

IDENTITY DEVELOPMENT, STIGMA, AND ACADEMIC RESILIENCE
IN COLLEGE STUDENTS WITH MENTAL ILLNESS

by

Ren VanderLind, M.A.

A dissertation submitted to the Graduate Council of
Texas State University in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
with a Major in Developmental Education
August 2018

Committee Members:

Sonya L. Armstrong, Chair

Eric J. Paulson

Taylor W. Acee

Deborah Balzhiser

Darren E. Lund

COPYRIGHT

by

Ren VanderLind

2018

FAIR USE AND AUTHOR'S PERMISSION STATEMENT

Fair Use

This work is protected by the Copyright Laws of the United States (Public Law 94-553, section 107). Consistent with fair use as defined in the Copyright Laws, brief quotations from this material are allowed with proper acknowledgment. Use of this material for financial gain without the author's express written permission is not allowed.

Duplication Permission

As the copyright holder of this work I, Ren VanderLind, authorize duplication of this work, in whole or in part, for educational or scholarly purposes only.

DEDICATION

This dissertation is dedicated to my family, who supported me through difficult times related to my mental illness and always did their best to make me feel capable of accomplishing whatever I set my mind to; my husband, who followed me to Texas to help me achieve my dreams and always supported me in my times of need; and, finally, to everyone diagnosed with a mental illness. You are more capable than you give yourself credit for; don't ever let anyone say you cannot accomplish what you want because of your mental illness.

ACKNOWLEDGEMENTS

Firstly, I would like to acknowledge each of my committee members for their support of my unconventional research topic; you all made me feel validated in my choice of target population and as if my research matters, and you may never know how much that has meant, and continues to mean, to me. Dr. Armstrong, thank you for your guidance and support through every breakdown. Dr. Paulson, thank you for pushing me to think through my conception of developmental education as it relates to college students with mental illness. Dr. Acee, thank you for stepping outside your comfort zone and serving on a qualitative dissertation. Dr. Lund, thank you for taking a chance on someone you'd never met before and joining my committee. Dr. Balzhiser, thank you for your insights along my journey and all your support.

I would also like to acknowledge Bernie Ramsey for his dedication to serving college students with mental illness. Bernie, without your help, this research could not have happened in the way it did. Thank you for allowing me access to the group counseling room for data collection in the duoethnography.

The final person I would like to acknowledge is Violet, my co-researcher in the duoethnography. I applaud you for putting yourself out there and allowing your voice to be heard in this dissertation even though you are not “out” as a person with bipolar disorder. Your insights were invaluable, as is your friendship.

TABLE OF CONTENTS

CHAPTER	Page
ACKNOWLEDGEMENTS	v
LIST OF TABLES	xi
ABSTRACT.....	xii
I. INTRODUCTION	1
Operational Definitions.....	1
Relevant Constructs	4
Student Resilience.....	4
Identity Development.....	5
Stigmatization and Identity	5
The State of Mental Illness in Academia	6
Academic Success.....	8
College Students at Risk	9
Identity Development as Literacy Learning	10
Research Questions	11
Overview of Studies.....	12
Theoretical Framework.....	13
Multiple Dimensions of Identity.....	13
Developmental Education.....	16
Representational Literacy	18
Theoretical Framework Synthesis.....	19

Summation & Preview	20
II. LITERATURE REVIEW	21
Developmental Education	21
The Developmental Education-Mental Illness Connection	22
Mental Health.....	25
Mental Illness in College Students	26
Mental Health and Academic Success	30
Depression, anxiety, and perfectionism in women	30
Stigmatization in college students with mental illness	31
Resilience in individuals with mental illness.....	32
Psychological resilience and mental health	33
Resilience and academic attainment	34
Identity Development.....	35
Summation & Preview	39
III. METHODOLOGY	40
Positionality	40
The Self as a Member of Developmental Education	41
Organization.....	43
Survey with Metaphorical Data	43
Metaphor Analysis	44
Data Collection	45
Data Analysis	47
Duoethnography.....	51

