanding of it in its social context. Depression could happen to anyone not just the typical stereotype such as the unemployed or the alcoholic. It's the people you meet everyday, it's the person sitting next to you on the bus or the person you socialize with on Saturday night it could even be you, but you too may not want to believe that depression could happen to someone who gets up every morning and goes to work or college or puts on a smile and a happy façade. Depression can affect people of any age group, whether you are twelve years old or ninety years old, it does not discriminate.

In relation to the research which I have carried out the causes of depression have ranged from chemical imbalances, to a build up of emotions over several years from childhood, to lack of support in times of crisis to the stresses and strains of simply growing up and going to college and dealing with new situations. There are no guidelines or books you

can read to help you get out of that situation. In most cases it is the family and close friends that are the last to know when a person suffers from depression as the sufferer fears the societal consequence of their illness. This is what Becker's theory argued that once a person is identified as being different from the majority they are often treated in a different way. In my study it was Michelle who acknowledge this point

"*People act funny sometimes when they think you're not like them*" (Michelle)

In other cases the parents in particular denies that their child could possibly suffer from a psychological illness and hope that it will pass, or that it is just a phase they are going through and they will grow out of it. Some individuals chose to confide in a friend. Others openly admit to their parents that they have problems and they deal with it together. It is never easy regardless of the amount of support you have. Becker's theory proved very useful in understanding stigma and how people can see something such as depression as threatening.

Depression has been described by those who have taken part in this study as the loneliness and most heartbreaking time of their life. It's a black hole with no end. These are the descriptions from people who even have someone to share problems with. For many, depression is hugely isolating not only from their family but also from the wider community. Issues with the medical profession have been raised on several levels, this too adds to the difficulty in taking the first step in admitting that they are feeling low or that they were having other problems. The medical profession, for many, is the first they approach when not feeling well. Therefore you would expect compassion and understanding from these people in the hope they can help you in some way, if even it

only means talking to someone. Depression is an illness, which shows no physical signs, which a doctor can say "yes well that's depression". This is the difficultly which so many in our society have a problem with because you cannot see it. Foucault offered an important insight into the medical professions surveillance and control over the patient. He also highlighted the point that it was the patient who was isolated during the diagnoses period, this was evident is relation to Julie's account in which the doctor had little concern about what she had to say. Goffman looked at the asylum and how the inmates played out their role in the institution.

The study highlights the lack of information available, either in schools, colleges or in general for people to try and understand it. For most people the reason they know anything about depression is usually because a family member or a close friend sufferers from it. Other than that it is rarely talked about. Although public opinion has changed over the past decade the general public are still skeptical and ignorant about the causes and treatment and generally how to help the person who suffer from depression. AWARE's (1999), study highlighted this when it compared two studies, which were done ten years apart, it still showed that there was great uncertainty about how readily one can recognize depression, even though in general people are more knowledgeable about the causes of depression and the link with suicide and the form of treatment. However, despite these advances, there are still negative and stigmatizing attitudes remaining especially amongst certain sections of the population, particularly with young single males and those over the age of 65 years. More education and information needs to be applied to these sections if stigma, depression and suicide are to lessen. Unfortunately,

for countless young people suicide is the end result of their depression. Keohane and Chambers and Durkheim all offered important insights into the possible explanation to why so many people take their own life. Keohane and Chambers looked at coroner's reports and statistics and examined individual case studies of those who had committed suicide. Durkheim looked at statistic from many different countries and attributed suicide to four possible situations- they were Egoistic, Altruistic, Fatalistic and Anomic.

The USI's study was invaluable in highlighting the attitudes of young students to depression among their peers. Among the interesting findings was that 60% of the respondents stated that they knew someone who suffered from depression but yet 4% of those surveyed said they would not disclose their condition or discuss how they were feeling with anyone. This is a worrying statistic especially because it has become apparent that more young people suffer from depression and are committing suicide. For many of the respondents, suicide was considered, at one time or another, but is was usually a fleeting thought. It was usually considered when they had hit rock bottom and they felt they had no other option. The more severe forms of depression carry major suicidal risks as the sufferer is consumed with negative thoughts. Depression, which is left untreated, may result in suicide. However, AWARE (2003) insists that suicidal thoughts are more common than actions, although 15% of those with depressive illness take their own lives.

