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WOMEN WITH DEPRESSION IN ONLINE LEARNING: A DESCRIPTIVE PHENOMENOLOGICAL ANALYSIS

BY

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**WOMEN WITH DEPRESSION IN ONLINE LEARNING:
A DESCRIPTIVE PHENOMENOLOGICAL ANALYSIS**

Submitted by:

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In partial fulfillment of the requirements for the degree of

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Abstract

This study explored how women in online learning contexts experienced and recovered from depression. Guided by the primary research question —*What are the lived experiences of women in online learning who have lived with and recovered from depression?* — and a descriptive phenomenological approach, I interviewed 11 women distance learners who suffered from depression during their online studies. Interviews were analyzed using Giorgi's (2009) descriptive phenomenological method. The Theory of Social Domains was used during the analysis as a sensitizing concept to bring the disciplinary concerns of social work to the study. Seven invariant constituents of the experience were identified: the development of depression; the impact of depression on learning; treatment of depression; peers in online learning; role overload; self-identity; and personal agency. The study concludes with recommendations including increased opportunities for peer interaction in online courses as best pedagogical practice and as essential for students with depression.

Keywords: depression, distance education, online learning, women, phenomenology, post-secondary

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Chapter 1. Introduction

This study investigated the experience of women as online learners living with depression, using Giorgi's (2009) descriptive phenomenological methodology. The sample population was purposively recruited to include female students in an online, degree granting program at a Canadian University, who had experienced a major depressive episode and recovered from it during their online studies. Excluded from the study were men, students taking single courses for interest, and students experiencing mental disorders other than depression (e.g., bi-polar disorder, schizophrenia). Research participants participated in a semi-structured interview of approximately 30 to 60 minutes duration, with the aim of eliciting rich descriptions of their experiences as online learners who had lived with depression during their studies.

Transcribed interviews were analyzed using Giorgi's (2009) descriptive phenomenological analysis. Layder's (1997) Theory of Social Domains was then utilized as a sensitizing concept as a means of bringing the concerns of the discipline of social work to the analysis of the context of the participants' experience. The ultimate aim of the research was to provide a description of the invariant structure of the experience of women in online learning contexts who lived with and recovered from depression.

This qualitative study addresses a gap in the research regarding students in online learning contexts living with depression. More specifically, it asks the question, "What are the lived experiences of women in online learning who have lived with and recovered from depression?" I used the Descriptive Phenomenological Psychological method of Amedeo Giorgi (2009) to explore the lived experience of women in online learning contexts who have lived with depression. As a social worker using this method, I also

used Layder's Theory of Social Domains (1997) as a sensitizing concept during data analysis in order to maintain a social work view and to ensure maximum consideration of context.

Rationale

Students with mental disorders are increasingly represented in post-secondary student populations (Belch, 2011; Castillo & Schwartz, 2013; Condra et al., 2015; Hartley, 2012; Heck, Jaworski et al., 2014; Kirsh et al., 2016). In part, this increase can be attributed to better treatment and more effective medications that allow learners to continue with their studies. Student support services have also contributed as many post-secondary institutions have responded by creating additional forms of supports and accommodations, by attempting to address the stigma of living with a mental health disorder, and by creating programs that initiate students to the role and skills of being a post-secondary student (Belch, 2011; Condra et al., 2015).

Statement of the Problem

The experiences of post-secondary students with mental disorders, let alone depression, are not well represented in the literature on post-secondary students with disabilities. Representation of these students is even less so in the literature on post-secondary students with disabilities in distance or online learning. This silence exists despite an increasing number of students with mental disorders who are entering and studying at a post-secondary level in both face-to-face and online learning contexts. Students with mental disorders are quite possibly the least understood and the most silent population of students with disabilities in distance education contexts today. Without the input of these students, post-secondary institutions, student support services, and

instructors cannot hope to create inclusive educational environments in a meaningful way and will continue to operate from a position of speaking for others. As Seale (2014) pointed out, we "need to engage in a relationship with stakeholders, where we not only commit to 'giving' them a voice, we also commit to acting on what we hear" (p. 18). This study aimed to hear the voices of women with depression as distance learners, to determine the structure of their experience, and to discover how their experience might help inform future online learning contexts. Research, thus far, has focused on students with mental disorders in face-to-face post-secondary environments. This study shifts this focus to distance learning contexts to explore how the context of distance learning might influence the experience of female learners with depression.

Purpose of the Study and Research Question

The purpose of this study was to describe the lived experiences of women as online learners who have lived with and recovered from depression. The study was grounded in the lived experiences of the research participants, and reflects the need to make visible a population of learners whose experiences are relatively scarce in current scholarly literature. Research, thus far, has focused on students with mental disorders in face-to-face post-secondary environments. This study shifted this focus to distance learning contexts to explore how the context of distance learning may shape the experience of female learners with depression. The primary research question for this study was "What are the lived experiences of women online learners living with depression?" Sub-questions included, "How might participants' experiences be similar or different to the experience of post-secondary students in face-to-face environments?" and

"What role, if any, might gender play in the experience of female learners living with depression in distance learning contexts"

Significance

This dissertation research study addressed the current gap in research regarding the experience of online learners who live with mental disorders, specifically women living with depression. I am hopeful that the findings will begin a conversation about this population of students in order to add to the base of knowledge in this area. This study, as well as future studies, may also be used to assist learners studying in online learning contexts by informing educators and student support staff so that learner needs can be more adequately met. In addition, learners may find their own experiences reflected in the participant accounts related in this study, thus normalizing their experience and reducing isolation.

Limitations

Limitations involve aspects of the study over which the researcher has little control that may impact outcomes of the study. Limitations are also related to the use of specific methodologies (Simon & Goes, 2013). A reality of phenomenological studies includes the possibility of the introduction of researcher bias. To address this limitation, I used descriptive phenomenology, assumed a phenomenological attitude during data analysis, and kept a reflexive journal throughout the research process in order to be aware of researcher bias. In addition, the focus of the study on the in-depth analysis of individual accounts of experience and the small sample size, which is congruent with phenomenological methodology and the aims of this study, makes generalizability to larger populations impossible. The inclusion of participants from a single university may

also limit comparison to the experience of students in other post-secondary settings. Also, as volunteers, participants were self-selected, which resulted in the experience of women who did not volunteer for the study to be excluded. Last, ethical research avoids harm to research participants including harm to members of vulnerable populations, which include participants who suffer from mental disorders. Therefore, the study included only women who had recovered from depression during their online studies. As a result, participants relied on the recollection of their past experiences of depression rather than current experience.

Delimitations

Delimitations involve decisions made by the researcher that provide boundaries for the study and narrow its focus (Simon & Goes, 2013). Delimitations can include the choice of population for the study. The population chosen for this study included female, post-secondary students in a wide variety of undergraduate and graduate degree programs offered via online learning with the aim to obtain as heterogeneous a sample as possible. Students identifying as male were excluded as well as students taking courses who were not registered in a degree granting program. The choice to include students who identified as female in the study was made because of the higher prevalence of depression among women (Pearson, Janz & Ali, 2013).

These limitations and delimitations served to provide parameters for this study as well as providing potential areas of research for future studies.

Summary

This chapter provided an overview of the study including the rationale, research question, limitations, and delimitations. In Chapter 2, I review literature on the

definitions of depression, determinants of mental health and mental illness, the gendered nature of depression, the experience of post-secondary students with mental disorders, and the experience of post-secondary students with mental disorders and women in online learning contexts. Finally, I provide a review and critical analysis of phenomenological studies of women who experience depression. Chapter 3 provides a brief overview of phenomenology; it describes the research approach of descriptive phenomenology, specifically the descriptive phenomenological approach of Amadeo Giorgi (2007), and the sensitizing concept of Layder's (1997) Theory of Social Domains. In Chapter 4, I describe the methods and methodology used in the study. Chapter 5 describes the findings of the study, including the overall general description of the women's experience as well as the profiles of the study's participants. Chapter 6 discusses the implications of the study and Chapter 7 presents conclusions and recommendations for future research.

Chapter 2. Literature Review

Introduction

The role of a literature review in qualitative studies differs from that of quantitative studies. Literature reviews in quantitative studies aim to provide large amounts of literature in order to introduce a theory which is revisited and compared at the end of a study; it follows a deductive approach in framing the research question(s) (Cresswell, 2014). In contrast, qualitative studies emphasize an inductive approach where literature is used more sparingly. In phenomenological studies, in particular, literature reviews are less often used as a means of setting the stage for a study (Cresswell, 2014). Rather than being an aid to directing the research, a qualitative literature review is used as an aid *after* patterns in the data have been identified (Creswell, 2014). The literature review is used at the end of a study as a "basis for comparing and contrasting findings of the qualitative study" (Cresswell, 2014, p. 29).

The literature review provided below was conducted in order to meet the requirements of my doctoral program. At the same time, consistent with the aims of qualitative literature reviews, it addresses the gap in the literature and research surrounding women's experience of depression in distance learning contexts. At the conclusion of the study, additional literature was consulted and included in response to the study's findings.

The literature review focuses on areas of literature relevant to the research question "What is the lived experience of women in online learning living with depression?" It includes definitions of depression, determinants of mental health, and research relating to women's experience of depression, post-secondary student mental

health, and post-secondary students with mental disorders and online learning contexts, as well as a critique of previous phenomenological studies related to women and depression. I conclude the literature review with a discussion of women in distance learning contexts. To date, scholarly literature available does not adequately address the experience of post-secondary students with mental disorders in online learning contexts.

Definitions of Depression

The participants of this study were women who had experienced depression. The term, *depression*, is widely used in even casual conversation. Meanings in these settings can range from experiencing a bad day at work to describing an incredible loss of functioning. Depending on the author and study, the terms psychiatric disability, psychological disorder, psychological disability, and/or mental illness are used as synonyms for mental disorder. I use the term *mental disorder* in the study.

The most commonly used definitions of mental disorders, including depression, are found in the Diagnostic and Statistical Manual of Mental Disorders DSM V (American Psychiatric Association, 2013). I chose to use the DSM V definition of depression for this study in recognition of the wide use of the DSM V in North America. The DSM V definition of depression is used in models of mental health and mental disorders such as Keyes' (2002) Dual-Continua Model of mental health, which is also used in this study. The DSM V criteria for diagnosis of a Major Depressive Disorder includes a change in an individual's previous functioning, which includes at least one of the symptoms of depressed mood or loss of interest or pleasure among five or more symptoms (see Appendix A).

Determinants of Mental Health

When discussing depression as a condition affecting mental health, it is important to define what it is that determines mental health. This section outlines some of the most commonly used definitions of mental health and its determinants including the definition used in this study. I also provide a description of Keyes' (2002) Dual Continua Model of mental health, which is a model used frequently in post-secondary institutions.

Mental health is defined in multiple ways by various organizations and individuals. There are policy definitions of mental health and scientific definitions of mental health based on the operationalization and testing of correlates of mental health. Policy definitions of mental health primarily originate from the *World Health Organization (WHO)* and Government of Canada. WHO (2013) defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (p. 6). The Government of Canada (2006) defines mental health as follows:

The capacities of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections, and personal dignity. (p. 2).

In these definitions, good mental health is seen as more than the *absence* of mental illness (Allan, Balfour, Bell, & Marmot, 2014; Barry, 2009, Keyes, 2002), and includes subjective feelings of well-being in various life areas. In an effort to investigate and begin to measure mental health, a further definition was offered by Keyes (2002),

who operationalized the concept of *mental health* as "a syndrome of symptoms of positive feelings and positive functioning in life" (p.207).

The three core components of the WHO (2005) definition of mental health are well-being, effective functioning of an individual, and effective functioning for a community (p. 2). Keyes' (2002) definition of mental health was operationalized through the measurement of subjective well-being, emotional well-being, psychological well-being and social well-being. His original research used data compiled in the 1995 Midlife in the United States (MIDUS) study. The MIDUS was a large national survey with a probability sample stratified by age and gender. The MIDUS survey had a high participation rate in its telephone interviews and questionnaires resulting in a sample size of 3032 respondents. The study "tested the fit of confirmatory models that test different theories of the latent structure of the measures of mental health and mental illness" (Keyes, 2002, p. 543). Keyes' (2002) latent content structure indicating mental health included three scales: emotional well-being; psychological well-being (Ryff, 1989); and social well-being (Keyes, 1998). These three components combined to create what Keyes (2002) described as mental health.

Emotional well-being was considered to be a concept that included subjective well-being such as life satisfaction as well as positive affect and absence of negative affect (Keyes, 2002). Psychological well-being (Ryff, 1989) was made up of six elements, which were "important in the striving to become a better person and to realize one's potential" (p. 111). These elements included the following: self-acceptance defined as a positive and acceptant attitude toward aspects of self in past and present; purpose in life defined as goals and beliefs that affirm a sense of direction and meaning in life;

autonomy defined as self-direction as guided by one's own socially accepted internal standard; positive relations with others defined as having satisfying personal relationships in which empathy and intimacy are expressed; environmental mastery defined as the capability to manage the complex environment according to one's own needs; and personal growth defined as insight into one's own potential for self-development.

Keyes (1998) also recognized that individuals were imbedded in social contexts and societies. He proposed five dimensions of social well-being as a part of mental health: social coherence defined as being able to make meaning of what is happening in society; social acceptance defined as a positive attitude towards others while acknowledging their difficulties; social actualization defined as the belief that the community has potential and can evolve positively; social contribution defined as the feeling that one's activities contribute to and are valued by society; and social integration defined as a sense of belonging to a community. Keyes (2002) used these definitions of the emotional, psychological, and social dimensions of mental health to describe the Mental Health Continuum which is now known as the Dual Continua Model of mental health and mental illness.

The Dual Continua Model of Mental Health and Mental Illness

The most recent description of mental health is described in the Dual-Continua Model of Mental Health (Westerhof & Keyes, 2010). This significant contribution to our current understanding of mental health questions the unipolar understanding of mental health, and presents the concept as two separate continuums or axes -- one representing mental health and the other representing mental illness. The Dual Continua Model of Mental health and Mental Illness is illustrated in Figure 1.

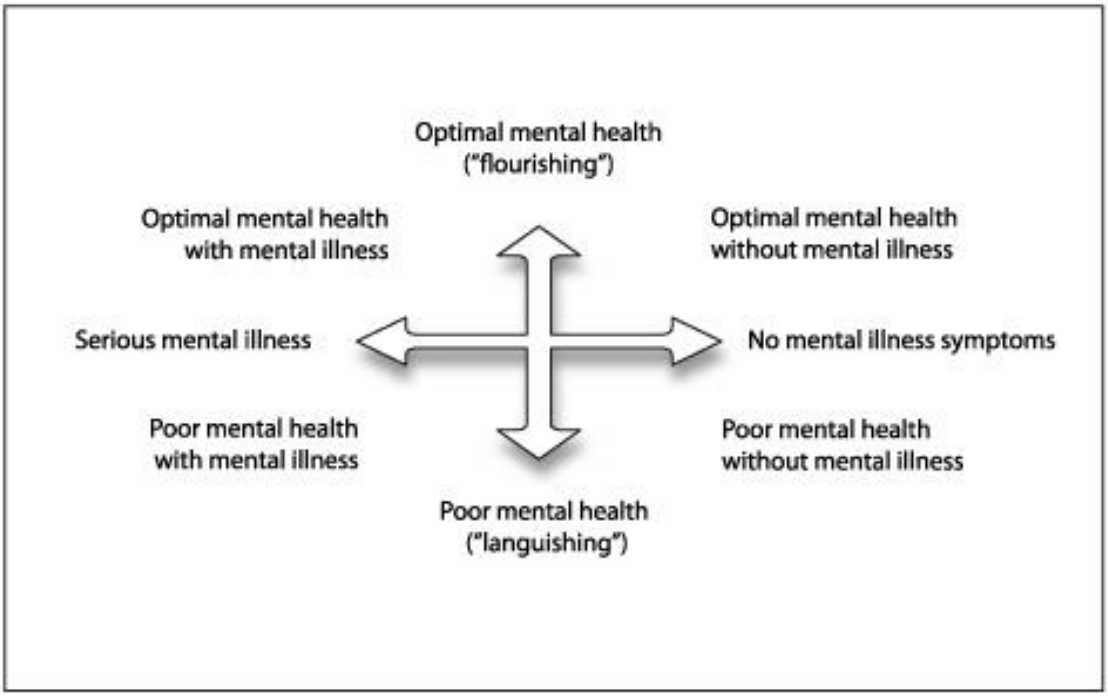


Figure 1. Keyes Dual Continua Model of Mental Health and Mental Illness. Adapted from the Post-Secondary Student Mental Health: Guide to a Systemic Approach by the Canadian Association of College & University Student Services and Canadian Mental Health Association, 2013.

One axis depicts a continuum ranging from serious mental illness to no symptoms of mental illness. The other axis depicts a continuum ranging from poor mental health (languishing) to optimal mental health (flourishing) as operationalized through the three components of mental health mentioned previously; emotional, psychological and social wellbeing. Keyes (2002) defines *flourishing* as a state where individuals combine a high level of subjective well-being with an optimal level of psychological and social functioning. It is the presence of mental health. Similarly, in a study applying the Dual Continua Model of Mental Health and Mental Illness to a Dutch population, Westerhof & Keyes (2010) defined *languishing* as "a state where low levels of subjective well-being

are combined with low levels of psychological social well-being" (p.112) or an absence of mental health (Keyes, 2002). The two axes are separate, but positively correlated. In other words, it is possible for an individual to have poor mental health, but not to be suffering from mental illness; similarly, it is also possible for individuals with mental illness not to be languishing.

The Dual Continua Model of Mental Health is used in Alberta and across Canada with reference to supporting post-secondary student mental health (Canadian Association of College & University Student Services and Canadian Mental Health Association, 2013, Alberta Advanced Education, 2017).

Women and Depression

This dissertation research study focused on the experience of women who have lived with depression. This choice was based on the reality that depression is disproportionally experienced by women both in Canada and worldwide. In this section of the literature review, I refer to Canadian literature on the gendered experience of depression, critical literature reviews on the epidemiology of depression in women, and several large epidemiological studies of depression.

The World Health Organization (2017) estimated that more than 300 million people worldwide suffer from depression, and cited depression as the "single largest contributor to global disability" (p. 5). The report also estimated nearly 7% of years lost to Canadians due to disability were due to depression. Worldwide, the incidence of depression increased by 18.4% from 2005 to 2015 (WHO, 2017, p. 8). The same study estimated that more than 1.5 million Canadians or 4.7% of the population had

experienced depression; however, this figure may be under-estimated as evidenced by the study reported below.

Earlier Statistics Canada data from 2012 showed that 12.6% or 3.5 million Canadians meet the criteria for a mood disorder (Pearson, Janz & Ali, 2013). Of the vast majority of people suffering from mood disorders, 3.2 million or approximately 11.3%, suffered from Major Depressive Disorder. This Canadian data also included data stratified for gender and showed higher rates of depression for women across all age categories under the age of 65 years, with the highest rates occurring in the 15 to 24 years age group. In this age group, women's rates of depression were almost double that of men's rate of depression (5.8% and 3.6%, respectively).

Numerous studies have shown that the experience of mental health and mental illness differed according to gender (Affifi, 2007; Kessler 2003, Piccinelli & Wilkinson, 2000; Dalgard et al., 2006; Angst et al. 2002). The World Health Organization also acknowledged this difference, both in its 2001 report on Gender Disparities in Mental Health, and in 2002 when its first gender policy was passed.

Socioeconomic factors also appear to play a role in the incidence of mental health and mental illness. In a U.S. study using the Midlife in the United States (MIDUS) data set, Ryff, Keyes, and Hughes (2003) focused on status inequalities among minority populations. (Recall that the MIDUS data set included a nationally representative sample of 3,487 individuals, stratified according to gender.) The researchers found that when the experience of discrimination was higher, self-acceptance and environmental mastery were lower for women as compared to men, and concluded that "being female was a significant negative predictor of autonomy" (Ryff, Keyes, & Hughes, 2003, p. 284).

They also observed that "compromised well-being [was] evident among all women, majority and minority, who [saw] themselves as suffering from chronic discriminatory experience" (p. 287).

Piccinelli and Wilkinson (2000) conducted a critical review of the literature on gender differences in depression. Their review of 71 studies established that "gender differences are genuine" (p.490), and that determinants such as adverse childhood experiences, previous experience of depression and anxiety in childhood, adverse experiences as a result of socio-cultural roles, and psychological attributes that contributed to a vulnerability to adverse life events were involved in the experience of depression for women. Experiences of poor social supports, as well as biological and genetic factors, were not seen to contribute to the gendered difference in occurrence of depression. Piccinelli and Wilkinson (2002) summarized the risk factors for women regarding depression with associated life experiences, as shown in Table 1 below.

Table 1

Risk Factors Explaining Gender Differences in Depression

Risk Factor	Difference
Childhood familial environment and adverse experiences	Females are at greater risk of sexual abuse and seem to be more sensitive to the effect of adverse experiences in childhood.
Prior depression and anxiety disorders	Females are at increased risk of depression and anxiety disorders at earlier ages.
Social roles and cultural norms	Role limitation with associated lack of choice, role overload and competing social roles contribute to females' increased risk of depressive illness
Vulnerability and coping style	No consistent gender differences in personality attributes and coping styles compatible with a depressive image
Social support	No contribution to females' increased risk of depressive illness.
Gonadal hormones	Partial effect, although smaller than that of environmental variables
Adrenal axis and thyroid axis	Contrasting findings for adrenal axis. Limited role for thyroid axis.
Neurotransmitter system	Uncertainty about their effects

Note: Adapted from "Gender differences in depression," by M. Piccinelli and G. Wilkinson, British Journal of Psychiatry, 177, p. 487. Copyright 2000 by Cambridge University Press.

Piccinelli and Wilkinson (2000) also identified a number of limitations of research on the impact of gender on the experience of depression including the following: the lack of longitudinal studies that tested several variables simultaneously; that studies looking at biological sex lacked consideration of underlying developmental processes in the development of gender identity; and the lack of models which took "assumed" risk factors for gender differences in depression into consideration because of difficulty in

empirical testing. They recommended that research into the risk factors for depression start by acknowledging that biological sex was an "immutable socio-democratic variable not influenced by disease" (p. 491). Piccinelli and Wilkinson (2000) concluded that important risk factors in the over-representation of depression in females were: "sexual abuse and adverse childhood experiences; role limitation with associated lack of choice; role overload and competing social roles; psychological vulnerability to life events and coping skills" (Piccinelli & Wilkinson, 2000, p. 491).

Gender differences in depression tend to emerge in adolescence. Kessler (2003) reviewed 53 epidemiological studies on gender differences in depression spanning the years between 1987 and 2000. Kessler cautioned against making conclusions about studies that emphasized the increase in depression among girls in puberty as being due to hormonal changes, and warned that studies emphasizing hormonal changes in adolescence and subsequent body changes as being evident of biological causes of depression should be interpreted cautiously (e.g., Angold, Costello, Erkanli, & Worthman, 1999) as these studies may underestimate the impact of environmental stressors common in this developmental period. He noted that gender differences in societal expectations may also tend to emerge during adolescence, although the interaction between biological and societal factors was unclear. Future researchers were encouraged to pursue descriptive epidemiological research that evaluated the potential joint effects of biological and social determinants of depression on girls and women. Kessler (2003) also spoke to the societal cost of depression and the need for research to be funded to study women's health, which lagged behind the funding available to study the health concerns of men.

Gender differences in depression outside of North America have also been studied. Two studies using large data sets are reviewed below.

Angst et al. (2002) conducted a study of depression using the Depression Research in European Society (DEPRES) data set, which represented sample populations from six European countries, and included 38,434 men and 40,024 women in the first wave of the study. The authors found marked gender differences in the six-month prevalence rate for major depression, but less so for minor depression; the gender differences for major depression persisted across all age groups. This finding was consistent with studies of depression in North America. Nearly twice as many women as men, across all age groups and all countries, reported having depression. Women consistently reported more symptoms of depression than males, although both groups reported significant impairment. In their analysis, Angst et al. (2002) considered the possibility of lowering the threshold of depressive symptoms for the diagnosis of major depressive episode in men; however, even when the data were adjusted to account for a lower threshold in men, gender differences were still found to be significant. Unlike other studies, Angst et al. (2002) focused mainly on the gender differences in reporting total number of depressive symptoms rather than incidence of depression. They also argued for the continued consideration of biological factors as contributing to the sex differences in the experience of depression while conceding that both social and biological factors needed further study.