A Note on Language	52
Data Collection	53
Data Analysis	54
Autoethnography.....	55
Autoethnography as Method.....	55
Performative Autoethnography.....	57
Data Collection	59
Data Analysis.....	60
Summation and Preview	61
IV. SURVEY WITH METAPHORICAL DATA	63
Recruitment	63
Exclusionary Criteria for Metaphors	64
Diagnoses	65
Findings: Academic Resilience	66
Findings: Stigma.....	67
Self-Stigma.....	67
Perceived Stigma.....	68
What is Metaphor Analysis?: A Refresher.....	68
Coding Procedures: Individual Metaphors.....	70
Coding Procedures: Cross-Metaphor Analysis	73
Findings: Identity Development.....	75
“Being a Person with a Mental Illness” Metaphor.....	76
“Being a College Student with a Mental Illness” Metaphor.....	78

Cross-Metaphor Findings.....	80
Brief Discussion	83
Limitations.....	84
Summation and Preview.....	85
V. DUOETHNOGRAPHY	86
Procedures	86
Identity Development.....	89
Identity as an Individual with Mental Illness.....	89
Identity as a College Student with Mental Illness	104
Perceived Stigma	105
Self-Stigma	115
Academic Resilience.....	119
Intersecting Constructs.....	125
Brief Discussion.....	133
Limitation.....	134
Summation and Preview	134
VI. AUTOETHNOGRAPHY	135
Formatting Key	137
Glossary of Medical Abbreviations and Terminology.....	138
Semester One: Fall 2013.....	140
Intermediary Period: Late Fall 2015	162
Semester Two: Spring 2016.....	174
Brief Discussion.....	246

Limitations	247
Summation and Preview	247
VII. CROSS-STUDY ANALYSIS, RECOMMENDATIONS, AND FUTURE DIRECTIONS	248
Overview of Findings	248
Identity Findings	248
Stigma Findings	251
Academic Resilience Findings.....	253
Research Question One	254
Research Question Two	255
Research Question Three	257
Research Question Four	259
Summation	260
Recap.....	261
Significance to the Higher Education Community Writ Large	262
Significance to the Developmental Education Community	263
Practical Recommendations.....	264
Research Recommendations	269
Final Thoughts	270
APPENDIX SECTION.....	272
REFERENCES	323

LIST OF TABLES

Table	Page
1. College Students' Self-reported Mental Health Symptoms	27
2. College Students' Self-reported Mental Health Diagnoses	28
3. College Students' Self-reported Mental Health Concerns.....	28
4. Reported Diagnoses and Frequency.....	65
5. Perceived Academic Resilience by Number and Percentage	66
6. Conceptual Metaphors and Elicited Metaphor Responses for Person Metaphor	76
7. Person Conceptual Metaphors	77
8. Conceptual Metaphors and Elicited Metaphor Responses for Student Metaphor	78
9. Student Conceptual Metaphors	79
10. Similar Conceptual Metaphors	81

ABSTRACT

Increasing numbers of college students are reporting mental health concerns (American Collegiate Health Association, 2014; Novotney, 2014), and research demonstrates insufficient supports are available on campus (Reetz, Barr, & Krylowicz, 2013). It has also been established that college students with mental illness are less likely to persist from semester to semester, through a course, and through to graduation, as well as have lower GPAs than their neurotypical peers (Breslau, Lane, Sampson, & Kessler, 2008; Cranford, Eisenberg, & Serras, 2009; Elion, Wang, Slaney, & French, 2012; Keyes, Eisenberg, Perry, Dube, Kroenke, & Dhingra, 2012; Thompson, Connely, Thomas-Jones, & Eggert, 2013). In this dissertation, I argue that college students with mental illness are a part of the developmental education community in that the two populations have similar needs: both populations are likely to encounter stigma (Higbee, 2009; Martin, 2010; Megivern, Pellirito, & Mowbray, 2001; Maxwell, as cited by Piper, 1988; Quinn, Wilson, MacIntyre, & Tinklin, 2009; Tucker et al, 2013; Weiner, 1999; Weiner & Wiener, 1996) and are less likely to persist to graduation than their peers (Boylan & Bonham, 2007; Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Fowler & Boylan, 2010; Keyes et al., 2012; Thompson et al., 2013).