The respondents which I interviewed could all relate in some way to the stigma which they acknowledged as being attached to depression. Unfortunately, this stigma is not only

present on college campus but in the wider community. The issue of stigma is generally seen as a difficult topic to tackle. 'Beat the Blues Campaign' hopes that through education and government funding that the age old view of depression will lessen for the next generation, but sadly for many involved in the study they felt that it was the older generation who held the most prejudice and stigmatized opinions on depression. The media could play a vital role in this, that they could show more real life stories and documentaries and basically even in a small way begin to re-educate all age groups. Many felt that the government's role was to provide financial assistance to different organization to help increase awareness about this illness. Access to counselling and psychiatric waiting lists were issues raised also, some people who could not go through the private health system were waiting up to three months just for one consultation. General Practitioner's need to be brought up to speed on mental health issues especially where the GP is the only access for many who cannot afford to go to different specialist.

It is the stories of these six young females, which are all very different and their struggle for meaning in the darkest days that give hope to all those who suffer in silence to find the strength to seek help, even if it is talking to a friend. No two people's stories are the same but each element and stage of treatment has something in common; that is trying to rebuild oneself.

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Appendix A.

Appendix A: Sample Transcript.

Interview with Julie- Beat the Blues campaign

Interviewer - Basically, what is the Beat the Blues campaign about?

Julie- It's really about raising awareness of depression in second level schools among transition year, fifth year and sixth year. And we try to make them see that depression is an illness, so that if they are affected by it then it is nothing to be ashamed of or frightened of and that they need to tell somebody or go get help for it really and that you can recover from it. I think depression can make you feel very hopeless but there genuinely is a way to recover but you need to ask for help because if you don't you won't get it. So that is really what we are trying to do when we go into schools. We do have a question and answer section, but generally students don't want to seem like they are looking for help or that they have a problem by other students. Students do come up to us at the end and ask question. And we are available for students to talk to us after the session or alternatively long term we have the help line which is set up in AWARE that is there twenty four hours a day so give them the number so that if they want to talk to somebody, anonymously.

Interviewer - How long has Beat the Blues campaign been running?

Julie- It was started in 1995.

Interviewer -How many schools has Beat the Blue been in contact with?

Julie- over the years I have no idea how many, in total this year we spoke to145 schools, all over the country. I work Dublin, Wicklow, kildare and Sean my colleague does the rest of the country. Over the years it has averaged out at about 18- 20,000 students a year.

Interviewer - Do you feel the campaign helps the students?

Julie- Yea I do definitely, I always get very positive feed back on the day certainly from the students themselves. We also give an evaluation sheet to the teachers. And they fill it out we always here really good things back, about people who have been helped, they have spoken to their parents or that they have gone to their GP, whatever it might be. So the word we are getting it that it is helping people.

Interviewer - Do you have contact with the parents?

Julie- No not generally its usually just the parents. Occasionally a school would ask us to give a talk to the parents maybe a few weeks before we come and speak to the students. We have no problem talking to the parents but the programme itself is aimed at the students.

Interviewer - When and why did you get involved?

Julie- Well actually I answered a job advert; personally where I was coming from was that is that I have a history of depression. I became depressed when I was twelve and I wasn't diagnosised til I was twenty-three. So I guess when I saw the advert I suppose it was an opportunity for some good to come out of what was a very painful experience and I felt myself that I could do some good. Really making young people aware of the signs and symptoms of depression so that if they were affected by it that they would know what to look out for and they may recognize it rather than being in the dark. So that's basically why I got involved.

Interviewer - Within AWARE what other work do you do?

Julie- My main work in the Beat the Blues campaign, I would be in schools three or four days a week, September to May. However, I do give other talks apart from that the Beat the Blues, say in family centers, FAS groups, occasionally businesses work get us in. So it's a wide range of other talks certainly going on and trying to get the same kind of messages across, what depression really is and that there is help available. Apart form that I really just work in the office.

Interviewer - How do you feel talking to young people about depression, having experienced it yourself?

Julie- Its not so much that its difficult, I think talking about it to young people is actually a very positive thing, I've never been ashamed of my own history or embarrassed about it and I suppose it's a type of mission for me to stand up and say to young people I had a psychiatric illness and I ended up in hospital and that its ok to talk about it because I think you can give them all the facts and figures in the world and they are important but when they see somebody who they think looks supposedly 'normal' standing and talking about this history it really breaks down some of the stigma they may have for that person. Although sometimes I can be quite emotional talking about very painful stuff but I think the good out weighs the bad

Interviewer - Would you tell me about your own personal experience of depression?