A large population study by Dalgard et al. (2006) looked at gender difference in depression in terms of negative life events and social support. This group of researchers, known as the Outcomes of Depression International Network (ODIN) group, conducted a

cross-sectional community survey of 8,832 individuals (4,143 men and 4,688 women) using the Beck Depression Inventory and questionnaires measuring both negative life events and social support. They hypothesized that more women would experience depression because of increased exposure to negative life events, a higher vulnerability to these events, fewer social supports, and a higher vulnerability due to this lack of social support. Differences in group means were analyzed using analysis of variance (ANOVA) and multiple logistic regressions were used to evaluate difference in proportions. The analysis allowed for potential confounding variables such as country and age. Analysis revealed that exposure to most negative life events did not yield significant differences in terms of gender, with two exceptions. Of the 12 negative life events mentioned in the questionnaire, significantly more women than men reported "injuries, illnesses, or assaults in close relatives" and "serious problems with friends, neighbours, or relatives" as events related to depression. All of these events were related to social networks. Male respondents reported significantly more "problems with police or court appearance" than women. "Injuries, illnesses, and assaults among close relatives" and "death among close friends or other relatives" were the most frequently reported negative life events for both genders. The researchers concluded that negative life events were strongly associated with depression for both genders.

Dalgard et al. (2006) also found a significant inverse relationship between social support and depression in that both genders experienced a decrease in the rate of depression with an increase of social support. Yet even with social support, women still rated higher levels of depression than men. In one subgroup of women, those who experienced a negative life event but had no social support, rates of depression were

almost twice that of men (42.9%, as compared to 23.9%). Despite the differences noted, the study concluded that "differences in life events and social support do not explain the gender difference in depression (p. 449)".

Similar to the Angst et al. (2002) study a limitation of the Dalgard et al. (2006) study was its use of cross-sectional data. Longitudinal data would have been useful in showing the development of depression in individuals in response to maturation, social environments and events, and social supports. In addition, following individuals from a younger age would have contributed to the understanding of depression in women given the research reporting the initial increase in depression noted in adolescent girls (Kessler, 2003).

Literature on depression clearly demonstrates that women are more likely than men to suffer from depression. Conclusions about why this phenomenon occurs are less clear. Hopefully more understanding will be provided by the dissertation research study reported herein that allowed for an in-depth exploration of the potentially complex biological, psychological, and social influences on women online learners who experienced depression.

Phenomenological Studies of Women and Depression

As a part of this literature review, I searched for studies that explored the experience of women online learners who suffered from depression with no results. I then searched more generally for phenomenological studies of women with depression using the search terms "women/woman/female" and "depression" and "phenomenological" and found four studies that I review in this section. Of the four studies I reviewed, one study explored older women's experience of depression, one

study investigated the lived experience of women at midlife with depression, another focused on the experience of depression among low-income South African women and a final study investigated the essential meaning structure of depression in women. One study utilized a hermeneutic phenomenological approach, one study applied an Interpretative Phenomenological Analysis, another applied a feminist phenomenological description and the last study used Giorgi's descriptive phenomenological approach.

Allan and Dixon (2009) used a hermeneutic phenomenological approach informed by van Manen (1990) to investigate the experience of four older women who had experienced depression. Inclusion criteria for their study included women aged 65 or older who were well at the time of the study but who had been previously diagnosed and experienced depression since the age of 65. The age range of participants was 69 to 82 years. In keeping with a hermeneutic phenomenological approach, Allan and Dixon (2009) identified several themes arising out of the participants' interviews including "self-loathing; being overwhelmed by the feelings; hiding from the world; the struggle of everyday life; Being-alone; misinterpreting self and other people; the stigma of mental illness – society and self; and seeking understanding from other people" (p.865). The authors used their study to inform the type of relationships nurses can aspire to in working with older women with depression. They also identified the limitation of working with participants' retrospective views of depression. My study shares this limitation.

A Taiwanese phenomenological study explored the lived experience of women at midlife with major depression (Li, Shu, Wang & Li, 2017). Four women between the ages of 43 and 55 years were interviewed for this study. A core theme that arose out of

the interview analysis was “a harder life”. Two major themes each containing two subthemes were also identified. The first major theme, “struggling to redefine the self”, was associated with the subthemes, “taking pills in the dump” and “the inane life”. The first subtheme highlighted the experiences of shame and helplessness associated with the diagnosis and treatment of depression as well as women’s struggle and search for meaning in their everyday lives. The second subtheme, “swinging to develop new social interactions” was associated with the subthemes, “being alienated from former social contact” and “starting new social interactions” (p.262). Participants sought new social contacts who would understand their experience of depression while also feeling misunderstood by past friends and family.

Although the authors identified the homogeneity of their sample as a potential limitation, there were other difficulties with this study. At no point did the authors identify the school of phenomenology that is reflected in their methodology and analysis. It is clear when reading the study however, that the researchers utilized a hermeneutic phenomenological approach despite comments about saturation which are more in keeping with a grounded theory approach. The authors also interviewed women who were currently depressed. Although this choice of population addressed the limitation of studies using retrospective data, there are ethical issues involved when interviewing vulnerable populations such as people with mental disorders which is why many studies, including the proposed study, choose to rely on retrospective data. Strengths of this study included the researchers’ attention to rigor in the form of peer review during data analysis and attention to interrater agreement (good at .86 Cohen’s kappa) as well as the process they established to address disagreements in interpreting the data.

A study by Dukas and Kruger (2014) aimed to provide rich descriptions of low-income South African women's experience of depression. The researchers used Interpretative Phenomenological Analysis (IPA) to analyze the transcribed interviews of ten women of various racial backgrounds who were diagnosed with depression and survived on low-incomes. This study also used a feminist analysis as a lens to interpret the gendered experience of low-income women with depression in South Africa. The researchers identified five superordinate themes arising out of the participant's stories: the bodily experience of depression; the emotional experience of depression; the complexity of coping with depression; subjective beliefs about the factors that cause or exacerbate depression; and subjective beliefs about the factors that alleviate depression. The researchers hoped that this study would be useful in improving mental health interventions for this population of women while also informing future policy development to support low-income women with mental disorders in South Africa.

Dukas and Kruger's (2014) study was consistent with IPA methodology in most ways except in their choice of sample population. Sampling in IPA studies aims, as much as possible, to establish homogeneity across participants. Although participants were similar in experiencing depression and low-income, they differed widely in age, race, education level and employment. Greater homogeneity in the sample population would have improved the overall design of this study. Strengths of this study included its use of women's voices in the examples of superordinate themes and the larger sample size of ten individuals.

Roseth, Binder, and Malt (2013) used Giorgi's descriptive phenomenological approach to describe the essential meaning structure of depression in women. This study

used the same methodology as my study but without the context of online learning. An abbreviated essential meaning structure of the development of depression described by the authors is described in the following statement:

> The women find themselves entrapped in a personal mission which had backfired. Motivated by shame and guilt from the past, they overinvest in work or others' emotions to relieve internal pain. They felt deeply sensitive to, and responsible for, other persons' distress while ignoring their own feelings and needs. Gradually their emotional body grows awry and acts in increasingly alienating and threatening ways. Ultimately they feel forced to submerge in their emotional body; they succumb to depression. (p. 153)

The three women who participated in the study were recruited from outpatient psychiatric clinics in Norway and from two general practitioners offices although the specific final selection sites for the participants were not identified. All participants were diagnosed with a major depressive episode. The women differed in their psychiatric histories, child bearing histories, ages and treatment. The aim of sampling was to be as heterogeneous as possible within such a small sample which was consistent with Giorgi's descriptive phenomenological methodology. The authors' description of their analysis was also consistent with Giorgi's methodology.

Of the four phenomenological studies I reviewed, the Roseth, Binder, and Malt (2013) study appears closest in its aims, methodology, and population to the dissertation research study reported herein. My study also used Giorgi's (2009) descriptive phenomenological method to describe the invariant structure of the experience of women online learners with depression. Sampling for the study recruited participants who were

as heterogeneous as possible outside of being online learners and having experienced depression.

After completing my analysis, I returned to the Roseth, Binder, and Malt (2013) study to see in what ways the invariant structures of women's experiences in online learning contexts that I had discovered were similar or different to the more general structure of the development of depression in the women described in their study.

Post-Secondary Students and Mental Disorders

Rising numbers of students with mental disorders in post-secondary institutions have caught the attention of researchers in recent years (Castillo & Schwartz, 2013; Storrie, Ahern & Tuckett, 2010). Belch (2011) referred to students with psychiatric disability [i.e., mental disorders] as "one of the fastest-growing categories of disability in the college student population" (p. 73). In a brief examining the growing number of post-secondary students reporting psychiatric disabilities, Johnson, Benson, Blacklock, Bruininks & Sharpe (2004) referred to the University of Minnesota as having more students identifying mental disorders as their primary disability (285) than students with learning disabilities and attention deficits combined (269). These results came from the Big Ten survey data of 1997-1998 (Measel, 1998) which investigated the number of students served by disability services in five American universities. The survey data showed an increase of 30% to 100% in the numbers of students with psychiatric disabilities served by campus disability support services depending on the campus.

The population of post-secondary students appeared to be particularly susceptible to depression. In a recent study, Evans, Bira Gastelum, Weiss, & Vanderford (2018) distributed a "survey that included clinically valid scales of depression and anxiety via

social media and direct email" (p. 282). This study of 2,279 graduate students across 26 countries and 234 institutions showed that graduate students were "more than six times as likely to experience depression and anxiety as compared to the regular population" (Evans et. al., 2018, p. 282). The study also found that non-gender conforming students and women experienced greater depression and anxiety than their male peers. Transgender and non-gender conforming students' rates of anxiety and depression were 55% and 57%, respectively and female's rates of anxiety and depression were 43% and 41%, respectively. Rates of anxiety and depression in males were 34% and 35%, respectively. The study also commented on work-life balance. In response to the statement, "I have a good work-life balance", 56% of students with moderate to severe anxiety and 55% of students with depression disagreed with the statement. The researchers were also concerned that 50% of students who experienced anxiety or depression did not feel that they were adequately mentored or provided with ample support by their advisors (49% and 50%, respectively). Evans et al. (2018) concluded their study with a call to action for additional mental health supports for students and cultural change in graduate studies. They recommended that faculty be trained on the impact of graduate studies on student mental health and the importance of work-life balance.

Many colleges and universities across North America have taken part in administering the National College Health Assessment. The National College Health Assessment (NCHA) is a national research survey organized by the American College Health Association (2019) to assist college health service providers, health educators, counsellors, and administrators in collecting data about their students' habits, behaviours,

and perceptions on prevalent health topics. A Canadian version of the NCHA survey was administered in 2017 to the online university where the dissertation research study took place. The subsequent report of the results compiled by Krasowski (2018) shed some light on the mental health needs of students.

The NCHA survey was sent to 1,886 online university students with a response rate of 12% (227 responses) which was slightly lower than the NCHA response rate. The margin of error was 6.1% and, consequently, caution is needed in generalizing these results to the larger population. Survey responses related to mental health concerns in the last 12 months included: 17.5% felt depressed it was difficult to function; 21.8 % felt things were hopeless; 25.8% felt overwhelmed by all you had to do; 25% felt very lonely and 27.7 % felt very sad. Krasowski (2018) found, "There were no significant differences between the responses by gender, or undergraduate and graduate students" (p.15). The survey results also showed that 32.1% of respondents replied that they had been diagnosed with depression at some point compared to 22.2% in the reference group. Gender difference in diagnosis of depression was male 15% and female, 25% which was similar to the reference group.

Students were asked about situations that they found traumatic or difficult to handle. The top four responses included: career-related issues (44.3%); sleep difficulties (42.4%); academics (41.8%); and finances (41.7%). In response to the question, "Have any of the following affected your academic performance?," 33.4% of respondents cited stress, 27.7% cited work, 18.8% cited sleep difficulties, and 18.2 % cited depression. Respondents were also asked about information received from the university and information they would like to receive from the university. A list comparing "received

information" with "interested in receiving information" included: Stress reduction (27.2%/60.4%); depression and anxiety (26.3%/52.7%); and sleep difficulties (8.5%/48%). Although the report communicated the survey results and did not interpret them, it did provide some insight into the struggles of this post-secondary population.

The experience of post-secondary students with mental health disorders also appeared to be somewhat different than that of students with other forms of disabilities, including other students with invisible disabilities such as learning disabilities (Condra, et al., 2015). In a review of the literature on academic accommodations for mental health disabilities in Ontario, Canada, Condra et al. (2015) examined the challenges involved in meeting the needs of these students. The authors stated that between 2006 and 2011, students with Mental Health disorders increased by 67% at colleges and universities in Ontario. Challenges that were identified in accommodating students with mental health disabilities included: increasing numbers of students with mental health disabilities; documentation of a diagnosis that can be temporary versus permanent; determining the nature of functional impairment; stigma; administering retroactive accommodation, faculty understanding of mental health, policy development; and accommodations in fieldwork (Condra et al., 2015, p. 288). Additional discussion about academic accommodations is provided in the next section.

Research involving post-secondary students who experience mental disorders can further be categorized into three main areas: persistence to completion; learning accommodations; and the experience of stigma.

Persistence to completion. Students with disabilities, in general, are less likely to complete their programs than students without disabilities (Kirsh et al., 2016; Koch,

Mamiseishvili & Higgins, 2014). Students with mental disorders are considered to be members of this population. Given the increasing numbers of students with mental disorders and that persons with mental disorders have an increased likelihood of experiencing unemployment with estimates up to 50% for persons with depression (Lerner & Mosher Henke, 2008), finding successful means to complete post-secondary education for these learners takes on even greater importance.

Research has examined the persistence of students with mental disorders in post-secondary programs of study. Koch, Mamiseishvili, and Higgins (2014) utilized descriptive data from the Beginning Postsecondary Students (BPS) longitudinal study out of the United States from 2004-2009 with the goal of building a profile of students with mental disorders. Of the 16,680 students beginning their post-secondary education, 350 students self-identified as having depression or another psychiatric or emotional condition. This number represented 21% of the number of students with disabilities, and 2.1% of the students in the entire data set. Koch, Mamiseishvili, and Higgins (2014) concluded that 77% of students with mental disorders progressed from first to second year. This persistence rate was similar to that of students with disabilities, as an earlier study (Mamisheishvili & Koch, 2011), using the same database, had found that students of all disability types had a persistence rate of 76%. Although the two aforementioned studies did not include comparative data for the entire population of post-secondary students for all years of study, a review of the BPS database (Wine et al., 2006) reported a completion rate of 93% after the first year of study for the entire population of students.

Kirsh et al. (2016) conducted semi-structured interviews with 19 students who self-identified mental health problems attending a large Canadian university. The purpose

of the study was "to understand the range of individual, interpersonal, and environmental factors that affect the lives of university students living with mental health problems (Kirsh et al., 2016, p. 325). A formal diagnosis was not required for students to participate in the study. Constructivist grounded theory methods were used to analyze the participant interviews. The researchers constructed a model of student experience that was influenced by social-ecological theory. The model addressed three interrelated themes of the self, the social, and the school as defining the experience of university students with mental health problems. The theme of "The self: Understanding and managing the illness" included the subthemes of the challenges in recognizing and understanding symptoms of mental illness as well as self-management of mental illness. Self-management included finding activities to divert attention from the illness, reframing their illness as a growth experience, and having some control over their academic lives e.g. course load, scheduling.

The second theme in the Kirsh et al. (2016) study was "The social: The importance of social support, family issues and the impact of stigma." Students valued friends who helped them feel "normal." They provided students with a sense of community. Family relationships were also valued except in instances where cultural beliefs around mental illness or when parents were also in need of support, Students sensed that there was a lack of legitimacy associated with mental illness and, as a result, they were hesitant to disclose mental health issues with others.

Finally, the third theme of the study was "The school: Less than adequate services and a competitive culture with high expectations of coping." Although some students had a positive experience with campus services, most saw them as "less than

adequate, difficult to access, and of variable quality (Kirsh et al. (2016, p. 331)". Participants were also of the opinion that many students didn't know about the mental health services offered at their university. The authors concluded by advocating for a multilevel approach to mental health that would impact the self, the social and the school.

A potential limitation of these studies is the self-reported disclosure of mental disorder and potential underestimation of students who did not identify themselves as having a mental disorder because of stigma or lack of knowledge of academic and other supports for students with mental disorders. The study by Kirsh et al. (2016) was also limited by the lack of a diagnosis or definition of mental disorder in their study. Nevertheless, these studies were encouraging when compared to previous studies that estimated lack of degree completion for students with mental disorders as approaching 86% (Kessler, Foster, Saunders & Stang, 1995)

Kessler et al. (1995) analyzed the effects of pre-existing psychiatric disorders on educational attainment using the National Comorbidity Survey Part I. The National Comorbidity Survey was conducted on a stratified, multistage area probability sample of 15-54 year olds in the United States. The survey had a high response rate of 82.4 % and resulted in 8,098 responses. The study did not include individuals who were institutionalized. Fourteen psychiatric diagnoses were assessed in the survey that used DSM-II-R definitions. These diagnoses included anxiety disorders, mood disorders, substance use disorders, and conduct disorder. "Data on the age at onset of each assessed disorder were combined with information on educational attainment to create a discrete-time survival file in which disorders were treated as time-varying predictors of school termination" (Kessler et al., 1995, p. 1027). The person-year data for all participants was

analyzed using a series of logistic regression equations. Equations were estimated for primary school years, termination during high school years, failure to enter college from high school and failure to complete college. College students with mood disorders, including depression were 2.9 times more likely to fail to complete college ($p<.005$). By the fourth year of college, the probability of students with prior psychiatric disorders failing to continue their education was 86%.

Learning accommodations. Managing life as a student with a mental disorder can be difficult. Living with a mental disorder does not necessarily require academic accommodations; rather, the need arises from how the mental disorder affects student functioning and academic accommodations are determined based on this impact. Accommodations for students with mental disorders do not differ greatly from accommodations for students with other forms of disabilities, although evidence of the effectiveness of such strategies is scarce (Sharpe et al., 2004). Accommodations typically include the following: extra time and/or a non-distracting environment for exams; priority registration; audio recording of lectures; note takers for lectures; modified deadlines for assignments; reduced course load; preferential classroom seating; and early availability of the syllabus and/or textbooks.

Finding effective accommodations for students with mental disorders is a challenge. In a report reviewing services to students with disabilities in Ontario, Condra et al. (2015) discussed the unique nature of mental disorders and accommodations specific to supporting this particular student population. They contended that current models of accommodation in practice in Ontario, Canada were largely inadequate for students with mental disorders due to the assumption of "consistent and continual

accommodations" (p. 279), which they argued were more appropriate for students with sensory or learning disabilities. They noted that students with mental disorders were more likely to experience fluctuating and cyclical appearance of symptoms, often made worse by stress that appeared as a crisis. As such, they recommended that accommodations required an understanding of the specific and often sudden functional impairments caused by the mental disorders. Condra et al. (2015) recommended retroactive accommodations for mental health crises involving missed assignments or exams, noting that few institutions have policies that grant retroactive accommodations.

Belch (2011) reviewed literature on college students with a psychiatric disability and described strategies for inclusion in a chapter entitled, *Understanding the Experiences of Students with Psychiatric Disabilities: A foundation for creating conditions of support and success.* Strategies for success included: educational and environmental initiatives; the availability of support; peer mentoring; student involvement in co-curricular activities; crisis support; and policy and procedures. Specific to policy and procedures, Belch (2011) recommended "flexibility in class attendance policies, leave-of-absence policies, course load levels, and tuition reimbursement policies related to withdrawal" (p. 88) and that these policies be applied consistently.

Stigma. Students with mental disorders may not disclose their disability or register with student disability services due to their expectation or previous experience of stigma. Prevailing attitudes and social stigma surrounding mental illness can reduce help-seeking behaviour. For example, Wynaden et al. (2014) investigated the attitudes of staff and students towards mental health problems at an Australian university. A total of

270 staff completed the Attitude Toward Mental Illness survey. In addition, 201 students, who self-identified as having a mental health problem, completed a Stigma Scale that divided mental health-related stigma into two separate areas: "discrimination (being treated unfairly/differently) and prejudice (stigmatizing attitudes)" (p. 339). Results included that students of all ages felt they had experienced discrimination; older students had experienced the greatest discrimination with more that 69% agreeing that they "felt alone because of their mental health problem" (Wynaden et al., p. 341). The results of the staff attitudes toward mental health survey showed positive responses toward people with mental illness. The staff survey included questions in the following 3 categories: regarding fear and exclusion of people with mental illness; understanding and tolerance of mental illness; and integrating people with mental illness into the community. For example, in response to the statement, "we need to adopt a far more tolerant attitude toward people with mental illness in our society", 92% of staff members agreed. The negative experience of students and the positive attitudes of staff in this study appear to be at odds with one another. A question about this study would be whether staff responses to the survey questions reflected a social desirability bias.

Closer to home, a quantitative study from the University of Lethbridge, Alberta (Hindes & Mather, 2007) looked at attitudes towards inclusion in post-secondary environment for students having sensory, language, motor, or attention-related disabilities or mental illness. Two groups from the university participated in the study: 687 students and 83 professors. Participants completed a short survey on attitudes towards the inclusion of students with disabilities, where inclusion was defined as being included in classes, provided with assistance and provided with accommodations. The study found

that students and professors were less positive towards including students with an attention-related disability or mental disorder in their classes compared to students with other forms of disability. Students with mental disorders and attention-related disabilities were also viewed more negatively in terms of being provided with instructor assistance and accommodations.

Qualitative research has attempted to give a voice to students with mental disorders and their experiences of post-secondary education including how they view faculty and the meaning and goals such education holds for them (Stein, 2014; Weiner, 1999). In a study using grounded theory methodology, Stein (2014) found that faculty members were a key factor in determining whether students chose to disclose that they had a mental disorder. Stein conducted in-depth interviews of 45 to 125 minutes, and 10- to 35-minute follow-up interviews, with 16 undergraduates who were identified through Disability Support Services as having a mental disorder. The interviews focused on participants' experiences with faculty members and their perceptions of how those experiences affected their academic performance. Thematic analysis of the interview data revealed core categories including considerations regarding accommodations and faculty characteristics and behaviours,

Stein (2014) found that faculty behaviour and interactions with students, in general, determined whether or not students disclosed their disability or requested accommodations. Faculty characteristics identified as being helpful included the following: providing accommodations efficiently and confidentially; being available and willing to communicate and teach behaviours; being clear about expectations and explanations of material; and being enthusiastic about the subject matter. Students

suggested that faculty receive training regarding disabilities; that disability/student services and faculty improve their communication with one another; and that accommodations be provided consistently. Caring was also mentioned as an important characteristic of faculty and the classroom; students "operationalized caring with behaviours such as providing encouraging statements, responding to emails and requests for assistance in a timely manner, availability during office hours, and providing accommodations with or without reminders" (Stein, 2014, p. 61).

In an earlier study using grounded theory, Weiner (1999) explored the meaning of education for postsecondary students with mental disorders. Weiner interviewed eight undergraduate students at York University in Toronto, Canada with the aim of exploring the purpose and goals of their academic programs. The conceptual model arising from this study entitled "Shifts and Variations: Integrating Mental Illness and Education," included the integration of two core categories – the university experience (Education/Recovery Continuum) and the illness experience (Identity/Coping Continuum).

The first core category, University Experience, included four main themes: an education/recovery continuum; meaning of education; barriers to learning; and supports to learning. Within the Meaning of Education theme were the subthemes of normalization of students' lives; provision of structure and routine; and a sense of hope.