This dissertation comprises three studies: a survey with metaphorical data, a duoethnography, and an autoethnography. Three studies were used for a telescoping approach, examining the driving research questions from the broadest level (the university-wide survey) down to the most narrow (the autoethnography) to give breadth and depth to the dataset and our understanding of the experiences of identity development, stigma, and academic resilience in college students with mental illness.

Findings from the first study indicate that college students with mental illness have predominantly troubling or negative senses of identity both as individuals and as college students with mental illness, they encounter both perceived and self-stigmatization, and the majority perceive themselves as academically resilient. Findings from the second study, a duoethnography, may indicate that identity development may be tied to factors such as support systems and perceived stigma from others, including faculty, peers, and family members; perceived and self-stigma are encountered by individuals with bipolar disorder; and academic resilience is often demonstrated even if not perceived as such by the student. Findings from the third study may indicate identity development is a recursive process spurred by identity crises, that stigma is present from the self when one is a maladaptive perfectionist, and that academic resilience, again, although demonstrated, is not always perceived as such. To address these issues, educators and student support staff should be aware of the nature of mental illness to help reduce stigma and increase the positive sense of identity perceived by students with mental illness.

I. INTRODUCTION

Developmental education, as a field of study, refers to the courses into which a student is placed (i.e., developmental literacy or math) based upon standardized test scores, but developmental education as a field also takes into account the needs of developing learners via academic and nonacademic supports, foregrounding the development of the whole learner, including as an individual (Arendale, 2005, 2007; Boylan, 1995; Boylan & Saxon, 1998; Casazza & Silverman, 1996; Clowes, 1980; National Association for Developmental Education, n.d.). From this theoretical perspective, developmental education becomes more than students placed into developmental courses, incorporating the viewpoint that all students fall along an academic developmental spectrum in multiple ways, including their development as individuals who are learning new identities or ways of identifying throughout their educational journeys. In this sense of developmental education, all learners are developing, and as such, are developmental, as they are continuously learning new ways to learn, think, and grow as individuals and students (Alexander, 2005).

Operational Definitions

Developmental education: for the purpose of this dissertation, developmental education is defined using the National Association for Developmental Education (NADE) motto as a starting point: “Helping underprepared students prepare, prepared students advance, and advanced students excel” (n.d.). This, however, is merely a jumping-off point for the definition used in this dissertation. For a student to be considered part of developmental education, they should fit into the following criteria: placement into a course at the developmental level, membership in a marginalized or

underserved population, and/or needing academic and nonacademic supports for success (Arendale, 2005, 2007; Boylan, 1995; Boylan & Saxon, 1998; Casazza & Silverman, 1996; Clowes, 1980). Under this definition, the umbrella that is developmental education expands to include students not traditionally considered members of the developmental education community. This is not to diminish the way of conceiving of developmental education as a field of coursework; this distinction is just as important as that of the transitioning student, as described above. However, this dissertation will focus on students in some form of transition who happen to belong to a marginalized population.

Mental illness: for the purpose of this dissertation, mental illness is defined as a diagnosed disorder as documented in the *Diagnostic and Statistical Manual of Mental Disorders-V* (American Psychological Association, 2013). Mental illness does not encompass situational stress, which may be experienced by a great number of students, but which does not convey the label of an individual with mental illness within the psychiatric community. For an individual to fall under the umbrella of having a mental illness, he or she must have a diagnosed mental illness. This will form exclusionary criteria in the studies; individuals with undiagnosed mental illness will not be included in the participants. This is because it is easier to self-diagnose due to the plethora of free online screening programs rather than seek out proper diagnosis through a medical practitioner.