Julie- Basically I was twelve, I was very out-going and very happy kid and I seemed that almost over night I became and felt very unwell It felt like the flu but it never past off and I had no energy and I would sleep all the time, I was so miserable, I was crying. The doctor couldn't find out what was wrong with me, nobody had any answers for me, basically over the next few years I was told I was hormonal, I wanted to skive off school, I was just feeling sorry for myself things like that. And I knew something was up, anyway more serious than that but I never knew what and I went through phases of being relatively ok but yet never really right and than phases of being very unwell, where I was sleeping twenty hours a day and not going to school things like that. Eventually, I went to my doctor about something and he was on holidays and I saw a stand-in GP and I broke down with her and she diagnosed me with. So I guess it was a complete fluke that I got a

diagnosis. And then I went on antidepressants I was feeling really well over the course of several months, it took time but I did get to the point of feeling very well. And I actually thought I had I beaten, but in 2001 I had a complete breakdown where over several months It built up and I feel apart I took an overdose one night and spent three months in St Patrick's psychiatric hospital in James Street. And I have been trying to build myself up from that since. I'm on medication and now I'm pretty well I still have bad days but generally I'm ok.

Interviewer – Does having another relapse like the one in 2001 worry you?

Julie- I think to say worry about it would be too strong but it does cross my mind occasionally I think the big thing is that once you have been diagnosed and you know how to spot the symptoms so that if it happens again at least you know what your are dealing with so you can go and get help. Where as I didn't really understand totally what I was dealing with in the past whereas now I have my psychiatry and I go o see her regularly and I know I would be on the phone straight away if either myself or my family spotted something going amiss.

Interviewer - At the age of twelve did your family notice a change in you?

Julie- They said that I became a different person, literally over night having been really confident, I became chronically shy even with my family which is so bizarre since its your own family you know what I mean. They were so frustrated, cos I had loved school

I had always been so involved with lots of activities but then I didn't want to have any involvement in anything and they were felt so desperate they were bring me from doctor to doctor and basically that they had been told that they were indulging me too much, and that "she needs to snap out of it and then she will be fine" It was very difficult for them obviously as parents you feel that you should be able to find answers if something has gone wrong with one of your children, so they went through a terrible time but yet they couldn't have done more than what they did.

Interviewer - Do you think the system has changed since the 1980's?

Julie- Yea I think there has been some changes, like that was 1987/88 and I think things have improved a lot, in relation to doctor attitudes but yet we have a long way to go still, but I do think we are getting there.

Interviewer - When you first consulted your GP, what was she like? Was she helpful?

Julie- initially, I suppose they were thinking that something was not right here and I was sent for tests and nothing showed up and I was sent to a specialist who thought I might have ME, which was also known as 'yuppie flu' back then when I was twelve after a while I think they thought nothing wrong here just get on with things and at the point I was pretty much dismissed then there was the phase where I was told that it was exam stress but I told them that I have been like this since I was twelve, I was like this for five

and a half years I couldn't be that stressed over my leaving cert when I was twelve. So they (the doctor) became very dismissive.

Interviewer - Did they listen to your point of view or was it the case they knew best?

Julie- Well my personal experience was "we know best, we're the experts and you're only a child and that was that basically. I think in that area things have improved a lot but certainly back in the 1980's it wasn't good.

Interviewer - Do you think there is a power struggle between the professionals and the layperson?

Julie- I think most doctor are very well meaning and that they genuinely want to help and they want to listen but as with everything you will get the occasional doctor that just doesn't listen. But from my own experience I think it was hard cos I was so young, they felt that maybe i was a typical teenager, with no energy who doesn't want to get out of bed, who isn't interested in school in fairness it does sound like a lot of teenagers, so I guess in a way you can't blame them. But I was very unfortunate with the doctor I meet.

Interviewer - What kind of treatment did you receive?

Julie- When I was twenty-three my GP put me on the medication, that was basic anti-depressants. Since I was in hospital I have been on a range of medication, I'm in anti-

elation and mood stabilizers. I'm bi-polar as well so I good high as well as low, which I never knew until I went into hospital. So I'm on a range of things to try and hold my mood stable.

Interviewer - Do you find there are any side effects to the medication?