The second core category of the Illness Experience involved four main themes: the manifestation or effects of mental disorders; the management of the disorder, which included issues of identity over time; the role of stigma; and students' own acceptance and understanding of their disorder. This study offered exploratory steps into the

experience of post-secondary students with mental disorders and provided a glimpse into a multitude of meanings for students.

These two qualitative studies gave meanings to students' experiences, ranging from the experience of stigma to what was experienced as helpful and unhelpful in the post-secondary education context they inhabited.

Post-secondary students with mental disorders and online learning contexts

Although there are few current studies of students with mental health disorders in online educational contexts, some literature and studies exist that look at the experiences of students with disabilities in general in online education contexts (Moisey, 2004; Seale, 2014). These studies, however, did not include a separate gender analysis that might allow a comparison between male and female students with disabilities in online education contexts.

Moisey's (2004) study involved 604 undergraduate students with disabilities enrolled at Athabasca University in the years 1998 to 2001. She described characteristics of students with disabilities including their enrollment patterns, completion rates, and support services received. Students with mental disorders represented 20% of the population studied and included students with depression, anxiety disorders, phobias, and bipolar disorder. Students with a mental disorder had a somewhat lower course completion rate (40.4%) than the average for students with disabilities (45.9%). The course completion rate for students without disabilities was 52.5%. Categories of accessibility and support services available to students included course accommodations, exam accommodations, external support services, and assistive technology. Extended contract time and exam deferral were the most common services received by students, at

68% and 58% respectively. Students with the greatest success in course completion were also the students who received more services. On average, students with mental disorders received the fewest services of all students with disabilities at 1.8 types of services compared to an average of 2.3 services for students with disabilities in general. Students who did not complete any of their courses used an average of 1.0 service. Moisey (2004) concluded that none of the services appeared to "make a significant difference in course completion" (p. 85); however, one form of course accommodation, extended contract-time, appeared to be of some support in assisting students with mental disorders to complete their courses. This finding was consistent with more current research mentioned previously (Belch, 2011; Condra et al., 2015), where extensions on assignments and flexibility in timelines were recommended as suitable accommodations for learners with mental disorders.

McManus, Dryer, and Henning (2018) conducted qualitative content analysis of interviews with 12 post-secondary online learners with mental health disorders to ascertain barriers to learning. Learners were recruited from the university's disability services unit. The type of mental health disorder was not disclosed and most students also had multiple health conditions including sensory and physical disabilities. Barriers identified by students included the impact of the mental health disorder such as impaired cognitive functioning resulting in requests for extensions. Barriers in the areas of personal and situational circumstances included financial strains and limitations of disability pensions, the strain of dealing with co-morbid health disorders, and lack of support from family for their role as students. Barriers in the learning environment involved approximately one-third of the participants having difficulty accessing

accommodations, while others limited their interaction with peers due to feeling intimidated. Still others felt that the lack of an onsite campus interfered with family and friends seeing their student role as legitimate. Conclusions of this study questioned whether online education provided students with mental health disorders with greater flexibility to engage in their studies and highlighted students' experience of isolation and disconnection from the university. Other recommendations spoke to the role of the disabilities support unit and importance of campus wide accommodations rather than individual accommodations. Although this study is closest in population and mental health concerns to my study, difficulties in defining the sample population (multiple unspecified mental health disorders and co-morbid health disorders) as well as the university being both a FTF institution as well as offering online courses makes comparisons with the current study difficult.

Grabinger (2010) addressed the needs of postsecondary students with mental disorders and described a framework for supporting students in online environments. This framework aligned cognitive impairments commonly experienced by this student population including impairments to attention and memory, language processing, executive functioning, problem solving and reasoning, and social functioning with Universal Design for Learning (UDL) strategies. In addition to highlighting the needs of students with mental disorders as a part of a larger and diverse student body, the author suggested supporting faculty to "increase instructional accessibility"(p.106) to all students including those living with mental disorders.

Seale (2014) called attention to the lack of progress in improving access to online education contexts for students with disabilities. She questioned narratives around

accessibility including the use of Universal Design for Learning which, while popular, remains to be thoroughly researched. Seale (2014) also drew attention to missing voices and silences from her earlier work as well as in current research involving students with disabilities. She identified these missing voices as those of stakeholders; more specifically, the voices of students with disabilities. Seale critiqued her own work and that of others working with students for making assumptions about what students need rather that pursuing firsthand accounts or working with students in more participatory forms of research, which she saw as a first step to remedying this exclusion.

From the paucity of writing reflecting postsecondary students with mental disorders, it appeared that these students represented some of the least heard voices in postsecondary education. My study explored the lived experience of a proportion of these students who study in online learning contexts and contributes to the knowledge and literature in this area.

Women in distance learning contexts

Earlier sections of this literature review explored the prevalence and experience of depression for women. This section reviews literature that speaks specifically to women's experience in distance learning contexts. The relevance of this literature to my study is its similarity in terms of population. My study examines the lived experience of women who are distance learners and who, in addition, experienced depression during their studies.

In North America, women make up the majority of both undergraduate students and consumers of online courses, yet "women in online education have the paradoxical experience of being simultaneously invisible – even while they are the core constituency

of distance learning" (Kramarae, 2001, p. 210). Although arguably not the same as invisibility, many women learning in online education contexts appear to value anonymity (Sullivan, 2002). Nevertheless, online learning continues to be a choice for women desiring access to educational opportunities.

Some research has addressed the topic of gender and online education (Anderson & Haddad, 2005; Kramarae, 2001; Sullivan, 2001/2002, Rovai & Baker, 2005). Common threads across this body of research focus on flexibility, accessibility, and anonymity.

In an extensive seminal study, Kramarae (2001) examined gender and post-secondary online education in order to explore the constraints and opportunities of online learning for women. Although this study is dated and distance learning is vastly different than when this study was conducted, Kramarae's (2001) study was the first of its kind. The study utilized focus groups, individual in-depth interviews, and an online survey in that order. Six focus groups that were homogeneous by occupation and included a total of 27 people were conducted. The gender of the people in the focus groups was not available. Individual in-depth interviews were conducted with 64 women and 36 men and included students, administrators, teachers, potential and former students regarding educational goals, experiences, access to technology, and connections with other learners. The interview protocol was designed to capture participant views of educational experiences, the possibilities and difficulties of online education and, in particular, women's concerns. Finally, an online questionnaire available through internet search and the American Association of University Women was completed by 410 respondents; 398 women and 12 men. Participants in total were 534 of which 481 were women. Only the

women's data was used in the study with the exception of a few quotes. The analysis of the data was qualitative and the results were communicated through themes arising from all research methodologies used in the study.

Findings revealed that, overall, the women in this study found that online education allowed them to work around their other responsibilities of work and family by studying at night or in the early morning – a time that was termed as "The Third Shift." In addition to valuing flexibility, the women commented on reduced costs of childcare and transportation as well as increased access for women with disabilities. Cost of education was still a concern, but for many women, online education represented a "last chance" opportunity to meet their academic and personal goals. Students varied in their stated preferences for face-to-face versus online education with some students preferring online education because of the perceived reduction in sexist, ageist, and racist barriers. Some learners mentioned reduced anxiety in online discussions and increased ability to think and respond in asynchronous discussions. In the conclusion, Kramarae (2001) called for further research into time as a gendered concept as it affected women balancing multiple roles.

Kramarae's (2001) study appears to be problematic in its analysis involving male participants. At no point in the study are the results regarding male participants fully explored. A few quotes from male instructors and administrators are included in the study and are used to inform discussion. An ethical issue concerning the study is the overall exclusion of the data of male participants who were invited to take part in the study. Clearer exclusion and inclusion criteria would have improved the study. The face-to-face

interview protocol, however, and online survey questionnaire were thorough and the results were reflected in the themes of the study.

Perhaps partly in response to this call for further research, Glynn, Maclean, Forte, and Cohen (2009) investigated the relationship between role overload and women's mental health. This large cross-Canada telephone survey randomly sampled 716 women. Data were obtained on socio-demographic variables, such as income, marital status and age, as well as role-related variables including role overload, social support, parental quality, marital status quality, job quality, and homemaker quality. The study concluded that "feeling overwhelmed by social role obligations has a greater effect on mental health than have some of the well-known social determinants of mental health, such as income, marital status, and employment" (p.221). The authors called for further research examining the interaction of women's roles.

Conclusion

This chapter reviewed literature associated with the experience of women in post-secondary online learning contexts who have experienced depression. Areas included reviewing literature on depression, determinants of mental health, women and depression, post-secondary student mental health, and women in online education contexts. In addition, I reviewed research studies that employed phenomenological methodologies. Notably absent within the literature, and in my assessment of articles reviewed, are post-secondary students, including women, with mental health disorders who study online. In the next chapter, I review the theoretical foundations of the proposed study including a brief overview of phenomenology, the specific phenomenological approach of Giorgi's (2009) descriptive phenomenology, and Layder's (1997) Theory of Social Domains.

Chapter 3. Theory and Method

Introduction

This study used the descriptive phenomenological psychological method of Amedeo Giorgi (2009) to explore the lived experiences of women who lived with and recovered from depression during their online studies. In addition, I used Layder's Theory of Social Domains (1997) as a sensitizing concept during the analysis phase of the study. This chapter reviews the Husserlian philosophical foundations of Giorgi's descriptive phenomenological method as well as how Giorgi's method is adapted to fit psychology and other disciplines. I also introduce Layder's Theory of Social Domains (1997) as a sensitizing concept and description of social work areas of interest. In addition, this chapter reviews the study's fit within the field of social work.

Phenomenology

Van Manen (1990) described phenomenological research as the study of lived experience which is the study of the lifeworld. According to Husserl, this lifeworld referred to "the common, everyday world into which we are all born and live. It is the life of ordinariness" (as cited in Giorgi, 2009). Dilthey described lived experience as involving "our immediate, pre-reflective consciousness of life: a reflexive or self-given awareness which is, as awareness, unaware of itself" (as cited in Van Manen, 1990). The current study was concerned with lived experience of women of women in online studies who experienced and recovered from depression.

Husserl is considered the founder of the branch of philosophy known as phenomenology. Langdridge (2007) describes Husserl's response to the prevailing positivist methodologies of his time by advancing phenomenology as a way to examine

experience in depth and to find the *essence* of experience in a way that transcended the particulars of that experience. Rather than applying and testing theories as is common in psychological research, Husserl (2001) recommended "going back to the things themselves" (p. 168), the world of ordinary experience,while also attempting to separate out pre-existing, taken-for-granted ideas of the world. The attempt to separate out these taken-for-granted ideas is referred to as *epoche* or bracketing (Langdridge, 2007). Husserl's form of phenomenology is referred to as transcendental, where enacting epoche allows researchers to stand outside of their preconceived notions to view "from above" participants' experiences (Langdridge, 2007). Husserl recommended that researchers bracket out the taken-for-granted world so that they might focus more clearly on the experience being viewed without the screen of pre-conceived beliefs, theories, and constructs. Giorgi (2009) made modifications to Husserl's philosophical phenomenological method to make it more relevant to psychology and referred this modified approach as a Scientific Phenomenological Method (p. 94). What follows is a description of Giorgi's adaptations regarding four main phenomenological concepts including the phenomenological reduction, epoche, eidetics, and transcendental aspects of phenomenology (Shakalis, 2014).

Phenomenological Reduction

Both Husserl and Giorgi acknowledged phenomenological reduction as an important first step in phenomenology. In this step, the researcher breaks away from the *natural attitude* or everyday way of viewing the world. Another term for the natural attitude is the *naïve attitude* where "everyday things, spaces and objects are experienced and accepted as they are" (Shakalis, 2014, p. 12).

Epoche

Epoche refers to the putting aside of, or the bracketing of, all prior knowledge, judgements or theories about the phenomenon being studied. Husserl recommended that all of these considerations, including one's ego, be put out of one's consciousness in order to allow the researcher to understand the phenomenon clearly or *as given* (Shakalis, 2014). He considered the epoche as a separate step from the phenomenological reduction. Giorgi's (2009) approach recommended that the phenomenological reduction occur *with* the epoche, rather than occurring as a completely separate step. He saw bracketing as a way of increasing one's attention to the phenomenon while also realizing that it is impossible to completely enact the epoche. Giorgi (2009) spoke to a shift in attentiveness; "A certain heightening of the present is being called for, not an obliteration of the past" (p. 93).

Eidetics and Free Imaginative Variation

Husserl sought the essence or "eidos" of a phenomenon as a part of transcendental phenomenology. Giorgi departed somewhat from Husserl in viewing the universal essence pursued by philosophy as transcending psychological interests (Shakalis, 2014). Instead, in Giorgi's (2009) methodology, the structure of the phenomenon being experienced and the invariant meanings of that structure are sought. Both Husserl and Giorgi used the method of *free imaginative variation* to uncover the essence or structure of phenomena. Moustakas (1994) described the task of free imaginative variation as seeking "possible meanings through the utilization of imagination, varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives, different positions, roles or functions" (pp. 97-98). The result of

free imaginative variation was the distillation of the data describing the phenomenon into the invariant constituents that make up the structure of the phenomenon; the constituents without which the phenomenon itself would not be what it is (Finlay, 2014).

Transcendental Aspects of Phenomenology

Husserl described our everyday experiencing as taking place in the natural attitude where our lives are lived out in a mostly taken for granted way (Giorgi, 2009). He recommended that researchers break with the natural attitude and take on a transcendental phenomenological perspective meaning the attainment of pure consciousness of a phenomenon. Giorgi (2009) distinguished between the transcendental and the psychological phenomenological reductions observing that the psychological phenomenological reduction is less radical and closer to the level of lived reality than the transcendental phenomenological reduction.

Social Work and Descriptive Phenomenology

As a clinical social worker, it was important to me to find an approach and methodology that would allow me to explore the question of my dissertation research study while also maintaining a person-in-environment view. After looking at various ways to approach the topic of women with depression in online learning contexts, I decided initially to use a phenomenological research approach and, ultimately, to combine descriptive phenomenological research methodology with Layder's (1997) Theory of Social Domains.

My choice of methodology fits within the field of social work practice in that the focus of a phenomenological study describes the lived experience for individuals of a particular phenomenon (Creswell, 2013). This lived experience reflects individuals as

they interact in the world -- as they engage with the specific contexts in which they find themselves. The Canadian Association of Social Workers' Social Work Scope of Practice document (CASW, 2008) states that a basic goal of social work is to facilitate the "social well-being" and "social functioning" of the "person-in-environment." The person-in-environment is described as follows:

> The person-in-environment domain gives social work a common organizing framework and a holistic context for its mission and vision. The global vision of social work is a world consistently working toward social justice and well-being for all citizens. The central mission is to have social workers engaged in activities that will improve social well-being structures and enhance individual, family and community social functioning at local, national and international levels. (CASW, 2008)

The choice of phenomenology as a means to investigate the experience of women with depression in post-secondary online learning contexts fits within the '"person-in-environment" concerns of social work. Layder's Theory of Social Domains provides a visual model reflecting the main concerns of social work as a profession and discipline.

Layder's Theory of Social Domains

My study utilized Layder's Theory of Social Domains as a *sensitizing concept* to reference during the analysis of participant transcripts. Bowen (2006) referred to the early work of Blumer (1954) to explain the difference between a definitive concept and a sensitizing concept in the excerpt below.

> A definitive concept refers precisely to what is common to a class of objects, by the aid of a clear definition in terms of attributes or fixed bench marks. A sensitizing concept lacks such specification of attributes or bench marks and consequently it does not enable the user to move directly to the instance and its relevant content. Instead, it gives the user a general sense of reference and guidance in approaching empirical instances. Whereas definitive concepts provide prescriptions of what to see, sensitizing concepts merely suggest directions along which to look. (Bowen, 2006)

The term, sensitizing concept, is used in qualitative research studies including grounded theory studies (Bowen, 2006). There is a good fit for use of Layder's Theory of Social Domains during the analysis of participant interview transcripts as a model of social work disciplinary concerns. As a sociological theory, Layder's (1997) Theory of Social Domains broadened the idea of human context and larger social relations that help shape human meaning. Houston and Mullan-Jenson (2011) referred to combining phenomenology with the sociological theory of Social Domains as providing qualitative inquiry with "ontological depth and width" (p. 266). From a social work viewpoint Layder's (1997) theory allowed participant descriptions to be viewed from several levels of analysis or domains.

Layder's Theory of Social Domains (1997) refers to four domains that are distinct from one another while also being mutually dependent. These domains include psychobiography, situated activity, social settings, and contextual resources. Each domain is described below.

The domain of psychobiography represents a person's unique experiences throughout the lifespan including critical life events and their meaning, the impact of significant and formative relationships, and, in general, the person's perspective of the world. The second domain of Layder's theory refers to situated activity – the domain of everyday social activities and interaction with others. This domain encompasses a person's encounters with others and how these encounters inform self-identity and meaning. Here we see how the meaning making of a person is understood only in the context within which it occurs. The third social domain is that of social settings representing all of the social environments where situated activities occur. Social settings may be work settings or educational settings, as in the current study, or may be as informal as friendship groups and families. These are the places of social rituals and practices both past and present.

Layder's final social domain reflects the contextual resources or macro contexts of a person's life. This domain includes two main aspects of contextual resources. The first aspect refers to the allocation and distribution of societal resources depending on social categories. Societal resources refer to items like capital, money or credit. Social categories may include gender, class, or ethnicity. The second aspect includes a historical view of how cultural resources can be used as socializing agents.

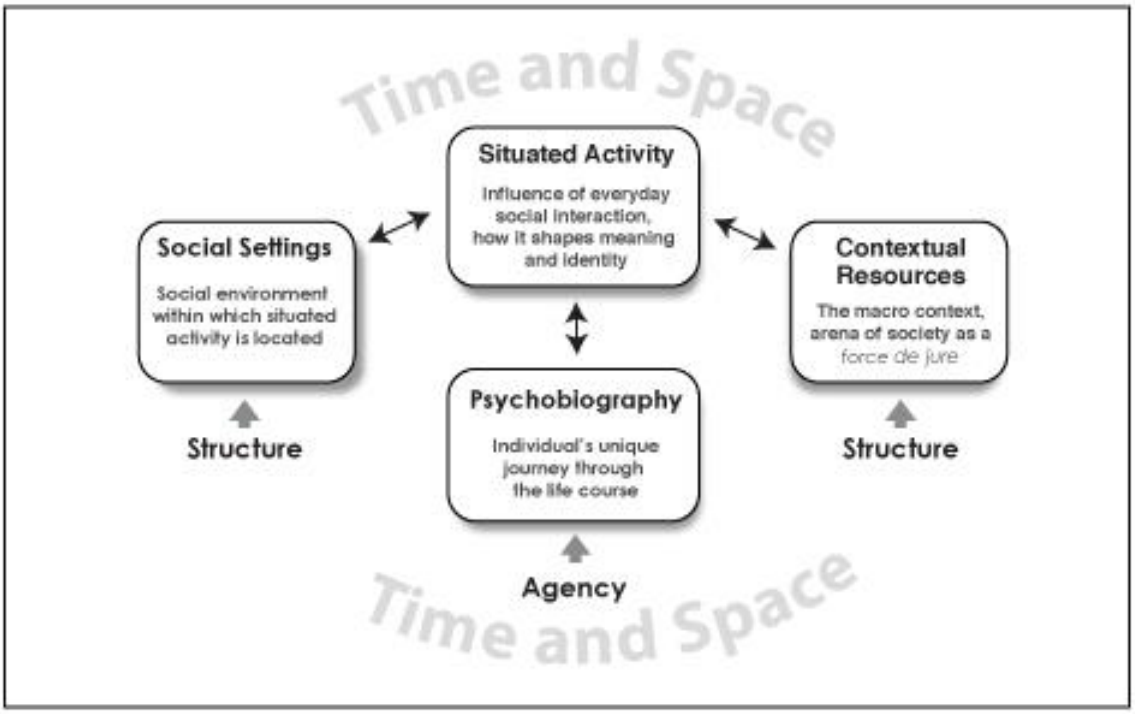


Figure 2. Model of Layder's Theory of Social Domains.

Adapted from "Towards depth and width in Qualitative Social Work: Aligning interpretative phenomenological analysis with the theory of social domains," by S. Houston and C. Mullan-Jensen, 2011, *Qualitative Social Work,* 11(3), p. 271. Copyright 2011 by SAGE Publications Inc.

Layder's model also emphasizes relations of power in that each of the four domains can be seen to be influenced by a different form of power. Layder (1994) defined power as "the capability of producing an effect. It is the ability to make a difference in and on the social world, of transforming (to some degree) the circumstances in which one finds oneself, that is perhaps the essential feature of human action" (p. 137).

Forms of power can be individual, inter-subjective, or systemic; they exist within and between domains where individual and situated activity are found. As shown in

Figure 2, domains are spread across time and space, which speaks to the historicity of existence where historical events and, perhaps, future events shape meaning in similar ways as social environments and place.

Layder's work has been referred to as "phenomenological sociology" (Houston & Mullan-Jensen, 2011). From a social work perspective, Layder's model is a visual representation of the concerns of social work as a discipline. His theory of Social Domains recognizes the person-in-society or person-in-context viewpoint which functions as a conceptual bridge between phenomenology and Layder's Theory of Social Domains. Using Layder's Theory of Social Domains as a sensitizing concept supported the analysis of this study and maintained the disciplinary concerns of social work.

Summary

This chapter reviewed the theoretical underpinnings of my dissertation research study including the influence of Husserl's Transcendental Phenomenological method based in philosophy and Giorgi's Descriptive Phenomenological method. I compared Husserl's approach with modifications made by Giorgi in the areas of the phenomenological reduction, epoche, eidetics, and transcendence. I discussed the fit between phenomenology and social work research, and introduced Layder's Theory of Social Domains as a sensitizing concept used during data analysis as the exemplification of social work disciplinary concerns.

Chapter 4. Methodology

Introduction

This chapter outlines the methodological choices for my study including the research design, rationale for the choice of participants, sampling, method of analysis, quality and validity, limitations and delimitations, the role of the researcher, and ethical considerations.

Research Design

The descriptive phenomenological method of Amedeo Giorgi (2000, 2009, 2012), as described in the previous chapter, was the qualitative research methodology used in this study. The phenomenon I explored using Giorgi's methodology was the lived experience of women who lived with and recovered from depression during their online studies. The research question was, "What are the lived experiences of women online learners who lived with and recovered from depression?"

Participants

A purposive sample was obtained that included 11 women who lived with and recovered from depression while studying in a post-secondary online learning context. The sample included 7 undergraduate students and 4 graduate students from a variety of academic programs.

Inclusion criteria were the following:

1. Participants were women who were post-secondary students enrolled at the time of the study in a degree granting program at a Canadian online university.

2. Participants had completed a minimum of three courses in their program of study.
3. Participants had experienced depression at some point during their online post-secondary studies and had been diagnosed with depression by a health professional.
4. Participants had recovered from depression prior to being interviewed.

Exclusion criteria were the following:

1. Participants were not student peer members of my doctoral cohort.

Recruitment

Students were recruited from degree granting programs at a Canadian online university. Research participants were invited to participate through the university's administrative messaging site available to all registered students attending the online university (see appendix D) The university's Access to Students with Disabilities department was not involved in the recruitment process. Within one month of posting the advertisement for participation in the research, 35 requests to participate were received. The first eleven participants who completed and returned their informed consent forms took part in the study. The informed consent included: the voluntary nature of the study and the right of participants to withdraw their consent to participate; the right to stop the interview at any point; or to request that a certain comment or discussion not be included in the transcript or used in the analysis.

Data Collection

Demographic information collected for the study included age, discipline, program of study, number of courses enrolled in, and total courses completed as an online

learner. I also asked participants if their program included a cohort component. The raw data for this study was the "naïve description" of the experience of depression in the context of online learning from the study's participants in their own words. Each woman who agreed to be a part of the study was interviewed once by phone. Interviews were approximately 40 minutes in length and were audio recorded using a high quality microphone. A backup recording was produced using a micro voice recorder.