Academic attainment: a student's ability to persist (or, be resilient) in completing a course, being retained from semester to semester, and obtaining a degree or certificate. This also relates to their academic performance, for example, as measured by GPA.

Metaphor: For the purposes of this dissertation, metaphor is defined not as a literary metaphor but as “understanding one conceptual domain in terms of another conceptual domain” (Kövesces, 2010, p. 4). For example, “being a college student with a mental illness is like difficult” (this is an actual participant-provided elicited metaphor) is not a metaphor because the two conceptual domains are literal (i.e., “difficult” is literal, not metaphorical). Metaphors must be broken down into root constructs underlying the source domain. The target is the concrete, the literal, (e.g., “being a college student with a mental illness is like. . .” whereas the source (the elicited metaphor provided by the respondent) must deal with a figurative concept, not a literal one.

Target: The target is the provided part of the metaphor. In this case, the target would either be “being a college student with a mental illness is like. . .” or “being a person with a mental illness is like. . .”.

Source: The source is the part of the elicited metaphor created by the respondent. Following the above non-metaphorical example, the source would be “difficult.”

Elicited metaphor: The respondent-provided portion of a metaphor (the source) in conjunction with the target that is then analyzed to determine a conceptual metaphor.

Metaphor extension: This is a rationale provided by the respondent that must explain clearly why or how the respondent sees the elicited metaphor as apt.

Conceptual metaphor: The definition used for this dissertation, based in the metaphor analysis tradition, is “two conceptual domains, in which one domain is understood in terms of another” (Kövesces, 2010, p. 4). This means there are two domains, the target and the source, and one adds meaning to the other. The source adds meaning to the target, and in finding an underlying concept or construct, one identified

the conceptual metaphor. As a note, conceptual metaphors will be presented in ALL CAPS, following metaphor analysis tradition for presenting data.

Relevant Constructs

The constructs that will be explored in this dissertation are identity development, stigmatization, and academic resilience. Below, each of the constructs will be explored in detail.

Student Resilience

One common concern among the developmental (Boylan & Bonham, 2007; Fowler & Boylan, 2010) and mentally ill student populations (Breslau, Lane, Sampson, & Kessler, 2008; Cranford, Eisenberg, & Serras, 2009; Elion, Wang, Slaney, & French, 2012; Keyes, Eisenberg, Perry, Dube, Kroenke, & Dhingra, 2012; Thompson, Connely, Thomas-Jones, & Eggert, 2013) is that of academic persistence (i.e., resilience). A goal of developmental educators is to assist students placed into developmental coursework persist not only into credit-bearing coursework, but also to degree completion (Boylan & Bonham, 2007; Fowler & Boylan, 2010). Although educational researchers have not ascertained what percentage of overlap there is between these two populations, it can be extrapolated that resilience is key to the academic experiences of students in developmental education and those with mental illness, and one must bear in mind that, given the rising numbers of college students reporting mental health concerns, there are likely students enrolled in developmental coursework who have diagnosed mental illnesses.

Just as it requires resilience to reach the mark of college readiness (Boylan & Bonham, 2011; Boylan & Saxon, 1998), it requires resilience to manage the symptoms of

mental illness while staying enrolled in college, particularly as these symptoms may interfere with a student's ability to learn and actively participate in and complete coursework (Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Keyes et al., 2012; Thompson et al., 2013).

Identity Development

Like resilience, identity development is a key component informing this study because it is encountered by all college students. According to Abes, Jones, and McEwen's (2007/2011) multiple dimensions of identity framework, this growing into new ways of identifying is a process all students undergo as they navigate what it means to be in a myriad of ways, including as college students. All college students go through this process, and it is one particularly relevant to the developmental education student population as they may be learning to re-identify as students who are not prepared for credit-bearing coursework (Boylan, 1988a, 1988b, 1990; Boylan & White, 1987, 1994; Higbee, 2009). It is likewise relevant to the subpopulation of students with mental illness who must learn what it means to carry this label, how to integrate it into how they view themselves, and how it affects their academic experiences.