Julie- I might get nausea and very thirsty. Which is very y small price to pay. My own feeling is that the pro so far out weigh the cons. For that I am more tan happy to take them. And I think that with almost any other illness if the doctors said take these tablets they will make you feel better you would say absolutely give the tablets and I will take them. There is just a different attitude to it when it comes to do with anything to do with mental illness, I suppose we need to break that down, it makes it more difficult for people.

Interviewer - Do you think there is still a stigma attached to depression?

Julie- Yes there is and I think that comes from all sorts of things, it comes from ignorance and from people thinking that we all feel blue sometimes, we all feel down sometimes but there is much more to depression than just feeling like that but people very often don't realize that and we have a long way to go. However, things have improved an awful lot. AWARE did research I think about twelve years ago and then two years ago and I know the numbers of people who had said that they would go to their doctors if they were

feeling depressed was hugely increased in the two year research than the previous so I do think people are becoming more willing to help themselves and admit the problem.

Interviewer - Do you think that the family situation has changed over the years?

Julie- I think touch wood, we were a very strong unit to begin with but I do think it has brought us closer together but having said that there were times when it (depression) came very close to ripping us apart but now that we have come through I think we are very strong. I'm very lucky that my parents are very supportive and very happy together so they were there for each other. I think it is an in creditably painful thing to look at anyone going through depression but to see your child going through it and they had no idea what was going on. My mum said to me that I became a skeleton of the person I once had been. And she was looking at me and she couldn't do anything to make me feel better. So it is very painful but particularly the hospital experience really brought us all together. They would come and visit me without fail, I was there for three months and it was then I realized how lucky I was I suppose so now we are a very strong unit.

Interviewer - Do you think it is tougher for your family to talk about it than it is you to talk about it?

Julie- Yes, I think my mum in particular there is a certain amount of guilt which is totally unjustified she has no reason to feel guiltily she did everything she could have done but because of that its is difficult for her. Also, because they are a different generation, my

attitude from my diagnosis was that I'm not ashamed of my depression, I'm not going to be embarrassed and I'm not going to hind from anyone but they are from a generation where you do not talk about it, so I guess it is more difficult for them.

Interviewer - So what do you think cause your depression?

Julie- Basically mine is a chemical thing, so it would have happened at some point. There was nothing really going on in my life that would have triggered it some doctor thought that it was the start of puberty and hormones playing up and what ever. And the changes in my body triggered it but it would have happened at some stage. I was just very unlucky that I happened so young.

Interviewer - Did you have many people you could turn to outside your family?

Julie- I had good friends, but I did loss a lot of friends along the way but I was lucky that I had a group of friends who were very supportive and encouraging and always trying to get involved in different things and whatever. So that was lucky, over the years I meet other people who I again became close friends with who were very good to me, which is not always easy when is depression. In my case I tended to push people away even though I desperately wanted them as friends and I wanted them to be there for me. I was very lucky I met good people who are still my friends now

Interviewer - Did it ever worry you that they may pity you because of your depression?

Julie- It was more that you feel so bad about yourself that you wonder why would these people want to be your friend, I felt I was a burden on everyone and they would be better off If I wasn't around. So that is why I tend to push people away but yet I really did want them to be there.

Interviewer - Did you ever feel people blamed you for your situation?

Julie- Yes, certainly to a certain extent, well when you look at it if a person doesn't get a diagnosis for years and years and no doctor can ever find an answer for them people are going to start thinking come on now really it is a case of snap out of it and get your self together and I think to a certain degree people were thinking that at certain times but having said that certainly the people who knew me the longest were thinking that this is so not the Julie we knew, its not like her to feel sorry for herself, its not like her to not want to do anything. So they knew something wasn't right but were frustrated and were thinking lets get going and sort things out some how.

Interviewer - How did the staff treat you?

Julie- Funny when I was in hospital they were pretty good, personally I took the overdose and went into hospital five days later and I thought I had hit rock bottom but when I went into hospital I actually went even lower because I felt save in their I felt relieved, and they could see how ill I really was and they were very encouraging but they were also

very strong and you have to do part of the work in getting yourself out of this. They were very much aware of the fact that I was sick but I suppose they encouraged me to take part in my own recovery and not just depend on the doctor to do it.

Interviewer – When you were in hospital did you meet other people who were in a similar situation to yourself and if so did you find it helpful to talk to people who were in a similar situation?