The interview was a semi-structured interview geared towards eliciting, as thoroughly as possible, the participants' experiences with the phenomenon being studied. Phenomenological interviews, as reflected in their minimal structure, can be referred to as conversations. Conversations are participant driven and meant to increase the comfort of the participant and rapport between the researcher and participant.

Prior to conducting most of the interviews with research participants, I took the time to practice 10 minutes of mindfulness meditation. I did this in order to assist me in moving from my own daily concerns to a focus on the conversation I was about to have with participants. Interviews began with a final review and discussion of the Screening Checklist for Depression (see Appendix D) to ensure that participants were not experiencing depression at the time of the interview. Demographic information was then collected and we often engaged in general conversation which included anything from parenting and summer weather to dogs barking in the background. When the conversation felt comfortable, participants were encouraged to elaborate on what was meaningful to them in response to the interview question. I redirected only when the conversation appeared to be moving far off of the topic of the research. The main question asked of all participants was the following: *In as much detail as possible, could*

you tell me about a time when you experienced depression while you were studying online?

This general question was meant to be open-ended and invited participants to consider a wide range of possibilities to describe their experience. As the researcher and interviewer, my role was to note areas where the participant might have more to say or where the conversation seemed to transition away from the topic (Broome, 2011). Once the participants completed their description, I used follow up questions from the noted areas using questions such as "you spoke about such and such, can you tell me more about that?" (Giorgi & Giorgi, 2003). This is a type of question used frequently in interviewing to help participants relate their experiences as fully as possible in areas that may have been underexplored. As a clinical social worker, I was used to assisting individuals in elaborating their experience without imposing my own ideas or using leading questions. Our conversation ended when it appeared that reflections on the research question were exhausted. At the end of each interview I also asked, "Is there anything else you can think of regarding your experience of depression as an online learner?" I followed up with two participants by email to confirm some of the demographic information for the study.

Data Analysis

The interview data from participant interviews yielded 102 single spaced pages of transcripts. I transcribed all recorded participant interviews and removed identifying information to ensure participant confidentiality. The transcripts were partly de-naturalized by the removal of speech sounds like "um" and "ah". Participants were asked if they would like to choose a pseudonym, otherwise one was assigned. Assigned

pseudonyms were chosen by accessing popular baby names for the year of the participant's birth and choosing a name from those lists.

Member checking was used in the study. Participants were asked if they wanted an opportunity to review the transcript of their interview. Five of the participants were sent their transcripts and one response was received from a participant confirming the transcript to be accurate.

Data analysis began once transcriptions of the natural or naïve descriptions of participants' experience of the phenomenon were complete. I began data analysis by assuming the phenomenological attitude, a disciplinary perspective (social work), and sensitivity to any implications of the data for the phenomenon being studied (Giorgi, 2009, p.128). To assist me in this task, I practiced mindfulness meditation for ten minutes prior to engaging with the data using a meditation timer app on my phone. I also engaged in reflexive journaling after working with each participant's transcript. The disciplinary lens of social work reflected in Layder's theory of social domains included considering, among other things: recognition of each participant's unique journey; that everyday social interaction shapes identity and meaning; that online learning is a social setting for situated activity; and that personal agency is a part of experience.

Giorgi's research methodology, as summarized in Shakalis (2014) outlines several procedural steps as follows:

1. Interview data is transcribed into text.
2. Transcribed descriptions of the phenomenon are read, and re-read, for a sense of the whole. Giorgi (2009) emphasized that although this step is familiar to most qualitative methodologies, in Giorgi's descriptive phenomenological method the

researcher's assumption of the phenomenological attitude allows the researcher to begin to be aware of the participant's intentional objects in their description of the phenomenon.

3. Meaning units are determined. In this part of the analysis the researcher engages in a closer reading of the transcript, paying attention to shifts of meaning from one part of the text to another. Participant shifts of meaning apparent to the research are marked in the transcript by a symbol such as a backslash "/".
4. Once again, the researcher returns to the beginning of the transcript which is shown with demarcated meaning units. Every meaning unit is then interrogated from a disciplinary attitude in order to express the social work implications of the participant's description. This process results in second order descriptions that are invariant meanings; the "structures that have the strength of facts" (Georgi, 2009, p. 131). It is within this step of analysis that the phenomenological procedure of free imaginative variation is used in order to achieve a level of invariant meaning out of possible variations. In free imaginative variation, the researcher changes aspects of the phenomenon within the phenomenologically disciplinary attitude in order to distinguish the essential features of the phenomenon without which "the phenomenon could not present itself as it is" (Finlay, 2008, p.7). Giorgi (2007) defined the meaning of imaginative variation as a process in which:

   …one imaginatively varies different aspects of the phenomenon to which one is present in order to determine which aspects are essential to the appearance of the phenomenon and which are contingent. If the imaginative elimination of an

> aspect causes the phenomenon to collapse, then that aspect is essential. If, on the other hand, the variation of an aspect of the given hardly changes what is presented, then that aspect is not essential. (p. 64)
>
> It is also within this discipline specific transformation that the researcher attempts to generalize the data and identify general structures across participant descriptions. This process is repeated for every meaning unit until all meaning units have been transformed.

5. The final step of the analysis involves creating a synthesis of the general social work structure from the constituents of the experience (Broome, 2011; Shakalis, 2014).

I used NVIVO 12 Plus qualitative data software in the analysis of the interview data. Giorgi recommended that the first transformation of interview transcripts include changing the data from first to third person. His reasoning for this first transformation was to assist researchers in avoiding over-identification with their research participants. To accomplish this I performed the first transformation of meaning units prior to uploading the interview data to NVIVO. The transformed interview data were then uploaded to NVIVO.

NVIVO software does not allow for interview data to be viewed horizontally on a computer screen, which would be typical of descriptive phenomenological data analysis where a researcher may make two, three, or more transformations of meaning units while viewing the data from both a phenomenological and disciplinary attitude. Uploading participant interviews having completed the first transformation of meaning units allowed

me to perform the second and third transformations of these units while also being able to view them vertically on a single screen.

Once the final transformations of the interview data were complete, I used NVIVO to establish the similarity of final transformations across individual interviews by assigning codes. I then used imaginative variation (described earlier) to determine which of the codes were essential to women's experience of studying online while they were depressed and recovering from depression. In addition to using NVIVO, I created a chart in Microsoft Word which displayed the codes and a horizontal display of participants' final transformations of meaning units so that I could review the codes with each participant's meaning units at the same time. Using this chart, I once again used imaginative variation. The final codes I chose represented the invariable constituents of the experience of women online learners who had experienced and recovered from depression.

In addition to using NVIVO for the interview data, the memo function of the software allowed me to keep a reflexive journal for each participant and attach it to the specific woman's data file. I used these journals throughout the analysis of the data. In addition to establishing the journals for each participant, I established a personal journal outside of the software to record my own research journey, personal reactions, and research decisions. I also used the women's first transformation data to create individual word clouds.

Trustworthiness

The concept of trustworthiness was introduced by Guba and Lincoln (1986) to address threats to rigour in qualitative research. The authors posited that four concepts

including credibility, transferability, auditability (also known as dependability), and confirmability work together to achieve trustworthiness (Guba & Lincoln, 1986). These four concepts were considered to be analogs for the quantitative research equivalents of internal validity, external validity, reliability and objectivity (Leitz & Zayas, 2010; Csiernik & Birnbaum, 2017). I chose to use Guba and Lincoln's (1986) concept of trustworthiness because of its longstanding use in evaluating qualitative research. As Whittemore, Chase, and Mandle (2001) state, Lincoln and Guba's (1986) criteria is the "gold standard" with "staying power" (p. 527).

Credibility refers to how closely a study's findings represent the meanings of research participants (Guba & Lincoln, 1985; Leitz & Zayas, 2010). Achieving credibility involves staying close to participant's meanings as well as managing potential researcher reactivity and bias (Leitz & Zayas, 2010). Techniques I used to address these concerns include: prolonged engagement with and commitment to research participants; using semi-structured interview format to support expression of participants' voices; member checking; and reflexive journaling. My commitment as a researcher was to interview each participant a maximum of two times. One interview was conducted with each participant although I followed up with two participants by email to confirm demographic information. Continued engagement with participants also involved the opportunity for participants to review their interview transcripts and the provision of a website where participants will be able to anonymously access the study's outcomes and any publications arising from the study. In addition, I engaged in reflexive journaling and the use of meditation as a means to review and bracket my own potential biases and

preconceptions congruent with a descriptive, phenomenological approach, preparing myself to hear participants' views of their experiences more clearly and attentively.

Transferability refers to the findings of the research and whether they are useful in informing theory, practice, or future research (Lincoln & Guba, 1985). Thick, rich descriptions of participants' experiences are desirable in qualitative studies as they allow readers to decide whether the results of the study may be applicable to other settings. My role as a researcher was to provide thick, rich descriptions of participants' experience as well as to adequately describe the context from which these descriptions emerge. Transferability was reflected in this study by setting the context of the study in the description of sampling procedures as well as through thorough descriptions of individual participants' experiences.

The concept of dependability involves the clarity with which the research process is presented (Csiernik & Birnbaum, 2017). Lincoln and Guba (1985) originally described this concept as auditability. I addressed the concept of dependability in the study by keeping an audit trail of the research process including journaling the process of decisions made involving interviewing, transcription, analysis and the final description of the invariant structure underlying participants' experiences.

Lietz and Zayas (2010) referred to confirmability as "the ability of others to confirm or corroborate the findings" (p. 197). Confirmability is reflected in how well the themes and the invariable structure of the participants' experiences are supported in the presentation of the study. Techniques I used to address the concept of confirmability included the provision of ample participant quotes and examples to support the themes and structures arising from the interview data (Csiernik & Birnbaum, 2017). I also

endeavored to clearly align these themes and structures with participant examples so that these linkages are clear to readers of the study.

Role of the Researcher

The role of the researcher within descriptive phenomenological analysis involves working with participants to produce rich descriptions of their experience of a phenomenon. This involves assuming the phenomenological attitude and rendering as un-influential as possible, the researcher's own preconceptions and history. Consistent with descriptive phenomenological methodology, such a stance by the researcher allows the experience of the phenomenon to be heard and described more fully.

The qualitative researcher's perspective is perhaps a paradoxical one; it is to be acutely tuned-in to the experiences and meaning systems of others-to indwell- and at the same time to be aware of how one's own biases and preconceptions may be influencing what one is trying to understand (Maykut & Morehouse, 1994, p. 123).

As a researcher who has experienced the phenomenon I investigated, it was important to consider this personal history in terms of my positioning as a researcher. Phenomenology as a research methodology reflects a postmodernist stance in that the context of the researcher must be understood in addition to that of the participants. A researcher can be viewed as being an insider or outsider in terms of the topic and experience of the research being conducted. Debate around having an insider or outsider status as a qualitative researcher has tended to take on a dichotomous perspective (Corbin, Dwyer, & Buckle, 2009). Being an insider or outsider researcher involves both advantages and disadvantages to the research process. An insider researcher, for example, might experience an increased level of trust and acceptance from participants

however the same researcher might also experience questions about subjectivity and ability to separate from the experiences of participants (Corbin, Dwyer, & Buckle, 2009). Corbin, Dwyer and Buckle (2009) invite researchers to consider "the space in-between"; the place of the hyphen where researchers manage the tensions between the roles of researcher and researched.

As qualitative researchers we are never truly separate from our participants. We engage, interview and listen to participants as well as sit with their stories in transcription form. So, rather than being insider or outsider, we are more likely to find ourselves somewhere in-between. In the spirit of "in-between," my aim was to articulate my role as a researcher including how I managed the tensions of "insider-outsider."

As a female researcher who experienced depression during my online studies, I identified my status as a researcher as one of being an insider. I shared this status briefly with participants in the description of the study. As an insider, it was essential that I participated in reflexive practices including ongoing journaling to assist me in bracketing my own experiences as much as possible. I documented my own experience as an online learner with depression as a means of ensuring clarity between my insider view and that of the study's participants. I share this experience below. Also, in adhering to the methodology of this study, I was diligent in assuming the phenomenological attitude throughout the study prior to interviewing and throughout analysis.

Personal Lens

Phenomenology allows for, and encourages, researchers to position themselves personally in the research process, particularly in a way that allows them to separate their own experiences and biases from the experiences of research participants. To that end, I

share my own experience as a woman in online learning who has lived with and recovered from depression.

My own experience with depression occurred during my third year of study towards my Doctorate of Education in Distance Education program at Athabasca University. The experience was both a devastating surprise and, potentially, a gift in understanding women with depression studying in post-secondary online learning contexts. A combination of events in my own life led to this experience. Over a short period of time my eldest child experienced a first psychotic episode and subsequent diagnosis of schizophrenia. Soon after this event, my position as a counsellor with the school board I worked for was eliminated and I was placed in another community as a grade three teacher after having worked as a clinical social worker for decades. I recall one day specifically when I was monitoring the crosswalk in my reflective orange vest, holding a red stop sign, and thinking "What has happened to my life?" The combination of these events overwhelmed me and I was subsequently treated for a depressive episode that lasted several months. I was unable to sleep, cried continuously, and suffered from panic attacks where I was convinced that I was going to die. My sense of self-worth was crushed and I felt unable at times to leave my home except to visit my doctor or counsellor. I was placed on sick leave and was prescribed medication for depression and sleep. It took three months for me to struggle back from this place, and another seven months before I was able to sleep without medication.

As I reflect on this time in my life, I am amazed that I was able to continue my studies. Choosing an online learning program was a deliberate choice on my part as I worked full-time, had barely adult children to support, and worked and lived in a rural

community. Studying by online learning allowed me to pursue a doctorate that was previously impossible due to the demands of my work, family, and geographic location. Continuing to pursue my online coursework while in the depths of depression was exceedingly difficult. I went back and forth between continuing or dropping out of the program. I had problems retaining information from what I read, taking many more times as normal for me to review material. Writing assignments was exhausting as my thinking was abnormally scattered, and I was slow to bring concepts together in an understandable way. I managed to complete the course that semester, but without the quality that I normally expect of myself. When I look back, I am glad that I was able to complete the semester at all.

On reflection, I have tried to consider what it was about the online learning context that helped or hindered me in completing my studies at that time. I continue to come back to the flexibility of the format where I was able to complete my work in manageable chunks when I was able. Even when I felt unable to leave my home, I could still study and attend virtual classes; I often felt not fully present, experiencing high levels of anxiety, fatigue, and difficulty concentrating. In addition, the cohort-based model of my doctoral program provided me with the ongoing support of a few close classmates who encouraged me not to give up. As a cohort, we took all of our courses together and met online regularly (both inside and outside of classes) to support one another through the doctoral program. I felt valued as a member of our cohort and felt a sense of responsibility to these colleagues and friends. Rather than being isolated by the online learning modality, I felt supported.

My own experiences were like the experiences of the women in my study in some ways and dissimilar in others. By way of reflexive journaling, I endeavoured to make my own experience and thinking processes visible so that I was better able to hear the stories of the women I interviewed. This preparatory step allowed me to investigate, with greater clarity, the experiences of women in online learning who have lived with depression.

Ethical Considerations

Ethical considerations for this study involved issues of consent, confidentiality, and the potential for harm. All participants received a description of the study and were asked to sign a letter of informed consent (Appendix C). The letter of informed consent included my contact information and that of my research supervisor, details about involvement in the study, assurances of confidentiality, and an acknowledgement that participants might withdraw from the study at any time without consequence or penalty. The proposal was submitted to the Research Ethics Board of a Canadian online University along with a copy of the letter of informed consent and a copy of the participant advertisement for the university's Facebook and Administrative Message Centre (Appendix B). In the end, only the Administrative Message Centre was used for recruitment of study participants. Collection of data did not occur until the proposed study had received full approval from the Research Ethics Board. The Research Ethics Boards evaluated my research proposal based on the 2nd edition of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2014). Confidentiality was maintained by assigning pseudonyms to participants to protect their identity. Place names were also changed.

Ethical considerations also involve evaluating potential harm to participants. This research study explored participants' experience of depression while studying in online learning contexts. People experiencing mental disorders are considered to be a vulnerable population, in which case a researcher must take steps to ensure the safety of research participants and to minimize harm. Participants in the study were recruited having experienced *and recovered from* a Major Depressive Episode during their time as online students. As an extra measure, women were asked to review a Screening Checklist for Major Depressive Episode (Appendix D) and review this checklist with the researcher in order to rule out any current experience of depression. It is also incumbent on the researcher to ensure that participants have the choice *not* to broach subjects if that is their desire.

Having practiced as a clinical social worker for several decades, I felt well positioned to monitor participants' level of distress during the interview process and to assist participants to access mental health supports in case a mental health crisis arose. I had referral contact information available if participants wanted to avail themselves of the counselling services offered through their university. At no time did any of the participants appear to experience undue levels of distress nor did anyone require a referral for mental health concerns or supports.

Summary

This chapter outlined the research methodology for the proposed study. Description of research participants, methods of data collection and analysis, issues of trustworthiness, and limitations and delimitations were reviewed. Finally, the role of the researcher in the study and ethical obligations were addressed.

Chapter 5. Results

This chapter describes the variety of online learning in which study participants engaged. Modes of online study varied according to program and particularly differed between undergraduate and graduate programs. It is followed by individual descriptions of the 11 women who agreed to share their experiences of depression while studying online.

In this chapter, I departed from Giorgi's (2009) methodology by describing women's individual experiences. It was important to me to recognize the individual participants of this study -- their unique lives as individuals, as students, and as women who had experienced depression and found creative means to manage it. Therefore I present here the profiles of individual women using the final transformations of meaning units from their interview transcripts. After these individual descriptions, I present the general description of women in online learning who have lived with and recovered from depression and discuss the invariant constituents and sub-constituents of the experience.

Studying Online

Participants in this study participated in a range of online learning activities depending on their programs of study and whether they were in an undergraduate or graduate program. All participants' courses had their own site on the university's Moodle learning management system. Undergraduate courses were typically self-paced with a 6-month window for completion. What this meant is that the students in self-paced courses could complete their course requirements at any time as long as they were completed by the 6-month deadline. With a few exceptions, undergraduate courses were primarily self-study with students having access to a tutor or bank of tutors as well as a

designated instructor in the event that they ran into difficulties with content or had questions.

Graduate courses were paced, following four-month semesters. Students were required to post weekly or more frequently to online discussion groups as well as sometimes to manage or co-manage a discussion forum. Many courses also involved group work. Several graduate programs and one undergraduate program required students to meet face-to-face (FTF) for a week-long course. One undergraduate and one graduate program also involved practicums where students worked in their chosen field, but not necessarily with peers from their program. Table 2 describes the individual participants who participated in the study using pseudonyms to protect their identity.

In the table below, I list the participants' ages, whether they were undergraduate or graduate students, and the type of peer interaction in their courses. There were 11 students, in total, who experienced and recovered from depression. One student, Sofia, suffered from panic attacks and was not included in the study's participant numbers. Her individual experience, however, is provided in the following section of the study. The average age of undergraduate students was 32 years while the average of graduate students was 36.7 years.

Table 2

Participation Information

Pseudonym	Age (years)	Grad/Undergrad	Type of Peer Interaction in Courses
Juliena	51	Undergraduate	None
Amanda	29	Undergraduate	None
Elisabeth	33	Undergraduate	None
Jasmine	28	Undergraduate	None
Virginia	26	Undergraduate	Occasional online posting
Brooklyn	27	Undergraduate	Occasional one-way online posting
Katie	34	Undergraduate	Online posting, FTF & Practicum
Megan	33	Graduate	Online posting, FTF & Practicum
Emily	26	Graduate	Online posting, FTF & Practicum
Justine	51	Graduate	Online posting, group assignments
Sofia	44	Graduate	Online posting, group assignments

Individual Descriptions

A description of each participant's responses to the question, "Can you tell me about a time when you experienced depression as an online learner?' was created using the final transformations of each woman's interview and related quotes from their original transcript. Preceding each individual description is a word cloud that was produced within NVIVO using the most frequent 100 words from participants' interview transcripts (first transformation). The most frequent words are reflected in the largest and boldest font. I've included word clouds as creative means to visually reflect the uniqueness of each woman's words and the patterns of these words.

Undergraduate students.

Juliena. What stood out to me in my interview with Juliena was her self-awareness of what she needed to manage depression. She brought a great deal of skill to her experience; balancing rest with exercise and practicing self-advocacy. Juliena had a long history of living with depression beginning in her early 20s; losing up to two years at one time to a depressive episode. She tried several medications over the years but described herself as quite stable on a particular medication for the last 20 years. Juliena's experiences with depression resulted in her learning to manage herself quite carefully. Managing depression meant allowing time for adequate rest, being able to say 'no' to others when needing rest, being aware of a tendency to perfectionism, and running regularly. Juliena's most recent experience of depression while studying online occurred after her position with the company she worked for was eliminated.

Juliena began to notice that she was sleeping a lot. She had difficulty getting up the energy to shower or take her dog out for a walk. Even though Juliena used her strategies of getting course materials early and chunking material into smaller parts, she found that she couldn't concentrate on what she was reading. Juliena carried her reading

with her in case she had moments where she was able to focus. During this time she accepted a position in her field with a company whose values resonated with her own.

Juliena functioned well in her new position but went home exhausted. She gave herself a month to adjust to her new position before returning to her studies but when she returned, she was still unable to concentrate or to pull her thoughts together enough to write well. Usually a high achiever, Juliena struggled and handed in assignments without all criteria for the assignments being fully met. She negotiated with her new employer to temporarily change her schedule allowing consecutive days off in order to finish assignments. She also negotiated her schedule to accommodate her running. Self-advocacy was essential for Juliena to keep healthy and avoid deepening the experience of depression.

Juliena paid for course extensions and, with the support of an employer who valued her as an employee, successfully completed her course. Extensions were an important part of Juliena's success in managing depression while learning online as was the ability to study from home. She felt that her lack of energy would make attending a FTF institution unlikely and contribute to exhaustion.

Amanda. Amanda was an undergraduate student with a history of depression that began during adolescence. She credited her husband with identifying the depressive symptoms associated with her most recent depressive episode during her online studies. Amanda's experience of depression began in response to a single course in her program where she struggled and eventually failed. She attempted and failed the same course a second time. This course became a barrier to Amanda completing her degree. She began to see herself as a *useless* and *worthless person*, unable to achieve her goal of obtaining her degree. Amanda's self-appraisal of being useless and worthless persisted throughout her depressive episode.

When Amanda began her studies, she was working full-time as well as taking two online courses. After a year of studying, Amanda quit her job in order to study full-time and complete her degree. She discovered that her workplace had provided her with many opportunities to socialize with others. Moving to full-time studies resulted in Amanda feeling alone. Her courses didn't require interaction among students and Amanda missed having access to the perspectives of her peers. In addition, Amanda's courses had

multiple tutors which she felt made it difficult for her to develop a close relationship with staff persons associated with her program.

Amanda took a nine-month break from her program when she and her husband moved from Canada to the United States. With the encouragement of her mother-in-law, Amanda investigated an option of transferring to a different program at the same university and was able to transfer almost all of her courses to a program which met her needs without the course that she had failed. Once Amanda was registered in her new degree program, she was able to take advantage of the rolling enrollment for undergraduate courses at her university and get back into classes quickly. Amanda will soon complete her degree.

Elisabeth. Elisabeth was an undergraduate student. She already had a Bachelor of Sociology from face-to-face studies at another university. Elisabeth described a complex history of depression dating back to adolescence as well having grown up in a home where there was violence. School became a safe place for Elisabeth and a place of success that gave her an alternative experience from home where her father routinely put

her down including referring to her as ‘dumb’. School confirmed for Elisabeth that she was, in fact, a smart person.

Prior to Elisabeth’s most recent experience of depression, she was working fulltime as well as studying. Elisabeth identified the trigger for this episode as being turned down for a position at work that she had applied for. This episode occurred during Elizabeth’s online studies and was the worst episode of depression she could recall. Elisabeth spoke about a spiral into depression including physical symptoms of feeling achy, oversleeping and psychomotor retardation as well as feelings of inferiority and suicidal ideation. She also experienced post-trauma-like symptoms of expecting to be hit from behind by co-workers or her partner. Elisabeth was diagnosed with major depressive disorder co-morbid with cannabis dependence disorder. She took a six-month leave of absence and was treated with both medication and counselling.