Stigmatization and Identity

Learning to be an individual with a mental illness is not different from some of what students placed into developmental courses face: potential stigmatization (Higbee, 2009), referred to in the literature as self-stigma and perceived stigma (Tucker et al., 2013), and learning new ways to navigate and make meaning of the world. In both cases, internal (self-stigma) or external (perceived) stigmatization may take place. Although, as of 2011, there was no research substantiating the link between stigma and developmental

education (Boylan & Bonham, 2011), theoretical literature points to this connection (Higbee, 2009; Piper, 1988). For an individual with a mental illness, there may be the perception of being “less than” their neurotypical peers, much like students in developmental education courses may feel behind their peers or unlike them because they were placed in a developmental rather than a credit-bearing course (Higbee, 2009). This stigmatization may, in turn, affect students’ self-perceptions and consequential identity development (Higbee, 2009). According to Abes, Jones, and McEwen’s (2007/2011) multiple dimensions of identity framework, students undergo a process of developing a variety of identities that may or may not overlap. In fact, it’s possible for these identities to be in dissonance with one another, one reason this dissertation explores the nuances of identity through the lens of identity as a person with a mental illness and identity as a college student with a mental illness.

The State of Mental Illness in Academia

Data indicate there are growing numbers of college students reporting mental health concerns, something college and universities may lack the resources to provide supports for (American College Health Association, 2014; Center for Collegiate Mental Health, 2013; Novotney, 2014). This special population has been shown to be at risk for not achieving academic success and degree completion (Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Keyes et al., 2012; Thompson et al., 2013). From the aforementioned developmental education perspective I am applying to this dissertation, these students deserve the requisite supports to succeed in their academic pursuits. If the goal of developmental education professionals is to help all populations, especially marginalized ones, develop as students and individuals, the developmental education

community should care about finding a way to support college students with mental illness. It's important to recognize that regardless of one's training in dealing with mental illness, educators can provide supports to college students with mental illness in ways that do not require professional training in areas such as counseling. There is danger in stepping outside one's area of expertise in this realm because it can be possible to overstep boundaries or inappropriately handle a situation which might cause emotional harm to a student with mental illness, but this can be mediated by a clear understanding of what these students experience and need from an educator standpoint. Academic supports are requisite to assist this population in attaining success in their coursework, much like they are requisite for students placed into developmental education.

I argue we should not exclude students with mental illness from the developmental education population. This requires viewing developmental education as a theoretical framework in addition to a field of study, but this viewpoint should not form a barrier to researching the needs of this special population (college students with mental illness), particularly given the focus of developmental education on supporting the whole learner (Arendale, 2005, 2007; Boylan, 1995; Boylan & Saxon, 1998; Casazza & Silverman, 1996; Clowes, 1980; NADE, n.d.). In providing supports to college students with mental illness, we are developing learners, a goal of developmental education we should extend to as many potentially struggling student populations as possible. Because college students with mental illness face so many barriers to academic success due to their illness (Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Keyes et al., 2012; Thompson et al., 2013), their needs should be taken into consideration by the developmental education community. As will be demonstrated in the literature review,

developmental education encompasses a myriad of supports (Arendale, 2005; Boylan & Bonham, 2007) and serves the whole learner (Arendale, 2005, 2007; Boylan, 1995; Boylan & Saxon, 1998; Casazza & Silverman, 1996; Clowes, 1980; NADE, n.d.), meaning developmental education, as a field, should be concerned with the needs of college students with mental illness. As it stands in the literature, there are similar needs of students in developmental education and students with mental illness; although the two populations should not be equated, we should extend the reach of developmental education to serve this need because it is part of the learner and because it affects the student's academic success (Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Keyes et al., 2012; Thompson et al., 2013).

Academic Success

College student mental illness interferes with degree completion and learning/academic success (Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Keyes et al., 2012; Thompson et al., 2013). No literature to date has examined potential overlaps between these two student populations (i.e., students in developmental education and students with mental illness). Examining how students develop as individuals during their emerging adulthood must take into consideration the ways in which students' differing identities may overlap to create barriers to their academic success. If we, as an academic community, are concerned with the academic success of students of color, non-traditional age, non-native speakers of English, and other such populations, we should likewise care about the success of this invisible marginalized population.