Julie- Yes because you begin to start thinking I'm not totally alone. I keep a journal and I always remember the first night I was in ST Patrick's hospital I wrote, "I can't believe I'm in here with all these mad people" and about five days later I had written, "I have just realized that I am one of these mad people". And that is totally what it was you release that these people are just like me that everyone is normal in here and you can talk more openly with people who are patients because you know they are not going to judge you and you know they won't say "sure go for a walk and you will feel so much better" I felt that it was a really important part of being in hospital.

Interviewer - Before you took the overdose, like did you plan it or was it the case that one day something just clicked?

Julie- Something just clicked, certainly I had contemplated suicide countless times over the years but that particular day I had a lot of other things going on in my life and I guess that day I hit my breaking point.

Interviewer - In your opinion, is there a strong correlation between depression and suicide?

Julie- There is, many people who are affected by depression get suicidal feeling that doesn't necessarily mean they want to die or that they are actually going to go through with the attempt on their life but certainly they would have fleeting thoughts of suicide and If you think of the symptoms of depression and living with them and in someway who can understand. And it is so sad; suicide should never be an answer for anyone. I was at a conference a few months ago and someone summed it up as a "permanent solution to a temporary problem". And I sat there and thought that is so true, and that is why it is so sad for those who actually go through with it.

Interviewer - At a general level, how do you the education system can help people to open up and talk about their situation and maybe help remove the stigma?

Julie- Educating people about depression is about helping them to see that they are not just people feeling sorry for themselves and getting people to open up and talk about their emotions and I always say in the schools that I'm not asking you to all sit around and cry at lunchtime but if something is going on you should feel that you need to say it someone like you're not feeling good or that you are worried about something or what ever it might be. And I suppose encouraging people not to be ashamed of feeling depressed or having whatever illness there may be. It's all about educating people and opening up.

Interviewer - And would that be the same for third level education?

Julie- Yes, well it's the same messages regardless of what age group you fall into, it's all about how you get the message across and how it is appropriate to get the message across. That's what I think.

Interviewer - What do you think the government's role is?

Julie- I suppose giving more funding really, there are so many groups out there AWARE is just one group of many who are trying to do good work and help people who are affected by illnesses like depression. And it takes money that's what we need, we get about 10% of our funding from the government and everything else is voluntary donated. And that is a huge undertaking each year so we need more support.

Interviewer- Over the years there has been a dramatic rise in the rates of suicide amongst young men, in your opinion what was the trigger?

Julie- Well I suppose I can't specifically say its this, but certainly there are certain factor, research done around the world research has shown that in times of social change show an increase in suicide, I think alcohol and drug abuse are major factor in it and I think everybody knows our culture of binge drinking amongst young people in Ireland is a major problem. And the issue that young men are less likely to talk about their emotions

than women are, I think it men are six times more likely to die from suicide than young women in this country, this is so shocking, I know in this country we (women) are slagged off for being emotional but I think that it works in our favor in many ways. So there are different issues involved but I think these are issues, which could all be addressed, but it is a long-term thing, which cannot be fixed today and tomorrow.

Interviewer- There was an article in the Irish Times about suicide and the decline in religion, in your opinion is there a correlation?

Julie- I think the religion issues is very interesting, I suppose having faith what ever religion you are gives you a sense of hope and I gives you something to hold onto and I think when you take that out maybe people will feel more hopeless so that will obviously be an issue for people who are potently suicidal. There was also a fear factor in Catholicism, that it was this mortal sin, so there a may have been two factor which held people back from suicide.

Interviewer - In that same article there were issues raised on the pressures to conform especially for young women, and this was linked to the rise in suicide amongst young women. What is your view on that issue?

Julie- In terms of pressures to conform I don't know how much of an impact that have, certainly I don't know how magazines and TV etc can have a positive impact when you

have to be a size 8 and 6foot tall to be seen as beautiful or whatever, those things are not realistic or obtainable for most people. What impact they have on people I don't know.

Interviewer - Would you yourself have a strong faith in religion?

Julie- I went trough a phase of being very anger with god, because I felt why the hell are you doing this to me when I have done nothing wrong, I felt like I don't deserve to be treated like this. But I have now got a faith but I wouldn't say I follow Catholicism particularly, but I would pray everyday and I feel that there is someone there looking down on me who ever he may be. And I think that does help me, even though there are times when I get mad and sick of you know maybe when I have bad days and I get sick of feeling like that and I guess it is nice to believe that you have somebody who ever he is there, it does help.