Within this leave of absence, Elizabeth successfully quit cannabis use, worked with a counsellor and was prescribed an anti-depressant medication. She saw the medication she was prescribed as providing enough energy to be able to engage in counselling and the steps needed to return to her ‘self’ as a student and partner. Elizabeth was able to start to structure her life again to accommodate her studies. Eventually Elizabeth quit her fulltime job in order to focus on school.

Elizabeth’s online undergraduate courses did not include peer interaction. They were essentially self-study courses. On the rare occasion when she was asked to respond to a post, the postings she responded to could be from students who took the course a few years prior to hers. Elizabeth mentioned missing having a connection to other online learners. However, she credited the extensions available through her university as

allowing her to return to being successful academically as well as providing her with a way of having the time to engage in her studies when she was feeling well enough.

Jasmine. Jasmine experienced depression as paralysis. At the time of our interview Jasmine was planning a return to a FTF university. She attributed her most recent episode of depression during her online studies to her experience with studying online. Jasmine made the choice to study online to avoid making the long commute from her parents' home to a FTF university in a nearby city. In the beginning of her studies Jasmine experienced success. At that time Jasmine was not working and focused her efforts solely on her studies.

Jasmine described several challenges that contributed to her experience of depression while studying online: the invisibility of her online study and institution to her family and workplace; the absence of peers; and perfectionism that was made worse by the lack of peers. As Jasmine began studying at home, she soon faced pressure from family to find employment and take on, first, part-time and then, fulltime employment. Jasmine was also expected to take on more of the household responsibilities including child-minding for her older sister who would regularly drop off her children with

Jasmine. While Jasmine became increasingly exhausted, her family and workplace saw her as having a lot of free time. Jasmine found that she was unable to manage her expectations of herself and other people's expectations of her. She quit activities she once enjoyed, some of which involved the reason Jasmine chose to pursue her studies, and became increasingly tired and depressed.

In addition to fatigue, Jasmine began to avoid being evaluated in her studies. When she got to a point in her studies where there was a quiz or an assignment to be handed in, Jasmine would skip the quiz or not hand in the assignment. She developed a fear of failing and of being judged or negatively evaluated. Eventually, and at the height of her depression, Jasmine was unable to pick up her books at all.

In our interview, Jasmine discussed how the isolation she experienced during her online learning and absence of peers contributed to her experience of depression and sense of paralysis. Jasmine's program did not include peer interaction. When Jasmine came to a challenging part of her studies, she wondered if other students were feeling the same way. With no reflection of her experience through peers, Jasmine began to compare herself to a non-existent and perfect peer against whom she could never measure up. She judged herself harshly. For Jasmine, extensions were not helpful as she remained 'paralyzed' and they functioned only to extend the inevitable.

Jasmine sought treatment for depression and was prescribed an anti-depressant medication and attended counselling. Jasmine found that the medication helped to bring her out of the extreme fatigue she experienced. Counselling helped to address what Jasmine described as perfectionist thinking. At the time of our interview Jasmine was

planning to attend a FTF university which she believed would help her set better boundaries with other responsibilities and give her access to peers.

Virginia. Virginia's last episode of depression began about one year into her online studies. She was four years into her online studies at the time of our interview. Virginia chose online studies so that she could complete the last two years of a bachelor's degree while working fulltime. She described a combination of factors that she believed triggered a depressive episode including disappointment in where she was in her career and education and a serious injury to the ACL (Anterior Cruciate Ligament) in one of her knees. The injury took approximately two years to recover from and Virginia experienced several medical setbacks including the development of blood clots and complications from a spinal tap related to another complication. A very independent woman, Virginia was at home, unable to work, and dependent on others to help her manage.

Virginia initially developed depression when she was an adolescent. According to Virginia, many of her family members had also experienced depression. Virginia was

unable to motivate herself to study, felt like she was "spiralling around", and eventually withdrew from several courses. In her latest episode of depression, Virginia was treated with medication and saw a counsellor. Virginia was a strong advocate for the use of counselling which she participated in, off and on, over the years. Unfortunately the ACL injury meant losing the ability to exercise which Virginia used as a coping strategy to help maintain her mental and physical health.

Virginia identified herself as someone who *lives with* depression. Virginia felt that the stance of *living with* depression made her life and role as a student much easier and informed how she approached her online studies. This included the daily decision of whether she was able to study which the flexibility of online learning could accommodate. Virginia's undergraduate courses were essentially self-taught with a six month window for completion. Virginia reduced her course load from 2 to 3 courses at a time to one course every eight months or so. Winter months were harder for Virginia so she chose not to schedule exams during January or February. She created lists and schedules and rewarded herself for achieving her academic goals. Virginia saw the steps she took to organize her academic life as controlling what she could.

Virginia mentioned missing having peers with which she could discuss course materials or questions about assignments. She wondered if her experiences as a student were similar to the experiences of other students. Although Virginia could contact the tutors assigned to her courses, she sometimes relied on a central email so that she didn't know the tutors that contacted her. She also relied on the timeliness of the response. This was what Virginia referred to as the "double-edged sword of online learning". The

flexibility of online learning in self-paced courses helped to meet her learning needs but left her without peers with whom to confer and commiserate.

Brooklyn. Brooklyn enrolled in online university courses directly from high school. At the time of our interview, Brooklyn was studying in an undergraduate science program. Although she experienced episodes of depression beginning at the age of 14, Brooklyn's most recent episode while studying online was also described as the hardest. In the semester of fall 2017, Brooklyn did not pass her courses.

Brooklyn, similar to Jasmine, experienced depression as paralyzing. In describing what she knew she needed to do to be successful academically, Brooklyn stated, "I have a very strong sense of awareness, I just couldn't do anything about it." What would previously have been considered simple tasks appeared "mountainous." Brooklyn worked with a team of professionals to address the depression and the outcomes of having been abused as a child including symptoms of PTSD such as flashbacks and nightmares. She talked about pursuing treatment for depression and the outcomes of abuse as necessary, as "having to get worse before it gets better." Brooklyn knew she was

getting better when she started to sleep again, eat well, and, "school-wise," when she began to love learning again. She described receiving the marks she felt like she'd earned and being back "on track."

Several participants mentioned the importance of organization when trying to study online when depressed. Brooklyn, in particular, emphasized the importance of organization in *course design*. Courses that she felt helped her during times of depression were ones that outlined expectations in great detail and provided timelines. Well-designed courses helped Brooklyn create her own routines around work and school when organizing herself was difficult to do.

Katie. Katie began suffering from depression during her online studies approximately eight months after the birth of her second child. She was one of the few participants interviewed who had no previous history of depression. Katie attributed the onset of depression to course overload (taking four courses at a time) while being a fulltime parent of two preschool children, one of whom was a newborn.

Depression began as sadness and crying for no particular reason. Katie didn't have her normal level of energy and had difficulty with motivation. She made schedules with deadlines and weekly activities to keep on track and struggled to keep going when she saw herself falling behind. Katie became increasingly irritable and had trouble sleeping. She remembered sitting on her sofa and just being in a dark place. At times she thought about ending her life. Katie was overwhelmed and just "went through the motions" to complete her school work and other tasks. Katie visited her doctor who diagnosed her with depression and prescribed an antidepressant. She tried several antidepressants but experienced many side-effects and was finally prescribed CBD oil which helped with the symptoms of depression without the side-effects she experienced with anti-depressant medication.

Katie was the only undergraduate student interviewed whose online bachelor's degree program was paced (4 months rather than 6) and provided multiple opportunities for peer interaction. To Katie, social interaction was a "huge thing". Katie's initial 2-year diploma was completed in a face-to-face institution which Katie remembered fondly because of the lifelong relationships that were made there. She might have chosen a face to face program if there was one that recognized her diploma and provided access to childcare; however, her online program *did* accept Katie's diploma courses towards her bachelor degree and online programming allowed her to stay home with her children. Social interaction included posting to discussion forums, typically three times a week in any given course, and a one week long, face-to-face course. Katie was the only student in a bachelor degree program who had face-to-face course components. It was in these face-to-face experiences that Katie met two other students. They became good friends

and still keep in touch. Katie felt that having fellow students with which to share the student experience would help students experiencing depression. To Katie, the ideal of studying fulltime and working fulltime was an unreasonable expectation. She continued to study but reduced her course load to two courses at a time while parenting fulltime and will graduate in the near future.

Graduate students.

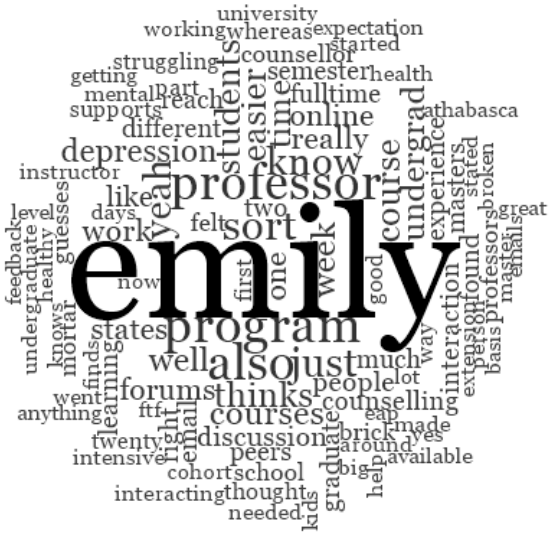
Megan. Megan's experience of depression as an online learner took place in the very beginning of her graduate program. Megan worked fulltime and cared for young son in addition to her coursework. Megan's depressive episode was triggered by a financial loss after a contractor she had hired damaged her property and stole her deposit worth tens of thousands of dollars. Megan experienced panic and extreme sadness. She was also frustrated when she initially started her courses and was late for her first online post. She found herself unable to concentrate or think clearly, had difficulty getting out of bed, and eventually started calling in sick for work which was very unusual. Megan went to see her doctor after an ex-boyfriend clearly noticed the change in her and voiced

his concern. She was prescribed an antidepressant. Megan enlisted the help of her partner and others to help keep her accountable. She created schedules to help her keep on track. She also involved her workplace as a source of support. Megan's partner encouraged her to get out of bed and complete her assignments, and her supervisor encouraged her to study when it was slow on night shift and to take days off to study. Megan clearly remembered when the medication started to work and she was able to retain what she was reading and be excited about her program and career once more.

Megan was one of two graduate students interviewed who had also completed a bachelor degree via online learning. Megan described her online undergraduate degree as self-taught and self-paced. She had up to six months to complete her courses and had no interaction with other students. In comparison, the courses in Megan's graduate program were paced and involved posting to discussion forums as well as participating in problem-based learning groups with peers. The program also included a face-to-face, week-long residency requirement. Megan met two students from her program with whom she continues to have a relationship. They meet to practice their skills associated with their program. They continue to communicate about the course, the challenges of the program, and challenges of being a student.

Megan found being an online learner was a means of keeping on track to having the life and career she wanted while still working full-time. She described balancing school and the "stresses of family, full-time work and real adulating." She learned to talk with someone right away when she realized that she was feeling low or angry and experiencing negative self-talk. When Megan's brain said "fuck it," "who cares," or "it

doesn't matter anyway," she knew it was time to make use of her personal and professional network of supports.



Emily. Emily, like Megan, shared her experience of being an undergraduate online student as well as her current experience as a graduate student. Unlike her undergraduate courses, Emily's graduate courses were paced and required frequent interaction with peers and professors in online discussion forums. Emily estimated her contact with peers to be daily and stated that her learning occurred more often through collaboration with peers and the course material than through the actual professor teaching the course. Emily's program also involved a week-long face-to-face component which allowed her to put names to faces. She felt that the paced nature of her graduate courses, deadlines, and interactions with peers and professors were useful for students experiencing depression.

Emily described having experienced depression during her undergraduate years as well as in the beginning of her graduate courses. Extensions were not of great use to Emily in her undergraduate program as she was too depressed to function. She recalled

failing one course and managing through others. At the time Emily didn't know where to turn for help.

Emily attributed a combination of working fulltime while pursuing graduate studies and experiencing the deaths of two clients where she worked as triggering her last depressive episode. Emily sought out counselling. She also reached out to her professor which she felt was much easier in the graduate program due to the online interaction that was present in her courses. Emily was able to negotiate some changes in deadlines and expectations of online interaction which allowed her to finish her course successfully. Emily also reduced her employment from fulltime to two days a week as she found the work load of her graduate program to be incompatible with fulltime employment. As much as Emily loved her program, she suggested, with humour, that it not be advertised as a great program for working professionals.

Justine. Justine was released by the military after being diagnosed with Major Depressive Episode and Post Traumatic Stress Disorder (PTSD). She came back from a tour in Afghanistan where there were many deaths. Shortly after returning from

Afghanistan, Justine lost her best friend, her mother, and her dog. Justine and her husband divorced and their daughter, 8 years old at the time of our interview, lived with Justine. Prior to her release from the military and as a part of Justine's transition into civilian life, she enrolled in an online graduate program.

Justine's experience of depression and PTSD resulted in fatigue and self-isolation. As an example, Justine described not entering her backyard for almost two years. She travelled two hours twice a week to access counselling. Justine credited her online program as having played a significant role in her recovery from depression and the monitoring of depressive symptoms. Although much of the coursework in Justine's graduate program could be considered self-taught, there were ongoing expectations of frequent postings to online discussion forums, a minimum of three per week and often additional smaller postings. These online discussions with peers drew Justine out. As she posted more and was drawn into discussion, her posts went from being very formal with references to sharing ideas with her peers. Eventually Justine also had phone conversations with some of her peers.

Within two weeks of being discharged from the military, Justine was hired in a position in a hospital in a nearby city. Justine and her daughter moved to the city and Justine enjoyed her new position and responsibilities. She also met colleagues who were taking the same graduate program and they got together intermittently. In her last semester, between work, parenting and school, Justine felt herself slipping back into depression. She recognized a familiar pattern of getting behind in her postings, being tired all the time, reduced functioning at work and less socializing. This time Justine took a week and a half off, spent time "decompressing" with her daughter and organized

herself and her office. This was enough to get her back on track and avoid another depressive episode. Justine attributed the flexibility of online studies, extensions, and the quality of professors to making studying while managing depression doable. She was also careful to do only one course at a time although her program allowed students to do more. Justine described her performance and participation in her online studies as her "canary in the coal mine" for monitoring depression and online interaction with peers as "the first little hand that pulled her out of it."

Including Sofia.

Sofia. Sofia experienced severe panic attacks and tearfulness during her online studies but did not meet the criteria for major depressive disorder to be included in the study. Rather, she was diagnosed at a time prior to being enrolled at the university. I chose to include Sofia's story in the individual description section of the study in order to honor her participation and learn from her experiences. I also invite comparison between Sofia's experiences and the experiences of the other participants. There are notable similarities and some differences in Sofia's experience when compared to other

participants. Sofia's transcripts and units of meaning were not used in the general description of the experience of women online learners who have experienced depression. Therefore discussion of the invariable constituents of the experience that follow reflect the experience and meaning of the remaining ten participants.

Sofia was a year and a half into her graduate studies at the time of our interview. Her first experience with depression occurred after she and her family moved from South America to Canada and before she started graduate studies. Sofia started feeling very sad, was often tearful, and felt like she was "making a big deal out of everything." Sofia also suffered from severe panic attacks. Eventually she visited her physician, and was diagnosed with depression and prescribed an anti-depressant medication. Sofia experienced side effects from the medication, gradually weaned herself off, and began walking, sometimes for hours, to manage her feelings. Eventually panic attacks were the only symptom that persisted.

Sofia's experience was somewhat different than the experience of the other participants in this study. Rather than experiencing depression during her online studies, Sofia had a re-occurrence of panic attacks. Even though Sofia's experiences of panic attacks did not meet the criteria for major depressive episode, her experience may add to knowledge of how anxiety is experienced when learning online. Sofia re-experienced panic attacks during her online graduate studies after receiving a mark in a course that she felt should be higher. Thinking that this might affect her future studies, Sofia approached her instructor and was very disappointed with how she was treated.

> *With this professor I wasn't getting a lot of help and she would shut me down every time. She was very assertive, really, really assertive. The professor was way too*

assertive to a point where I would ask her a question and the way that she would reply to me, it made me feel like I was, like I was not smart, I was really dumb.

Sofia immediately started to experience panic attacks. She walked for hours that day and on subsequent days as well as experiencing periods of crying. She referred to herself as "silly" and "stupid" and was prepared to drop the program.

Two things seemed responsible for Sofia staying with her program. First, Sofia talked to a staff member associated with her program who was able to help her realize that she belonged in the program. Second, Sofia was assertive and able to develop relationships quickly. Her program involved making multiple posts to online forums as well as managing and co-managing discussion forums. Group assignments were also required. Sofia made several good friends in her program with ongoing discussions on WhatsApp. Sofia's peers shared their experience of anxiety over assignments, which helped to normalize Sofia's experience as a student. They were also a source of support throughout Sofia's experience with anxiety.

General Description of Women Online Learners Who Have Lived with and Recovered from Depression

The aim of this dissertation research was to describe the lived experience of women who lived with and recovered from depression during their online studies. The general description of this experience was developed from the invariable constituents of the experience of women who lived with and recovered from depression during their online studies identified in the data across all ten participant interviews. What follows is the general description of their experience constructed from the seven invariable constituents of the experience.

The experience of major depressive disorder for women learning online starts with a trigger event that leads to a cascade of depressive symptoms. As online students, depression begins to impact the women's ability to focus, understand and retain material, and complete assignments. Their academic performance suffers. Women access treatment for depression in the form of medication and/or counselling. The availability of peer contact and interaction in online learning affects the women's experience of depression and how they view themselves as students. Women with depression as online learners experience role overload which contributes to the experience of depression. Depression also affects self-identity. Women experience depression as not self and recovery from depression as a return to self. In the context of online learning this not self is reflected in decreased academic performance and failure or reduction in online posting. Recovery from, or management of, depression involves a return to previous levels of academic performance including ability to focus, understand and retain material, completion of assignments and increased participation in online posting. Women demonstrate their personal agency in managing depression including taking advantage of the affordances of online learning and practicing self-management.

Invariant Constituents of the Experience

In this section of my dissertation, I present each invariable constituent and sub-constituent of the general experience of women as online learners who experienced, and recovered, from depression. Rather than focusing on individual stories as I did in the previous chapter, I support the invariable constituents and sub-constituents of the women's experiences by grouping their experiences under each constituent.

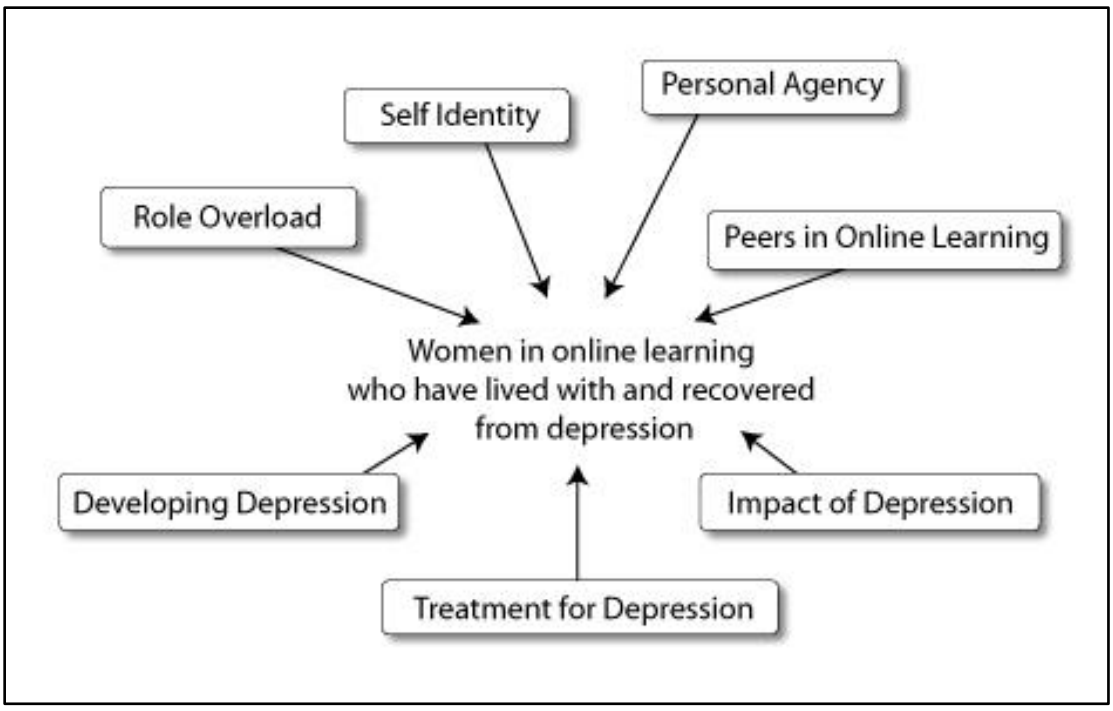


Figure 3. Invariant constituents of the experience of women in online learning who have lived with and recovered from depression.

Developing depression while learning online. For most of the women in this study, the experience of depression during their online learning was not their first experience of a major depressive episode. Indeed, 9 of the 10 participants, related experiences of depression dating back to adolescence or early adulthood, and two participants related their first experiences of depression as one of the outcomes of childhood abuse. The co-constituents of developing depression while learning online included trigger events that led to participants' experience of depressive symptoms.

Trigger events. A co-constituent for developing depression while learning online was the experience of a trigger event. All women experienced a trigger event or events that they could trace to the beginning of the depressive episode. Juliena, Elisabeth, and Justine experienced changes to their employment. Juliena's most recent depressive

episode occurred after the position in the company she worked for was eliminated. Juliena had high expectations of herself in other areas of her life which resulted in feeling additional pressure. She learned to recognize this and worked to reduce some of these expectations. She was a bit late in doing so during her online learning.

> *I'm looking for a job, you know, but there shouldn't be any reason that I can't just bang off this course. You, know, get all my reading done, and kind of map out all my assignments, knowing that I couldn't submit anything until it started. Right? That was not the case. I could not, I couldn't focus on, on hardly reading. But I, at first when I was off work, I allowed myself just to focus on processing my job and then I turned around and I thought, ok, well I'm ready to pick up my coursework and start reading it and I really noticed at that point that it was very difficult for me to concentrate. And part of it was that I was thinking in terms of, I know in the back of my mind I was still waiting for emails to come in and all that kind of thing for job opportunities but I noticed a significant decline in my ability to concentrate on the content I was reading.*

Elizabeth applied for a new position, but was not successful. The disappointment from this experience led to a depressive episode.

> *Yeah, this was my, I think I'd say like third or fourth major depressive episode...Well it was related, I think it was triggered by just a work situation too. Not getting, because I'd been getting, like I work, or I was working, I quit my job recently but I was working and I didn't get a job that I thought I was going to get, and that just kind of, I think it was just a combination of stress and different things but it, that disappointment just kind of spiraled out of control for me and I*

just felt like it…It just triggered a lot of symptoms for me and then I ended up taking a leave from work. And I was studying simultaneously.

Justine experienced depression in the beginning of her online studies and felt another episode potentially coming on.

This last semester I had a hard time cause I'm in a job now that's pretty high pressure. We're going through a lot of changes in our health region and between work, my eight year old, and school, I started getting behind in postings and things…,but I started recognizing those old patterns coming back where I was tired all the time. Just, you know, feeling like I got slapped by a wet fish basically. You know, I was just waiting during work. I wasn't socializing very much and I recognized I was starting to slip down again. And it was a big trigger to get my poop in a group.

Megan's episode of depression was triggered by a major financial loss experienced just before starting her online program. She was not taking medication at the time. Megan was to start a course but was late on her first post. She experienced panic, sadness, and frustration with herself. She couldn't concentrate or think clearly and began calling in sick for work which she experienced as "not her". She had feelings of "I'm not good enough," "I can't do this." Megan described feeling so low and sad that she "couldn't get out of bed" and "was super sad."

Others, like Amanda, Brooklyn, and Katie experienced depression in response to academic performance and pressures. For Amanda, one course became the barrier to degree completion. Katie felt that the course load and pressure of the program triggered her depression

I assumed it was something completely else and then when [the doctor] told me its depression, I was kind of like ok, it makes sense now. I can see that that's what's happening. It slowly crept up on me and I do think a lot of it is the course load and the amount of pressure from the program that I've put upon myself in a way because I was, it's an intense program and I was trying to get through it, I'm trying to get through it as quick as I can. So, I don't know, it was just, It kind of slowly creeped up on me and before I knew it, I was just not coping and I was not able to function, like, yeah.

Virginia experienced depression a year into her studies and was triggered by academic pressures and after an injury to her ACL. Everything seemed to happen at once for Virginia. She lost motivation and she withdrew from several courses. Virginia describes this time a "spiraling around." She emphasized that the experience of a depressive episode just once in one's life is not the reality for everyone.

Symptoms of depression. A second co-constituent of the experience of depression involved the experience of depressive symptoms. All participants experienced the most common symptoms of depression including depressed mood, loss of interest in previously enjoyed activities, and fatigue.

Elisabeth described her experience of extreme fatigue, motor retardation and changes in mood.

I had just slow motor effect where I was just talking slow and I felt like just pushing through slog. Like your whole body is just dragging, your limbs are like, you know, like you just have trouble holding your body up. It was just so, it felt like cement blocks around my feet or something.

> *My worst symptom I would say would be, well I guess the most severe symptom would be like suicidal ideation and like no specific plan but that was one of the main, probably the scariest symptom. And then, just oversleeping, like crazy amount of sleep, probably 16 hours a day sometimes Lots of naps a day and just mood, my mood was so bitchy.*

Brooklyn recognized she was depressed and was paralyzed by the experience.

> *The hard part about depression is I have a very strong sense of awareness, I just couldn't do anything about it. So I knew what I was feeling and I knew shouldn't be feeling that way but I couldn't get from point A to point B. And so our conversations with my [therapist] were fascinating because it was like I know this, I just can't do it.*
>
> *Low energy was a big one especially because mine would trigger… I wouldn't be able to sleep. So I would be exhausted because of sleep which also impacted my focus so I could re-read the same stuff 8 times and still not grasp it. Not great when you're trying to study.*

Other participants also experienced loss of energy and motivation and letting go of previously enjoyed activities. In retrospect, Jasmine and Katie noticed that they had given up many of the activities that they used to enjoy. Jasmine described her experience.

> *It came to a point where like I stopped working out. I stopped doing yoga like I used to, I stopped all the things that got me, that I started doing that got me interested in taking this program in the first place, I had stopped doing.*

Depression came on slowly for Katie. At first she had no energy or drive, then was sad and crying off and on. She didn't have the energy she normally had and couldn't motivate herself. She was irritable and started having trouble sleeping. She "went through the motions" to complete her school work. When Katie was diagnosed, she realized that she was not coping and was "not herself." She was crying often and didn't have the motivation and drive that she was used to having. She gave up her painting and artwork. The experience of depression interrupted Katie's ability to cope as a wife, a mother, and student.

The impact of depression on learning. Depression impacted women's ability to learn. All participants described challenges in their ability to think and focus and retain what they were reading which resulted in late assignments, late posts to discussion forums, and sometimes an inability to complete assignments. Several women also described having difficulty organizing their ideas and writing coherently.

While Megan was depressed it was hard for her to focus and keep on track with her coursework. She wasn't retaining the material. She described her experience of depression as having a "really thin layer of cotton in the front of [her] brain or eyes" that didn't allow her to understand what she was reading. She found herself procrastinating and distracting herself. Sometimes she would stare at the computer screen for hours. Brooklyn also described difficulty focusing on what she was reading which was made worse by lack of sleep.

> *Low energy was a big one especially because … I wouldn't be able to sleep. So I would be exhausted because of sleep which also impacted my focus. So I could*

> *re-read the same stuff 8 times and still not grasp it. Not great when you're trying to study.*

Emily lost her ability to read for school as well as for pleasure.

> *My concentration had been shot from the depression. And I used to, before it hit, I was a super avid reader. I'd probably read two books a week, or something like that, two novels a week on top of work and school. I just love reading and when I got depressed I could barely read a chapter. It would take me so long. Like my brain was just not there.*

Many women, including Juliena, related how depression affected their ability to write and complete assignments. Juliena found it difficult to pull pieces of her writing together into an understandable whole. She handed in assignments which were short on word length and not up to her usual standards. Justine also described her efforts to write while depressed.

> *So the depression definitely affects online studies. I was trying to carve out time but I just wasn't able to write. I would have things, chunks of material and content written out in paragraphs but it didn't make any sense. I had the outline kind of done and some really good words and sentences but to put it all together start to finish, it was like, you know, to do that and make it logical for the person who was marking it.*

When depressed, Jasmine also experienced anxiety, a fear of failure which prevented her from completing or handing in anything that would be marked. This feature of Jasmine's experience was somewhat different than the experience of other participants. Although anxiety experienced with depression was not uncommon for the

women, Jasmine's experience of anxiety approached a level of phobia. She avoided what she anticipated would be negative feedback. Finishing her studies was the only way Jasmine saw to reach her career goals but she wasn't experiencing success. She became paralyzed. As Jasmine stated "all roads lead to depression."

> *Because I was already depressed, I felt like any negative feedback that I got from actually submitting that would make me worse emotionally. Then I would kind of stop at that point or I'd move on to the next unit without doing the quiz or without handing in the assignment. I'd just kind of read the stuff. A lot of the triggers for me, pretty much running into things I did not understand or anything I was unable to grasp onto quickly enough. So it was kind of that frustration would throw me into that feeling and then… I just kind of stayed there and it became, as time went on, it became more and more difficult for me to actually even pick up my books.*

Online asynchronous postings to discussion forums are an essential part of many online courses. Justine and Megan found that depression interfered with their ability to keep up with online posts to the discussion forums in their courses. A decrease in this activity was a sign to them that they were becoming depressed.

Treatment for depression. Treatment for depression was an invariable constituent in the experience of depression while learning online. All women sought out help, were diagnosed with a major depressive episode and accessed a range of professionals including family doctors, psychiatrists, social workers, counsellors and alternative therapies. The most common treatments accessed were medication and counselling. Eight of the ten women interviewed continued to take medication once their symptoms subsided as a means of maintaining their mental health. For most women the

experience of depression during their studies was not their first experience with depression which meant returning to medication as a means of treating depression.

Megan noticed that as the medication started to work, her ability to focus increased. Up to that time Megan realized that she hadn't retained the information she had read to that point. She had to re-learn parts of courses that were foundational to other courses in her program. She continued to take an anti-depressant which she credited with keeping her feeling stable. Megan's experience with medication reflected the experience of many of the women in the study. She explained that the medication she took allowed her to use her brain like a "normal person" so that she could accomplish things and do the things that made her happy. It allowed her to enjoy learning again and be engaged with what she wanted to accomplish.

> *For the first six, eight weeks. And then once I started, my meds started kicking in again and I started feeling better again. Then it was like, ok, it was coming more and more easy to do that focus and it was less and less and less a task…What it does do for me is not necessarily make me happy, it's put me, and I wrap my mind around it this way too. It's not the drug that's making you happy. The drug is only clearing your brain enough, it's increasing your serotonin levels enough so now you can use your brain like a normal person so that you can accomplish things. The pill isn't going to make you happy. The pill is going to give you the ability to do the things to make you happy. So, doing school actually does make me happy now. It makes me feel good learning stuff. It keeps me engaged with what I want to accomplish.*

Other participants, like Juliena, were treated with various antidepressants over many years until a medication was found that resulted in greater emotional stability. Juliena spoke about the importance of medication long term as it allowed her to manage life events more successfully and to use skills she had learned in counselling, like getting adequate rest and exercise, to manage her most recent episode during her studies. Although the depression experienced in her online studies was a first for Katie, she also went through several medications before finding one that worked well for her with fewer side effects.

Eight out of 10 of the women interviewed identified their first experiences of depression as occurring during adolescent or early adulthood. Two women identified as having been abused and witnessing abuse as children. Dealing with early trauma was a part of treatment for both Brooklyn and Elisabeth. Brooklyn sought professional help from a counsellor, a psychiatrist, and a social worker. The professional help Brooklyn received was essential to her recovery. Brooklyn had to deal with historical abuse meaning, for her, that the symptoms got worse while she did the work of therapy before they got better.

> *I had a really strong team of doctors in my corner this year. And so you would think I'd be doing better, but unfortunately I had to get the heart of very serious issues and that just, just shut me down really. I feel like I've endured quite a spectrum of things in my young little life.*

Elisabeth also described the work she engaged in to address depression and early trauma. She benefitted from the treatment, but also struggled with what taking medication meant for her.

A huge part and it just freed me up mentally so I could do like the emotional work with my therapy…So, like the only thing is, so I kind of wonder, if I ever want to go off of it, are you at a higher risk to relapse again? So it's almost like it's better just to stay on it forever now. But it's also, you kind of feel like, I don't know, like you're a false success in a way? I want to be just naturally happy but I know it's like a total brain chemistry thing.

I found a great therapist and that's like 50% of the battle. Finding the right person and she really worked with me. …we used dialectical behaviour therapy and I was also taking group therapy and the combination of the medication, the group, and the individual sessions helped really kind of shake me out of it.

Jasmine's treatment for depression initially involved her doctor, then a therapist and antidepressant medication. The first thing she noticed was being less tired. In therapy Jasmine challenged cognitive distortions like perfectionism, and developed more realistic goals and confidence in reaching them.

Virginia was treated with counselling and anti-depressants. She used counselling services regularly and is currently self-managed. Learning to manage depression started in Virginia's teens. She started counselling and anti-depressants, learned new coping strategies, and gave up unhealthy coping strategies. Virginia stated that counselling "is the best thing" and advocates that everyone see a counsellor now and then. "Why wouldn't you go to talk with someone?" she added.

Peers in online learning. The presence, or absence, of online peers and type of interaction was an invariable constituent of women's experience of depression in online learning. Peer interaction ranged on a continuum from no interaction with peers to a high

type of peer interaction including online discussion forums, group work, FTF course components, and practicums. With the exception of one student, women in undergraduate programs described their coursework as self-taught with no, or minimal, exposure to peers. These students had access to tutors or groups of tutors and had contact information for an instructor assigned to their courses but did not share their struggles with depression with them. Students assumed that the lack of peer contact was just the reality of online learning.

Women in graduate studies, including two women who did both their undergraduate and graduate studies online, experienced far more peer contact and interaction than undergraduate students. Graduate students and one undergraduate student interacted regularly with their peers in frequent asynchronous discussion forums, completed group projects with peers and several graduate students participated FTF with peers in one week courses where all students came together in one geographical location and/or practicum experiences where they may or may not have been with peers but engaged in the social life of a work place. Graduate course instructors were more likely to be contacted regarding the women's struggles and requests for extensions although not all women disclosed that they suffered from depression. Although course instructors were mentioned a few times in the interview data, the absence or presence of peers was, by far, the most pressing concern for women. The following continuum of peer interaction illustrates the range of peer interaction experienced by the women in the study.

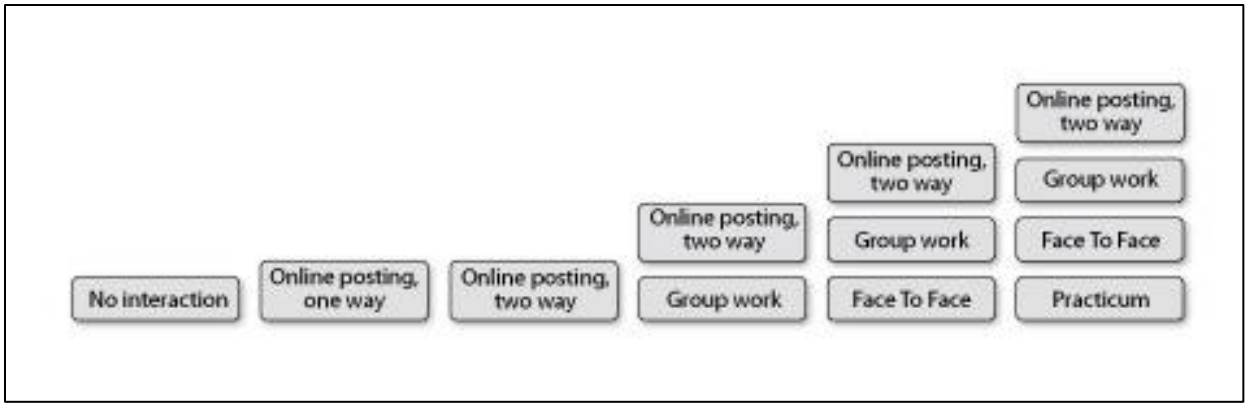


Figure 4. Continuum of peer interaction in online learning.

I relate women's experiences of peer interaction in more detail than other invariable constituents in order to emphasize the priority of this constituent among them and to display the continuum of experienced peer interaction more thoroughly. I begin by highlighting Amanda's with online learning.

> *I found it hard in general because I don't have any social interaction. When I originally started I was taking one or two classes at a time and working fulltime. So it wasn't, it wasn't as bad because I would go to work and I would have that social interaction with people and even though I'd do school at lunch, I'd talk with co-workers. But it was about a year in that I quit my job to do school fulltime to get it done. That was the hard part. I think I lost that social interaction. Even though I was doing class and I could see everyone was online, I don't know anyone. And so I'm like, I'm kind of an introvert so I'm not going to reach out to people in my class and be "Hey! So you want to talk about this? So I found I was just alone…*
>
> *…It was horrible. I mean, I sort of lucked out when, because I had a cousin who began attended the University [C} and I would, so when I'd find out she was there*

> *studying at the library ok, I'm coming to join you. I don't care if you talk to me. I'm just coming because I can't be on my own, alone. My dogs are great but I need real people.*

Amanda wondered if she could have passed the course if she had experienced it FTF rather than the self-study experience of her undergraduate online course. An experience of passing a difficult statistics class in a FTF environment seemed to support her theory. To Amanda, failing a class was the equivalent of proof that she was dumb, worthless, and useless. Passing the FTF class allowed Amanda to give up her self-identity as dumb, worthless, and useless and to consider that the learning context (FTF vs. online) might also be responsible for her experience rather than who she was.

Jasmine felt alone and had no one, including family, who supported her choice to study. She felt a lack of support from the people around her (including work and family) Jasmine had no peers to discuss challenges with, labeled herself "dumb." With no reflection of her experience through peers, Jasmine compared herself to non-existent perfect peer and could never measure up. Jasmine didn't have a realistic view of her student self.

> *Being alone and as much as I try not to compare myself to other people, but I feel like sometimes in [FTF] school that helps. Like in situations where I'm like, "Am I the only person that doesn't understand this?" But then if other people don't understand it, you don't feel like you are like you are, dumb. I kind of feel like online school put me in a situation where I was constantly comparing myself to a student that doesn't exist, that was perfect and getting a 100 on everything and understanding everything. And I couldn't live up to that expectation.*

Teaching herself was difficult as was having no one to reflect back whether her struggles in learning were "normal." Jasmine felt increasing pressure with every quiz and assignment and self-judgement arising from comparing herself to a perfect other.

Jasmine's experience of online school was that it added to the feeling of being alone, more so than FTF institutions. Even when she knew of a person or resources offered at her university, she was too depressed to reach out. Only two of the women in the study knew that resources for mental health existed at their university.

Elisabeth missed having a connection with other learners in her online learning. Her online courses did not include interaction with classmates. In the one course she had where she was expected to post, she posted to a forum from a different year.

> *One of the courses I took…part of the complement was participation in the online forums, where you just post your answers, to like a question and then you're supposed to kind of, engage or comment with your classmates. But it wasn't super effective just because people take the course at different times. The posts that were in the forum were from, like, 2017 or something. I think I was probably the only, me and maybe one other person, were the only two students in that course at that time, commenting on somebody's post that's not even in the class anymore just to get your grade.*

Virginia missed having peers. She missed knowing if others share her struggles with material and being able to talk with peers about course content. Many of the women in undergraduate programs assumed that what they experienced as online students was typical of online learning. Virginia described learning online as a "double edged sword"

especially in self-paced courses. She expressed that "You're not really able to pair people up or anything like that. I think it's just the reality of online learning."

Justine's program was essentially self-taught but included posts to asynchronous discussion forums at least 3 times a week. The online discussion with peers and sharing ideas drew Justine out. Peers she met in her city who were also in the program got together occasionally. Online learning allowed Justine to connect with other students safely and as a peer. In the beginning this was risk taking for Justine. Eventually she also talked with peers on the phone. Justine credited her online experience with peers with helping her recover from depression.

> *I interacted with people from work very formally… I lived in a house and I didn't step a foot in the backyard for a few years and then when I got online and started studying it was almost like a bright light for me. So interacting with people online was almost like putting myself out there because I was putting my ideas and thoughts and having to ... Like at one point I did a course where we had to have phone conferences and I actually talked to people, you know outside of Captain, staff, or talking to a subordinate or, you know, mom talking to daughter. I actually had to talk to the person. And that helped me pull out of [the depression]*.

Justine described the process of developing comfort in posting and in sharing her ideas. She also described what it was like for her to witness the sharing of affect in online forums.

> *At first it was hard for me to even post, it sounds silly now but it's kind of like I isolated myself to the point that just anything going external of me was hard. So*

> *my posts at first were very formal and I remember the first course I took, there was a guy who used emojis and I was just appalled. I couldn't understand, how can he do that? You know because it was, it just seemed so farfetched for me at that point. Because it was like he was trying to talk to people and I was just like wowed by this guy. Like what is wrong with this weirdo? But then, as I posted more and got drawn into discussion, it went from being a formal post with references to actually sharing ideas. You know that, that really helped and you know eventually, now, I use emojis. I'll go there. Yeah it was those, you know how posts dwindle down to back and forth," What do you think of this?" and "we do this at work." Those conversations are what drew me out.*

Emily interacted with peers in her program but they were different peers depending on the course. Unlike her undergraduate online courses, the graduate courses required interaction with peers and instructors in discussion forums. Emily interacted with her peers on almost a daily basis. There was also an in-person component where she met with other students FTF at the university every summer for a week. This portion of her program allowed Emily to put faces to the names of her peers.

> *I felt like it was a lot easier to reach out to my professors for help in the Master's program. And also even just like the forums like often, like a lot of the topics, you know, were relevant and we were encouraged you know to share our own personal experiences.*

Emily found that the level of instructor presence differed from course to course. She stated however that learning was more often through collaboration with peers and through the material provided by the course author more than the actual instructor

teaching the course. She found it easier to interact with peers though the discussion forums rather than her experience of "stand and deliver" teaching in FTF institutions.

A primary function of interaction of women with their peers appeared to be the act of commiseration and normalization of the role of student. There was a need to know that other students shared similar concerns and frustrations including the difficulty of programs or particular topics and assignments. It also helped to be able to share worries and be able to laugh with one another.

Megan studied online for both her undergraduate and graduate studies. In her undergraduate studies she felt like she was on her own. Megan's graduate program included two postings a week to her group discussion forum, and week-long FTF opportunities with peers. The FTF portions of her program allowed her to meet people that she continued a relationship with. They met to practice the skills portion of their program and commiserated about the difficulty of their program.

> *This semester I actually had an awesome group because I got to meet some people at residency. There was one girl there from [C] that was in my group so when I went up to write in [C] she was there. And so we were able to practice like a week before because I went up to [C] to meet them. And she had another friend in [C] that was there so it was nice because I actually got to meet some of these students that I'll be graduating with that are sitting there in the same boat going, "What the fuck? This is so hard!" So we all got to have meltdowns together. It was nice.*

Katie also had interaction with peers in a FTF summer course as well as having a practicum. She interacted with student peers outside of class that she met through the

program and lived in her area. They became friends, met in person and studied together. They used texting or WhatsApp to continue their friendship outside of courses. Katie still preferred her previous FTF education. She found online learning more challenging than FTF in forming close relationships…She missed the sense of community that she had in her FTF program but was thankful for the friends she met on practicum.

> *I have people that I've met throughout the last three years that I've been doing the program with that have become friends and we've met in person and we've actually met up to study and do things together. I contact them through like texting or WhatsApp, that sort of thing to touch base of where we are in the course.*
>
> *In general, I found it different than a classroom experience because you're not meeting everybody face to face and it's harder I guess because you're just communicating through text for whatever. WhatsApp is a common one that a lot of students will use because you can kind of have a group chat. It's a little bit more challenging because you're not, like I said, meeting them face to face. So, you know, you're just kind of talking from here and there and touching base on certain things like deadlines and that stuff.*

For Katie, the practicum experience made the most difference in developing relationships with her peers. She was in a work setting for a week and made lasting friendships.

> *It was a really good experience because all of those girls that I met in that [practicum]. I'm still friends with now. We still talk all the time. Whereas I've*

been in many different courses with many different students and I don't have any communication with any of them.

Katie felt that having deep connections with peers, and sharing similar struggles and being able to relate to them are helpful in managing depression. She identified the social aspect of being a student as being of primary importance to her.

Role overload in women's lives. The women in this study juggled many different roles in order to pursue their education. Most participants worked fulltime as well as studying. Many women were also parenting children. The term, role overload, describes the women's experience prior and during depression. "Role overload occurs when the total demands on time and energy associated with the prescribed activities of multiple roles are too great to perform the roles adequately or comfortably" (Higgins, Duxbury, & Lyons, 2008). In some cases, the experience of role overload led to participants responding by reducing their course loads or hours of work.

Emily and Katie both expressed that full-time work and full-time study was an unreasonable expectation or as Katie put it, "full-time studying and full-time anything." Katie felt that full-time studying was necessary in order not to let her family down. At the time that Katie was diagnosed with depression, she was taking four courses to be eligible for student loans as well as parenting a preschooler and newborn. She found that her youngest was far more active and fussier than her first child. Katie typed over top of her baby at times in order to complete assignments. The plans she and her husband made for their family depended on Katie finishing her program.

We have all our eggs in that one basket with this program. I mean I stopped working and I have two little kids that are dependent on me doing this. And my

husband, my husband is too. Like he's the breadwinner right now obviously so that I can continue to do this program and eventually, well we're hoping to pay off the student loan debt and all that. So it's a lot of pressure to finish the course. It's also something I really wanted to achieve for myself, was my degree.

When Katie was depressed, she felt that all of her roles suffered. Looking back, Katie had no idea that staying at home with her children and studying online at the same time would be such a challenge.

Justine dealt with a new job and a lot of changes and high pressure at work. Between work, parenting, and school, Justine felt herself slipping back into depression. She recognized familiar patterns of getting behind in her postings, being tired all the time, reduced functioning at work, and reduced socializing. Getting home to make supper and help her daughter with schoolwork before getting her own studying done was a daily challenge. Justine described time as being "super tight."

Jasmine was not working during the first year of her studies when she was successful. Unlike other women in the study, the people in Jasmine's life did not take online school or her need to study seriously. Family members infringed on Jasmine's studies with demands on her time including child care, housekeeping, and preparing meals. Online school was seen as something that could be done later. Jasmine added full time work to her load. People at work saw her study time as free time. Jasmine experienced pressure to take on more shifts. Online school was not recognized by others as "real" school. She experienced fatigue trying to fit in school around other commitments. Online school was seemingly invisible. In reality Jasmine had little time that was her own.

> *I felt like I wasn't meeting other people's expectations and then I got into a thing where I was trying to balance my expectations, I wouldn't even say balance, it wasn't really a balance at all. I was just trying to, I was trying to do both, manage my expectations of myself plus other people's expectations of me but that did not work because they were very conflicting.*

Megan described how she balances family, fulltime work and school.

> *I have accountability to my kid and I have accountability to our home. I have accountability to a lot of people. And it's easy when you're in that depression state to not want to be accountable to anybody and you can easily let things go… you need to keep your shit together, you know, and you're constantly, It's almost like this constant, you're consciously aware. You have to put yourself in a state of mind to be consciously aware of the subtle changes in your mental health or it completely derails what you're trying to do because life in general is very overwhelming and you enter into one of these online programs and it becomes more …You're balancing stresses of family, you're balancing the stresses of full time work, you're balancing real adulting.*

Self-identity, depression and online learning. Depression involved recovery which resulted in the women regaining their abilities to study, complete their assignments, and enjoy learning as well as enjoying other activities Many of the women in the study experienced a depressive episode as not themselves and recovery from depression as a return to themselves. People close to the participants also used the language of self and not self when referring to depression and the women's experience of it. Regardless of experiences of self and not self, two participants described themselves

as living with depression. Megan and Amanda both received feedback from others that they were not themselves and were urged to seek treatment. Amanda saw her husband's support of her as rooted in his own experience and knowledge of depression. He knew that Amanda when she was depressed was "not her" and recovery from depression was Amanda returning to "herself."

> *He, himself, had experienced depression. He was somebody who actually considered suicide. He said "I recognize everything you're doing and I know that's not you, that's the sickness." I think that's the only reason that he was [supportive] because he knew the symptoms of the sickness. He experienced it. He's just," If I can just get you out of that, you'll be back to the person I know*.

The experience of support, both professional and family, helped Brooklyn to pull herself out of depression.

> *Well I used to suffer through some pretty severe flashbacks, so when those stopped and the nightmares stopped, I was able to sleep. So then once I was able to get a solid night's sleep, it was a lot easier to see, it was easier to see the other impacts. So I was able to eat better because I was more comfortable cooking and I liked going to the gym again. So then I just got bits and parts of me that I had lost over the years started coming back and then I noticed an improvement at work and things like that. And it was easier to create a routine for school.*

Recovery from depression was reflected in Brooklyn receiving the marks that she thought she had earned. It made a difference in completing her work and doing it well. It also resulted in loving learning again and gaining back her memory. Her quality of life improved including going out, wanting to see people and getting up in the morning.

Brooklyn described acting as if she was not depressed as not who she really was. Others could not tell that this fake self was not her real self. Being well meant Brooklyn felt she was her real, or "genuine" self, again in her interactions with others.

> *I've been doing really well. I'm getting the marks that I feel like I've earned. I'm on track. I think school-wise my biggest [change] is I love learning again. I found it so simple to retain information which was so difficult for me for the last little bit. I would only read a chapter and could recite it to somebody which is my normal memory. But I just could not do that prior.*

Katie described her experience of depression as a really dark time, as sitting on her sofa and being in a dark place. She experienced this as "not herself."

> *But when I was told that it's depression I was, 'really?' But then it kind of clicked. Like you know what, it is because I'm not myself. I'm not coping. I'm crying all the time and I don't want to, I don't have that motivation I guess even though I'm doing those things, I don't feel that drive I need to have. I stopped doing. I used to be really into painting and artwork.*

Elisabeth went on a mental health leave for 6 months and hoped to focus just on school. She hoped this would allow her to "pull herself out of this hole" but, instead, she found school difficult. This was not her usual self.

> *I've always put high value on getting good grades…It's been a source of confidence for me. I think maybe part of it would've been, I don't know why, but as a kid like with my dad telling me I'm dumb and things like that, all those kind of adversive, abusive things that I grew up with. When I went to school and I was able to be successful there, even though it's just a grade, that made me feel like,*

like it always made me feel like, I am good at something. It was something to kind of like feel better about yourself and um, so knowing that, you know I'm … It's kind of validating, right? A good mark on something is telling, is kind of affirming that you are a smart person, you can be successful, all of that.

Through the experience of depression, Elisabeth lost her ability to succeed in an area of her life that was of utmost importance to her since an early age, her education. Recovery from depression was reflected in a return to being able to learn and be successful academically.

Megan recalled the first time that she didn't experience "fuzz on the front of her brain." She recalled her enthusiasm for her studies and areas of interest returning. She was back to herself once more.

[It was] Christmas and I remember for the first time, when I went to sit down and [study] looking and finally having the fuzz off of the front of my brain. I don't know how to describe it, it like a fuzz. It was like this weird fog in my brain that I couldn't go around. And I remember looking at the community profiles and for the first time, reading through about four pages and actually retaining what I was reading and going, "Oh my God! I do like this! I remember why I was taking this! I remember why! I want to do this health promotion." Like, and I remember feeling that like "I'm doing this. This is why I'm doing this!"

Another expression of identity that was evident in the interviews was the notion of *living with* depression or depression as a *part of self*. Although several women experienced episodes of depression since adolescence and managed their lives to minimize the odds of recurrence, one participant viewed her life overall rather differently.

Virginia used to look at depression as something to be over with. She now looks at depression as something that she will live with. Virginia knows that she will experience days where she has difficulty functioning and those where she is productive. Virginia stated that she realized *living with* made her life and role of student much easier. The idea of *living with* avoids the sense of guilt and failure and fear of sliding backwards that she used to experience. Virginia now says "it was just a rough patch" and moves on. She sees functioning as a "daily decision." Some days are good and some are not regarding her motivation for school.

> *A lot of time in my late teens and my early twenties, I was looking for the finish line a little bit. I was really looking for that point where it was just going to be over. And I think in the last couple of years, it's really, it's part of my personality. It's always going to be a struggle. There's going to be days where I can't get out of bed and there's going to be days where, you know, I'm completely 100% productive from like 7 am to midnight. And it just, it's just something that I've started learning how to live with instead of trying to correct.*
>
> *That's, my whole thing was, eventually when I got around to, not trying to cure it but trying to live with it Over the years I've come to the realization that everybody or what I believe and what makes me feel better is that everybody struggles to some degree with mental health whether it's chronic like mine or if it's cyclical or situational, or they only struggle when certain things are happening.*

Virginia described managing depression was about knowing her limitations, recognizing where she might struggle and finding ways around it. Although all of the women of the study did this, their experience of self-identity and depression differed

Personal agency including the affordances of online learning. The women in the study found many ways of persisting in their studies despite their experiences of depression. In a few instances students failed courses, sometimes one, sometimes an entire semester. Overall, however, women found numerous ways of demonstrating agency through the affordances of online learning and managing their lives and studies.

Extensions. Some of the women made use of extensions. Course extensions allowed Elisabeth to wait out the depression until she felt better and she was able to pass with decent grades. Extensions were essential to Elisabeth's academic success. They helped Elisabeth to wait to do schoolwork until she felt able. Elisabeth did schoolwork on days when she felt more able… good days. Without extensions, Elisabeth didn't believe she would have been successful.

> *School, because of the university's deadline, I extended it. I knew in my head, like I'm not mentally in a place to be able to do this right now. I'm going to push back how long I have to do the course and when I started noticing my symptoms abate… I was like "Oh good, now I can actually, I'm like, today's a good day", Like not every day… On the days when you do feel good, "what can I do to feel productive, you know"?*

Juliena also paid for an extension knowing that her coursework depended on her time in the evening and weekends when she was most tired. She contacted the university to request an exception due to her life circumstances and although they agreed, she got her final assignments in without applying for it. Justine reached out to her professors during times of the year when she was more vulnerable to depression letting them know ahead of time that she might need an extension. During these times Justine paid

particular attention to self-care, sleep, eating, and making sure she maintained some kind of attachment with others. Justine stressed the importance of extensions for people suffering from depression.

> *I know when my times are, like, July's bad because that's when my mom died. And when I was on tour we had a lot ... In 2008, I was in Afghanistan from March to October and we had a lot of deaths. It was a really horrible rodeo. And then I came home and then [in] 2009 my best friend died. Then the year 2010 my mom died and then later that year I adopted my daughter and then in 2011 I divorced my husband which was a good thing. And then it kinda, well, and my dog died. I had a few years that were really bad.*
>
> *So Julys are bad because that's when my mom passed away and we were having a lot of deaths on tour. So July, August, November, like in around the 11th is just, because Remembrance Day and my mom's birthday is the 15th. So I'm very aware of when things are due during those times. I talk to my profs and I say 'Look, you know, things come up at those times and I may need an extension' and they've been very good about it…Even having that [extension] in place is an amazing accommodation for someone with depression. You know, if you're struggling trying to keep up.*

Brooklyn and Emily attempted using extensions in their undergraduate courses without success. Depression persisted for both and neither was well enough during the extension period to be able to complete the courses they were taking. Emily felt that extending the course completion date increased pressure and made things worse.

I completely maxed out all of the extensions for all of my courses just because of the, oh like I still was like, you know, too depressed to like do anything and was just like, how, you know, 'I'll feel better in a couple of weeks' and it just didn't, it wasn't getting better so I just kept pushing it and pushing it. Um, and then that sort of made it worse.

What worked for Emily in her graduate studies was an extension on an assignment and a week off of posting to discussion forums that she arranged through her instructor. These accommodations helped her to pass the course.

So I would say that my second semester where I had that really good professor, that is where I was um struggling the most. And I had I had two clients that had passed away during that semester and then I had some other family members pass away which wasn't necessarily that difficult for me but it was just like, oh here's another one, and another one more of the issue there. But, I mean my professor, I reached out to him because there was like a paper coming up and I'm like "I can do this paper if you really need me too but like I am in by no means, it will not be good work. And then he said that he could give me a seven day extension but that if I needed more time than that, that I could also like, we could discuss with like the person in charge of the course as well, if I needed more time. And then there was also a week where I didn't have to participate in the forums because I needed that like recovery time from that death. So that was, I mean that was good. I felt like it was easier. I felt like it was a lot easier to reach out to my professors for help in the Masters program.

Flexibility. The flexibility of online studies allowed all participants to continue working, parenting, or as Amanda put it "to have another life outside of school". Jasmine mentioned not having to commute long distances. Amanda's online studies allowed her to finish her degree after she moved to another country. Katie liked that online learning allowed her to stay at home with her children although she also attributes online learning as contributing to extra stress and depression.

Although flexibility is an affordance of online learning in general, seven women in the study also made specific use of this flexibility to manage their experience of depression, especially fatigue. Having access to online studies allowed Brooklyn to pursue post-secondary studies while working fulltime. She would not have gone to FTF classes because of exhaustion due to depression. Being able to attend school online helped to mitigate Brooklyn's experience of depression. It also helped Brooklyn feel optimistic that she could do something once she "dug herself out" and she proved to herself that she could. It was easier for Brooklyn and others to attend school even when they weren't feeling well. A concern for Juliena was that pushing herself to attend class when unwell or depleted rather than getting the rest that she needed would trigger depression. Virginia also found that she could catch up more easily in online studies after a difficult day or days.

> *Online learning has helped a little bit with that. Just because I was able to figure out what does work for me and how to make it work for me in a way that taking in-class classes wasn't…And it would have been much harder to catch up after days where I couldn't do it.*

Monitoring online activity. Several women in the study specifically mentioned monitoring their online activity as a way of monitoring possible depression and helping them to remain well. The online discussions with peers and sharing ideas drew Justine out of her depression. When Justine noticed that she wasn't posting as much, this became a sign to her that she was becoming depressed. Justine related that online studies helped her in recovering from depression. She's used her response to the requirements of online studies, like posting to online discussion forums, as a way of monitoring her mental health.

Justine's performance and participation in her online studies became her "canary in the coal mine" in the experience of depression. She credited online learning for assisting her recovery from depression.

> *I talked about interacting with peers on line kind of was the first little hand out that pulled me out of it. And then just the confidence you get doing well in a course. That all feeds into feeling better. But it's like the bird in the mine. If the bird dies you got to get out of the mine because the oxygen's going down. It's the same thing with the course. Like if my coursework starts getting behind like it did last semester, you know that was my big like, 'Woo hoo Justine, you need to get your stuff together. Things are starting to slip'. It's my canary in the coal mine. It really is. If it starts going down you know it's time to start pulling back and looking at priorities and what's going on.*

Megan moved from just needing to get through her online course when she was depressed to online education as a means of being happy. It keeps her on track to having the career and life she wants.

Yeah, related to that depression. Just not wanting to think. And then when I am thinking though and I am doing these classes. So you know with people with online learning I guess. You can take it as a very overwhelming situation, you can take it as a 'Oh, I'll do this when I want to' or you can take it as, 'this is a means to keep me on track'. And at first, it was not. It was, I just needed to get through it. But now it's a means to keep me on track. It's a means to keep me happy. I think about my future when I'm done this and I'm so excited. I get so happy.

Self-management.

Reduced Load. Several participants demonstrated personal agency by choosing to reduce their course loads. Emily worked fulltime when she started the program but found it to be too much. She went from fulltime work and study to two days a week of work to be successful in her program and reduce the pressure.

That is definitely one of the things I did to keep myself healthy. I know my grades would have suffered because I wouldn't have been mentally healthy enough to do any school work. But it was really starting to impact my mental health. I was like yeah… no. I need to cut something and cutting school was not an option… so I cut work.

Justine was careful to do one course at a time. She also learned to watch herself and her self-care at certain times of the year. Katie went from taking four courses at one time in order to be fully funded to two courses at a time. In hindsight, she wondered how she was able to get through that time.

Virginia described how she decided to reduce her course load.

I eventually got back around to a point where I started feeling a little bit more, moving around a little bit more… And I re-enrolled in one of the courses and I started taking it a lot slower at that point. And that kind of got things going again…Yeah, before taking two… initially with your enrollment, you have six months to complete a course. Initially I started with two or three courses at a time and I'd been doing ok with that but then at that point it just completely fell apart and I'm down to one course every eight months or so.

Negotiation.

Megan and Juliena negotiated with their employers in order to complete course work and maintain self-care practices. Megan's workplace supported her by encouraging staff to work on their courses when on night shift. She involved her workplace as a source of support. She switched shifts or took sick days when she had to, with her workplace's blessings, in order to complete her coursework on time.

Being able to talk to my work too and I have a really good management team here and so it would be like 'No, like you guys, I'm sorry I can't.' Like I'd tell them, I'd be like, you know what, I was supposed to do this paper. I tried for a couple of days. I can't do it. I'm going to have to, not call in sick, but I have to switch my shifts to a different day or give me sick hours for those times, like I can't do it because I, I fucked up. Like I, I didn't do my paper. I've got to get it done or else I'm gonna screw this up. So they were super flexible and like, understanding with me and I think it's probably because I work in mental health.

Megan also took a year's leave of absence to do other work as she was having difficulty with the stress of her work. She experienced this as a refreshing break and

developed transferrable skills for her transition back to her former work. The change in routine with her new position made it difficult for Juliena to maintain her running which was a key activity in maintaining her mental health. She negotiated the maintenance of her running routine with her new employer. She also negotiated study time.

After struggling with a single course twice without success, Amanda was left without a pathway to her degree. She took time off and her family moved to the United States during that time. Sparked by her mother-in-law's idea, Amanda investigated the possibility of changing her major and she switched degrees. She had only a few courses to complete before graduating with her degree.

Self-care. Self-care was mentioned repeatedly in participant interviews. Concomitant with the experience of depression and role overload, women's own personal needs and self-care activities were often the first to go out of a long list of priorities.

Virginia's experience of depression also included anxiety. In response Virginia tried to control what she could control. Exercise helped her manage depression and injury took away one of her primary coping strategies.

> *I think too a lot of the attitudes you take…I also know a lot of people where there's a lot of 'why does everything happen to me?' or 'I can't do it because of this' and instead it's more about knowing where your limitations are, where you're going to struggle and trying to find ways around it for you.*

Megan learned to "pump herself up," and replace negative self-talk with encouragement. She also reminded herself of the supportive people in her life who wanted her to succeed. When Megan talked about self-care, she really meant that she needed her people. Megan developed a support system and learned to recognize when

she was becoming depressed in which case she sought out someone with whom she could discuss her thoughts and feelings. The experience of depression taught her different coping and self-care skills.

Megan learned to talk with someone right away when she realized she was feeling low or angry or was experiencing negative self-talk. The thought of just "fuck it" was an initial sign that Megan was starting to feel depressed.

> *So when I'm, when I feel low or something like that, like I sit down, I've kind of now trained myself to say "Ok Megan, this is your trigger, this is your key that you need to find somebody to support you. You need, you need to talk to somebody." And for me, if I can get it out right away, like if I'm frustrated or I'm feeling sad and I'm going down that low, one of the first things that I find for myself, when I'm starting to get depressed or I start to get angry, is the initial sign of my depression and that feeling of "fuck it." I don't know how else to say it but that's like, words like that my brain thinks is "fuck it", "who cares," like, "it doesn't matter anyways" and then I have to like, "No Megan, you know better." You are very smart and you are engaged. You have two goddamn degrees. And I have to sit there and like pump myself up that, don't even think that way. Don't even go down that road… But, so it's, you have to, I've just found I've had to have a lot of supportive people for me, [who] believe in me. That I can do this when I couldn't believe I could do it myself.*

Juliena learned to manage her life in order to keep herself well. She knew that overstimulation drained her and so allowed herself to come home from work or change plans in order to accommodate a need for rest.

> *I do have to manage myself quite carefully and if I get overstimulated I really need to pay attention to that. Because it sucks all my energy from me so I've given myself permission over the years that if I have to come home from work or change my plans to just, you know, lay on my bed, that's completely fine…Things that I know help me immensely is running. Yeah, and running outside. It's kind of being out in a different element. So I know that helps quite a bit too.*

Justine noticed depressive symptoms and, in response, she took 1.5 weeks off to regroup, to be with her daughter, and just relax. Justine stressed the importance of self-care and being aware of oneself as necessary skills to completing online school while managing several roles, work, and family to avoid slipping into depression.

Organization. Most women mentioned the importance of keeping themselves organized as well as appreciating well-designed and detailed expectations and timelines in undergraduate courses. Depression resulted in Brooklyn having increased difficulties in keeping herself organized. Organized course design was very helpful for her when she was depressed. The detailed week-by-week expectations helped Brooklyn to plan her studies when she was struggling. Brooklyn stated "Because it is just common thing, well maybe not common, it is for me, for whenever I'm not feeling well is that being organized and everything like, is quite difficult for me. So to have someone have already organized that on my behalf makes it easier for me."

Emily also felt that program design was a factor in managing depression as a student. She was one of two women who completed their undergraduate programs online and was able to compare her experience of being in both online undergraduate and graduate programs. She felt that program design was a big factor in differentiating her

undergraduate and graduate online learning. Emily viewed the graduate course design and delivery as easier and friendlier to people struggling with depression.

> *Yeah I was saying the undergrads the way it was set up through that way it was more difficult with depression. But I'm finding with the graduate program it is easier with depression. And I mean, it's also tough to know what all those variables are. I think it could be a big thing of like program design right? I think that's a big factor.*

The most common way that most participants used to manage cope with depression and multiple roles was to carefully schedule coursework, family commitments, and work life. When recovering from depression, Elisabeth worked with her counsellor to re-establish and schedule self-care activities and then moved on to scheduling school activities as a part of her routine. Katie planned out her course work to meet deadlines, writing out a schedule including deadlines and weekly activities to keep her on track to complete her course. That way, if she noticed herself falling a bit behind, she could catch up in time.

Virginia planned out her schedule to help manage her time. She also set her own deadlines which helped her when she was doing well. She planned for the times of the year when she struggled most and lessened her expectations of herself during those times. When Virginia struggled with depression, it was more difficult to motivate herself to stick with her self-created schedule. She described making use of lists and detailed calendars with stickers and rewards to organize her time and studies as well as to motivate her. This organizational strategy helped Virginia to keep track when she struggled and helped her do what she had to do to get back on track.

Megan and Justine also described their strategies to keep organized and included all of their role commitments in describing these strategies. For example, Megan and her partner kept a large calendar at home where they put their activities and their children's activities. Megan described organization of the family's commitments as "huge." In order to complete her class while waiting for the anti-depressant she was prescribed to start working, Megan set out a schedule to the end of the semester and scheduled time into every day for her course work. It was important for Megan to be accountable for what she had to do.

Justine found that scheduling her coursework around her daughter's activities and work was essential in preventing depression.

> *This semester coming up, I've made a schedule. My daughter goes to Sylvan on Saturday mornings and has a modelling thing she does and then in the afternoon we just chill and do nothing. Sunday morning, whatever, fart around. Sunday afternoon, that's my time to sit down and do my real core of school work. I've also worked time into my work day to do school work. Just so I can get in there more frequently because I think it's the frequency that really does the trick…Yeah, scheduling's important and if I don't schedule properly it feeds back into that cycle where I'm up late to do homework and missing sleep. I get tired and it snowballs.*

Chapter 6. Discussion

This study was conducted to investigate the experience of women with depression in online learning and their recovery. The aim was to describe the invariant constituents of this experience using Giorgi's (2009) descriptive phenomenological analysis. Underlying the method used in this analysis is the philosophy of Husserl. Layder's (1997) Theory of Social Domains provided a social work disciplinary lens and informed the analysis of participant data. Invariant constituents of the experience included *developing depression after a trigger event, symptoms of depression, seeking treatment, peer interaction, role overload, changes in self-identity,* and *personal agency.* Several constituents also contained sub-constituents. Constituents were experienced by individual participants on a continuum, for example the severity and type of symptoms of depression and amount of peer interaction.

The general description of the women's experience in this study and related invariant constituents were different than those described in Roseth et al.'s (2013) study of women with depression with a few exceptions. Recall that the study used the same methodology, descriptive phenomenology, as my own. Similarities included "overinvestment in work or others' emotions to relieve internal pain" (p. 153), being responsible for "other persons' distress while ignoring their own feelings and needs" (p. 153), as well as succumbing to depression. In my study these descriptions were closest to the experience described as role overload where, rather than an attempt to relieve pain, women experienced this as their everyday reality. Women in my study also ignored their own needs in response to role overload and felt responsible to their partners, families, and colleagues for meeting their role expectations. This was not described however, as taking

responsibility for other people's distress. Eventually women in my study did succumb to depression which is in agreement with the Roseth et al. (2013) study however they continued to try ways of continuing their studies while living with depression. The dissertation research study followed women's experience past the initial depressive episode and into recovery.

This study adds to our knowledge of women who experienced and recovered from depression during their online studies. Some of the most important findings of this study are in their uniqueness to the context of online learning including the role of peer interaction for students as well as the role of agency in women's use of the affordances of online learning and self-management. These findings are of particular interest because of the limited literature on mental health disorders and online learning.

Students experienced online learning differently depending on whether they were undergraduate or graduate students as well as depending on the specific program in which students were enrolled. Peer availability and variety of peer interaction depended largely on whether participants were enrolled in an undergraduate or graduate program. A continuum of peer interaction was introduced in the previous chapter. Undergraduate students tended to have much less interaction with their peers, from no interaction and one-way interaction in a discussion forum to two-way interaction in occasional discussion forums. Graduate students had much more opportunity for interaction with peers including participation in online discussion forums several times a week to one-week FTF courses offered yearly and, for some, participation in practicum experiences. Undergraduates therefore had the least exposure to peers as they learned what studying online meant and what being a post-secondary online student involved. Virginia referred

to the experience as "the double-edged sword" of online education as if a trade-off was necessarily made in terms of connection with peers for the flexibility of online learning. Unfortunately, undergraduate students may accept that isolation is a necessary component of online learning rather than an institutional and design decision.

The experience of loneliness and isolation were particular to the undergraduate online experience. Most important in this study were women's articulation of the *type* of peer interaction they desired. Participants in the study talked about a felt need to commiserate with other students and compare experiences and expectations of being students. In essence, they desired to see themselves reflected in the experience of others. Not being able to do so exacerbated the experience of depression. Kirsh et al. (2016) identified the importance of social support, family issues and stigma to students with mental disorders. Social support was identified as having friends who helped them feel normal and who provided them with a sense of community. Weiner's (1999) grounded theory research investigating the meaning of education for students with mental disorders also posited the importance of normalizing students' lives as a subtheme of student experience. The results of the dissertation research clearly agree with these findings. Normalization of the student role and connection with others was desired by most of the women in my study. This may be particularly important in online environments where student interaction is only available by design. McManus et al. (2017) also found that online students felt isolated and disconnected in their online studies. Unlike many participants in my study however, students who felt this way included students who were engaged in two-way discussion forums.

Undergraduate students were also somewhat younger than graduate students and closer to adolescence or young adulthood when first signs of mental health problems tend to occur. What this suggests is that the students with the least experience in managing depression and with the least exposure to online learning also experienced the least peer interaction.

Participants who were graduate students found that their interactions with peers resulted in greater opportunities to commiserate about course material and course expectations as well as sharing their experiences of being students. Opportunities for peer interaction led to the use of other modes of communication in the form of texting, chat apps like WhatsApp, phone calls, FTF meetings and the development of friendships. Several graduate students used their peer interactions in online forums as a means of monitoring depressive symptoms and one participant credited this interaction as helping her recover from a depressive episode.

Particular to online learning environments was the use participants made of its unique affordances. Participants demonstrated agency in making use of these affordances. Affordances of online learning valued by participants included course extensions and flexibility. Although not successful for everyone, several participants credited course extensions in enabling them to 'wait out' a depressive episode until their medication began to work. This observation is consistent with Moisey's (2008) study where students with mental health concerns used the fewest supports, while also finding that course extensions were of most use of those supports that were available. In the dissertation research study, course extensions and, in paced courses, assignment extensions and modifications supported several participants during episodes of

depression. Course extensions continue to be a valuable tool that online programs offer to students with depression.

Also of importance to participants was the *flexibility* unique to online learning that allowed women to study when, and where, they chose. This study identified *how* flexibility was useful to women experiencing depression. Flexibility meant that, when depressed, women could wait for moments of clarity before engaging in their coursework and they could complete bits and pieces of their studies as they were able. The fatigue that accompanied depression could also be managed by studying from home or after resting rather than making the effort to travel to and from a FTF institution in addition to their other roles and responsibilities. Without the flexibility inherent in online learning, most women would not have been able to continue or complete their studies. As is the case with many online learners, the flexibility of online learning also allowed women to continue their education while also fulfilling their roles as employees and parents although fulfilling these roles often proved problematic. This result disagrees with the conclusions of McManus, Dryer, and Henning's (2017) study that questioned online learning as providing greater flexibility for students with mental health disorders and contended that students with mental health disorders experienced *additional* barriers because of the online mode of delivery. The women in this study would not have accessed educational opportunities had online options not been available.

The women in this study also experienced *role overload.* The women fully expected that they could fulfil all of their roles as students, employees and, in many instances, parents and still be successful. They did not question the validity of these expectations until they became depressed, sometimes in response to role overload. The

experience of depression necessarily moved them to reconsider their multiple roles and make adjustments by reducing course loads or hours of employment. Adjusting the role and responsibilities of parenting was not possible in the sense that several women were lone parents or, in one instance, a stay-at-home parent. Role overload contributed to the experience of depression. This finding was consistent with the Kramarae's (2001) qualitative study that described women in online courses as completing a *third shift* by completing their online education around the additional responsibilities of employment and childrearing. The Canadian survey research by Glynn et al., (2009) supports the importance of "measuring women's experience of their multiple roles rather than focusing on single roles (p. 217)". Their research demonstrated that poorer mental health was significantly associated with perception of role overload ($p<0.0001$). Role overload continues to be impact women's lives including the lives of women in online learning. Online learning, as a means of completing a degree while working however, is an attractive concept and often the sole means of working women to access education. Women valued the flexibility inherent in online learning.

This study illustrated the sequence of events in women's development and experience of depression throughout their online studies. Depression began with a trigger event which resulted in the development of depressive symptoms. Similar to the phenomenological studies of Dukas and Kruger (2013) and Roseth, Binder and Malt (2013) women described the bodily experience of depression although these themes and experiences are worded somewhat differently. Unique to the dissertation research study was women's diagnosis of major depressive episode by a health professional as well the study's continued focus past the initial experience of depression and into recovery.

All women sought out treatment for depression which most often included a combination of medication and counselling. Although women described what many referred to as "recovery" from the depressive episode experienced during their online studies, depression was also most often experienced as a recurring condition. Recovery can denote complete resolution of a medical condition. Most participants were clear that, in their experience of depression, recovery was from a single episode of a disorder that has a history and a potential future in their lives

The women expressed that managing their lives and depressive symptoms was essential to remaining well. In this regard, the organization of their time in terms of course expectations and family expectations in response to depression was a common strategy. In their Canadian study Kirsh et al. (2016) also mentioned self-management over academic life as important to students with self-identified mental health problems. The students in their study valued having control over course load and scheduling. In the dissertation research women spoke of their appreciation for well-organized and well-designed courses. Many also adjusted their course load in response to depression. A shift in the importance of self-care also took place which meant scheduling rest, social connections, and, in many cases, ongoing mental health support. Being able to understand the development of the experience of depression in these students as well as the multiple ways in which they adapted to depression may allow university staff and administration to account for this experience in student supports and in course and program design and delivery.

In addition to the development of depression, participants described, in depth, the impact depression had on their ability to learn and their self-identities. Depression

interfered considerably with women's ability to think clearly, and to read, retain, and organize information. Depression resulted in fatigue and exhaustion. Symptoms of depression made completing and submitting assignments difficult if not impossible. Women were often unable to perform academically until the worst of the symptoms had subsided. This was similar to the results of McManus et al. (2017) who described the cognitive impact of mental health disabilities on their sample of online learners including slower processing speed. While some students in the McManus et al. (2017) study attributed impaired memory and concentration to the medications they were taking, several women in my study identified these as symptoms of depression prior to being prescribed medication.

The experience of self-identity was reflected in women's identification of themselves as depressed as *not themselves*, in contrast to when well, as their *real selves*. This self-image was confirmed to them by loved ones and people close to them, but also through their changing academic performance. Notably, one participant reflected on her longstanding experience of depression as a part of her self-identity. Depression as an episodic and often long-standing disorder seemed to shift how women viewed themselves. For some participants, being depressed was an experience of not-self; for others it was experienced as a part of self. Women may fall on a continuum between these two. While an episode may be experienced by women as not-self, this did not preclude them from planning and managing should another episode or symptoms occur.

Chapter 7. Recommendations and Conclusion

Implications of this study include its relevance to post-secondary educational institutions in terms of the design of online learning and approaches to student support. Participants described isolation most concretely in terms of lack of access to interaction with peers and identified the *type* of peer interaction that they most desired. Participants wished for opportunities to see themselves reflected in their peers, particularly their experiences and identities as students. Effective peer interaction in online learning was essential to the well-being of women with depression. It was apparent in interviews with women (and the resulting continuum of peer interaction) that the isolation of students from their peers was the result of institutional choices in course design and delivery rather than due solely to the experience of depression. The institution where the study took place provided a range of opportunities for peer interaction depending on the type and level of program, with undergraduate programs having the least or no interaction and graduate programs providing the most. Efforts to establish some form of peer interaction, such as discussion forums in courses, would improve the experience of online learning particularly in undergraduate courses where students currently have the least peer contact. Undergraduate courses that incorporated peer interaction were appreciated by participants.

Opportunities for peer interaction could be a challenge for institutions where frequent or rolling enrollment results in very few students per course, however even as few as two students creates some possibilities for peer interaction (e.g. study partners). The availability of peer interaction that focused on the experience of being a student is possible outside of course sites; however, without being a course requirement, it is

unclear whether students with depression would have the energy to access an additional resource. At the very least, online students and students with depression require opportunities for peer interaction as a component of a healthy learning environment.

None of the women who participated in this study had identified themselves to the university as having a disability. In addition, at no time during our interviews had women referred to themselves as having a disability and, consequently, might not have considered themselves to have a disability. This finding differs from McManus, Dryer, and Henning's (2017) study where participants with unspecified mental health disorders were recruited from the university's disability services unit in order to confirm the diagnosis of a mental health disorder. Most students in their study also had additional health disabilities including sensory and physical disabilities. None of the women in the current study had accessed the university's disability services. Only one woman had considered this source of support, but had decided not to contact supports for students with disabilities due to her belief that it would be a crutch that she didn't want. Rather, students who participated in the study self-identified as having been diagnosed specifically with major depressive disorder by a health professional, most often a physician

Without registering with the university's designated services to support students with disabilities, the students in this study and their experiences were essentially invisible to the institution and to their instructors. Relying on institutional offices for students with disabilities to recruit participants for studies on student experiences regarding mental health disorders may contribute to the invisibility of this population as well as conflating

the experience of these students with others who experience multiple disabilities and related challenges.

Participants made use of the course extensions available to *all* students which were helpful as long as depressive symptoms started to lift in time for the women to make use of them. Having extensions available to all students made it possible for the women to access them despite not having registered with supports for students with disabilities. However, had they done so, they wouldn't have incurred additional costs for the extension as the Assistance for Students with Disabilities department at their university provided a free 2-month extension when requested. Because the women were not registered with this service, the availability of additional accommodations deemed appropriate for persons with mental disorders such as retroactive accommodations for missed assignments and exams would also not have helped them.

Although the relationship with university staff was not an invariable constituent of women's experience of depression, it was reflected in women's agency in negotiating support. Particularly in graduate studies where students had a relationship with their instructors, accommodations for the experience of depression were negotiated directly according to individual needs and often without having to disclose a diagnosis. Overall, graduate students with depression experienced their instructors as supportive. Women in undergraduate studies, for the most part, did not seem to form close enough relationships with course staff to reach out or negotiate course requirements to assist them in managing depression. It is possible that the various roles of tutors depending on the program, including many and changing tutors for the same course, and the relative absence of

instructors in terms of interactions with students in undergraduate courses, contributed to students' hesitance to seek support.

Course design needs to be clear and un-paced courses need to offer detailed examples of scheduling for completion of readings and assignments. Courses that included these design elements were appreciated by both undergraduate and graduate students. Depression temporarily disrupted students' ability to organize their lives and contributed to the experience of role overload. Well organized courses that included detailed schedules allowed women to integrate their academic schedules with the scheduling of work and family responsibilities. Course designers might keep this in mind when considering the student body for which the course is being designed.

Role overload has been shown to have a stronger relationship to women's mental health than any other sociodemographic variable (Glynn, Maclean, Forte, & Cohen, 2009). Women in the current study clearly experienced role overload during their online studies which contributed to their experience of depression and, sometimes, triggered an episode. Most of the women expected to work and study fulltime and many were also parenting. They discovered that these were unrealistic expectations and, eventually, many reduced their course load or work hours to cope with the overload. In agreement with Kramarae's (2001) seminal study of women and distance learning, the current study found that role overload continues to impact women's experience of post-secondary online learning as well as their mental health. Their experiences suggest that it is important for institutions to offer and advertise multiple paths to academic success in addition to fulltime studies. Institutions may also need to consider the gendered nature of role overload in their provision and promotion of mental health education and supports.

Most of the women were not aware of the supports for students with disabilities and of the mental health supports offered by their university. An exception was the example of one professor who took class time to talk about how to access mental health supports. Online institutions need to consider the visibility of messages regarding mental health and mental health supports on their course sites as well as ensuring that instructors can appropriately communicate the importance and normalcy of accessing supports.

This study highlighted the experience of women who persevered in their online studies while living with depression. What is unknown is what happens to those who are unable to navigate this experience. How many students leave their studies because of depression or other mental health disorders? What pedagogical, program, and course design decisions might best support students including those living with mental health disorders? These are all areas for further research. The relative invisibility of students with mental disorders, including depression, may make implementing changes to supports and course design and delivery challenging, but the prevalence of mental health disorders in post-secondary student populations also makes this essential. Implementing changes to courses consistent with research on student engagement in online learning contexts and reduction of isolation would be a significant step in meeting the needs of students with depression.

Future research might look at how students view their experience of having a mental health disorder in terms of identifying as having a disability. Finding ways of tracking students who live with mental disorders, and who do not register with services for students with disabilities, is encouraged. These students have insight into what worked and did not work for them in online education and could help inform educational

institutions with feedback on course and program design. They could also provide information on desired forms of support. Data from large North American survey studies investigating post-secondary populations including the National Collegiate Health Assessment (American College Health Association, 2019) mentioned previously could also be of use in improving program supports for students with mental disorders. Exit information on why students leave their programs which include mental health concerns would provide needed information for educational institutions that desire to improve their programs.

The importance of studying student experience in a wider societal context not limited to, for example, the online experience itself, may assist in the development of online experiences that encourage greater student support and, as a result, retention. Future studies might focus on the experience of depression while learning online regardless of gender and for males specifically, as well as on students' experience of other mental disorders in order to see whether the recommendations from this study remain appropriate or need to be adjusted for these populations. For example, Sophia experienced anxiety that impacted her learning and almost led her to withdraw from graduate studies. As another mental disorder which is experienced widely in both educational settings and in many populations in general, the study of anxiety in online student populations could add to our knowledge and development of supportive environments for students.

This phenomenological dissertation study of women as online learners who have experienced and recovered from depression while learning online provided a rich and in-depth view of the experience. I am hopeful that the personal experiences of the women

in this study will be used to improve the experience of online learning for other students who experience depression including, but not limited to, program and course design, academic paths to success, and supports for students. Researchers are encouraged to compare this study with previous studies on post-secondary students with depression and other mental disorders and to expand on research specific to online learning contexts.

The lived experience of women as online learners who lived with and recovered from depression is an experience of increasing frequency among post-secondary students as a whole. This study helped to make members of this mostly invisible population visible and their stories heard. It is incumbent on us as researchers, teachers, administrators, and designers of online education to respond in ways that will improve online learning contexts for these students. By doing so, we may improve the online learning contexts for all.

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Appendix A: Symptoms of Major Depressive Disorder

Major Depressive Disorder 296.xx (F32.x and F33.x) A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Note: Do not include symptoms that are clearly attributable to another medical condition.

A 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation.)

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition. Note: Criteria A-C represent a major depressive episode. Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the contest of loss. (p.160)

Appendix B: Participant Advertisement for Athabasca Administrative Message Centre

Doctoral Student, Department of Distance Education

Athabasca University

PARTICIPANTS REQUESTED FOR

RESEARCH INTO THE EXPERIENCE OF WOMEN IN ONLINE LEARNING WHO HAVE LIVED WITH DEPRESSION

I am a looking for volunteers to take part in a study of the experience of women who have lived with depression in post-secondary online learning contexts. To be included in this study you will:

1. Be registered in one of University of Athabasca's online degree granting programs (undergraduate or graduate).
2. Have completed at least three courses in your program. Have been diagnosed with depression by a health professional during your online studies.
3. Have recovered from depression.

As a participant in this study, you would be asked to participate in 2 interviews by phone or computer-mediated audio call of approximately 60 minutes for the first interview and 15 to 30 minutes for the second interview

For more information about this study, or to volunteer for this study, please contact:

Tracy Orr, doctoral student

at

403-846-8717 or

Email: *orr.tracyd@gmail.com*

Thank you for considering participating in this study

This study has been reviewed by, and received ethics clearance through the Athabasca University Research Ethics Board

Appendix C: Letter of Informed Consent

LETTER OF INFORMATION / INFORMED CONSENT FORM

WOMEN IN ONLINE LEARNING WHO HAVE LIVED WITH DEPRESSION

May 15, 2018

Principal Investigator (Researcher):

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Supervisor:

Susan Moisey, PhD

Centre for Distance Education

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Dear Online Learner,

You are invited to take part in a research project entitled *Women In Online Learning Who Have Lived With Depression.*

My name is Tracy Orr and I am a doctoral student at Athabasca University. As a requirement to complete my degree, I am conducting a research project about women who have lived with depression in post-secondary online learning contexts. I am also a researcher who had this experience during my own online studies. I am conducting this project under the supervision of Susan Moisey.

This form is part of the process of informed consent. The information presented should tell you what this research is about and what your participation will involve, should you choose to participate. Take time to read this carefully as it is important that you understand what I am asking of you. Please contact the principal investigator, Tracy Orr, if you have any questions about the project or would like more information before you consent to participate. You may also contact my research supervisor Susan Moisey if you have questions.

If you choose not to take part, or if you decide to withdraw from the research once it has started, there will be no negative consequences for you now, or in the future, and any data collected from you will immediately be destroyed.

Why are you being asked to take part in this research project?

You are being invited to participate in this project because you have self-identified as a woman who has lived with depression while studying in a post-secondary online learning program and has since recovered from depression.

What is the purpose of this research project?

This is a qualitative research project exploring the lived experience of women who have lived with depression while studying in post-secondary online learning contexts.

The main research question in the project is, "What are the lived experiences of women in online learning who have lived with depression?

What will you be asked to do?

If you agree to participate, I will interview you in person or by phone or by computer-mediated AUDIO call. The interview will be loosely structured, more like a conversation than a formal question-and-answer session. The interview should last approximately 60 minutes.

After the in-person interview, I may ask to conduct a shorter (up to 30 minutes) follow up interview with you two to four weeks later at a time that is convenient for you. This follow up interview could by phone or by computer-mediated AUDIO call, whichever is most convenient for you. If the follow-up interview occurs by phone, I will cover the cost of any long-distance fees incurred for the call.

Oral interviews will be audio- recorded and I will make a written transcript of the interview afterwards. You may review the transcripts of your interview(s) to check for accuracy and to correct transcription errors and clarify your comments if needed.

I will also ask you for a limited amount of demographic data, including your age, whether you are an undergraduate or graduate student, and whether your program includes a cohort. You may choose to not answer any of these demographic questions if you do not wish to provide that information.

What are the risks and benefits?

As a participant in this study, you can choose what information you wish to disclose or not disclose. The research questions will be focused on your experiences as a woman who has lived with depression while studying in a post-secondary online learning context. Discussing mental health concerns and related issues may bring up difficult feelings. I will endeavor to be attentive to any signs of distress to minimize the possibility of such a risk. The benefits of this project are to improve our understanding of distance learners who live with depression as well as to inform the practice of instructors and staff who work directly with students. Future students may also benefit from learning from the experiences of the women in this study.

Do you have to take part in this project?

Involvement in this project is entirely voluntary. You have the right to withdraw your consent to participate, including the right to stop the interview at any point, or to request that a certain comment or discussion not be included in the transcript or used in the analysis. If you decide to stop your interview, you may also request that data gathered from you prior to that point not be used in the research.

How will your privacy and confidentiality be protected?

As a participant in this project, your privacy and confidentiality will be protected in the following ways:

- You will not be identified by name in the project.
- Your location and the program in which you are studying will not be identified in the project.

How will confidentiality be maintained?

Confidentiality refers to the ethical obligation for researchers to safeguard participants' identifying information, such as name or description of physical appearance, from unauthorized access and misuse. Every reasonable effort will be made to ensure confidentiality. You will not be identified in publications. All participants will be given a pseudonym that will be used if there is a need to refer to a specific participant in the written version of the final project.

How will the data collected be stored?

All data, both audio and written, will be stored safely in a locked cabinet. I will be the only person with access to data.

At this point there are no plans for future secondary use of the data. In the event that the researcher proposes a subsequent project, any secondary use of this data will require further Research Ethics Board approval. Additionally, any secondary use of this data would be in

accordance with the guidelines set out by the Tri-Council Policy statement on Ethical Conduct for Research Involving Humans, available at http://www.pre.ethics.gc.ca/default.aspx

Who will receive the results of the research project?

The research will be listed in an abstract posted online at the Athabasca University Library's Digital Thesis and Project Room and the final research paper will be publicly available at https://dt.athabascau.ca/jspui/

Who can you contact for more information or to indicate your interest in participating in the research project?

Thank you for considering this invitation. If you have any questions or would like more information, please contact me at orr.tracyd@gmail.com or by phone at 403-846-8717; or my supervisor at susan.moisey@athabascau.ca. If you are ready to participate in this project, please complete and sign the attached Consent Form and return it by scanning it and emailing it to me at orr.tracyd@gmail.com or by mail to this address:

Tracy Orr

Box 5, Site 10, RR 3

Rocky Mountain House, AB

T4T 2A3

Thank you,

Tracy Orr

This project has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns regarding your treatment as a participant in this project, please contact the Research Ethics Office by e-mail at **rebsec@athabascau.ca** or by telephone at 1-800-788-9041, ext. 6718.Informed Consent:

Your signature on this form means that:

- You have read the information about the research project.
- You have been able to ask questions about this project.
- You are satisfied with the answers to any questions you may have had.
- You understand what the research project is about and what you will be asked to do.
- You understand that you are free to withdraw your participation in the research project without having to give a reason, and that doing so will not affect you now, or in the future.
- You understand that if you choose to end your participation **during** data collection, any data collected from you up to that point will be retained by the researcher, unless you indicate otherwise.
- You understand that if you choose to withdraw **after** data collection has ended, your data can be removed from the project at your request, up to midnight on January 31, 2019.

	Y ES	N O
I agree to be audio-recorded	◯	◯

I agree to the use of direct anonymous quotations	◯	◯
I would like to review the transcripts of my interview(s) to make sure my comments were accurately transcribed.	◯	◯

Your signature confirms:

- You have read what this research project is about and understood the risks and benefits. You have had time to think about participating in the project and had the opportunity to ask questions and have those questions answered to your satisfaction.
- You understand that participating in the project is entirely voluntary and that you may end your participation at any time without any penalty or negative consequences.
- You have been given a copy of this Informed Consent form for your records; and
- You agree to participate in this research project.

_____ _____

Signature of Participant Date

Principal Investigator's Signature:

I have explained this project to the best of my ability. I invited questions and responded to any that were asked. I believe that the participant fully understands what is involved in

participating in the research project, any potential risks and that he or she has freely chosen to participate.

_____ _____

Signature of Principal Investigator Date

Appendix D: Screening Checklist for Depression (Pre-interview)

Thank-you so much for participating in this study. Depression may be experienced as cyclical or re-occurring. For safety reasons, it is important that interviews take place when participants are not currently depressed. Please take a moment to complete the following checklist. Checking off five of these symptoms listed below suggests that you may be experiencing sufficient symptoms of depression to warrant checking in with your health professional. What this also means is that you are still a valued participant in the study but that we will arrange your interview for a later date.

Major Depressive Episode Checklist

Five (or more) of the following symptoms being present during the same 2-week period and represent a change from previous functioning. At least one of the symptoms is either #1 or #2.

Please check off any of the following symptoms that you are currently experiencing.

- ☐ 1. Depressed mood most of the day, nearly every day, as indicated by subjective report (e.g., feels sad, empty, hopeless).
- ☐ 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
- ☐ 3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
- ☐ 4. Insomnia or hypersomnia nearly every day.
- ☐ 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down.
- ☐ 6. Fatigue or loss of energy nearly every day.

- 7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day (not merely self-reproach or guilt about being sick).
- 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
- 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Thank-you for completing this checklist.

Appendix E: Certification of Ethical Approval

CERTIFICATION OF ETHICAL APPROVAL

The Athabasca University Research Ethics Board (AUREB) has reviewed and approved the research project noted below. The AUREB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS) and Athabasca University Policy and Procedures.

Ethics File No.: 23031

Principal Investigator:

Ms. Tracy Orr, Graduate Student

Centre for Distance Education\Doctor of Education in Distance Education

Supervisor:

Dr. Susan Moisey (Supervisor)

Project Title:

Women in online learning who have lived with depression: A descriptive phenomenological analysis

Effective Date: June 12, 2018 **Expiry Date**: June 11, 2019

Restrictions:

Any modification or amendment to the approved research must be submitted to the AUREB for approval.

Ethical approval is valid *for a period of one year*. An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

A Project Completion (Final) Report must be submitted when the research is complete (i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable)) or the research is terminated.

Approved by: Date: Jun 12, 2018

Carolyn Greene, Acting Chair

Centre for Distance Education, Departmental Ethics Review Committee

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Athabasca University Research Ethics Board

University Research Services, Research Centre

1 University Drive, Athabasca AB Canada T9S 3A3

E-mail rebsec@athabascau.ca

Telephone: 780.675.6718