Marginalization also occurs through the quiet, although growing, conversations about mental illness. It is an issue that is becoming more acceptable to speak about

openly, although many individuals still do not feel comfortable disclosing their diagnoses. Ultimately, students with mental illnesses carry a unique set of needs into the classroom, not unlike students in developmental education; instructors and staff should be aware of how these identities may multiply the issues or roadblocks these student populations will face.

College Students At Risk

College students with mental illness are at risk for not attaining academic success and degree completion (Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Keyes et al., 2012; Thompson et al., 2013), a major concern of the developmental education community. This research, then, purports to access information regarding academic persistence—here, more frequently referred to as resilience—and factors that may influence the academic success of this population.

Part of this picture lies in how college students with mental illness learn new ways to “be” (requiring a reconceptualization of self) once they’ve been diagnosed. This requires a restructuring of how one views oneself, a process not dissimilar to that which students placed into developmental education may face. For example, these students may have held a conception of themselves that did not match up with being labeled developmental readers or writers. To navigate this new way of identifying, students must reconceptualize how they perceive themselves. As becomes apparent when breaking down these processes, college students with mental illness face some of the same issues students in developmental courses may encounter.

Identity Development as Literacy Learning

Furthermore, there stands a direct connection between students placed into developmental coursework and students with mental illness in that both groups are learning new literacies, albeit this differs slightly because students placed into developmental coursework are developing different identities than students with mental illness. In the case of students in developmental literacy courses, this may take the form of learning to make or create meaning with text, but it also extends to identity development. In New Literacy Studies, two foundational researchers, Cope and Kalantzis (2009), point to several modes of literacy, one of which is representational literacy, that of representing oneself to the world. This, in essence, is identity construction as a literacy, something also described as social literacies (Gee, 2005, 2009, 2013; Lea & Street, 2006). As college students with mental illness begin to forge identities related to their diagnoses, they engage in a literacy act: identity development, or representational literacy. In this way, college students with mental illness develop their literacy skills much like students in developmental literacy courses do. This may even be a parallel process as students placed into developmental courses may find themselves likewise constructing new academic and nonacademic identities or ways of representing themselves. Some individuals may not consider this a literacy act, but when one views the world as a text as opposed to viewing only print-based texts as representing literacy, representation of one's identity becomes a literacy practice (Cope & Kalantzis, 2009; Gee, 2005, 2009, 2013). Students are learning new d/Discourses (discourse referring to language itself, and Discourse referring to language considering the power structures, beliefs, values, and ideologies inherent therein) unique to their respective communities as

ways to express how they view themselves and want to be viewed by the world (Gee, 2013; Smagorinsky, 2001), meaning they are learning the predominant modes of expression unique to differing settings, such as in the classroom or social situations. This itself is a process of student development: finding ways to identify based on students' unique characteristics such as race/ethnicity, gender, age, LGBTQIA membership, and visible or invisible disability, to name a few (Abes, Jones, & McEwen, 2007/2011). These are all special populations that the developmental education community seeks to support through to degree completion, which includes people with mental illness, an invisible disability (Higbee, 2009).

Research Questions

This dissertation purports to access how students with mental illness develop their identities as both individuals in general and college students in particular (that may not fit into societal norms) as well as whether and how they perceive stigma and academic resilience in a higher education setting and how these factors intersect with their academic and nonacademic identities. To achieve this, I will investigate four driving questions:

1. How do college students with mental illness conceive of their identities as people with mental illness?
2. How do college students with mental illness conceive of their identities as college students with mental illness?
3. Do college students with mental illness perceive themselves as stigmatized within academia?

- a. If so, in what ways or for what reasons are they stigmatized within academia?
- 4. Do college students with mental illness perceive themselves as academically resilient?
 - a. If so, in what ways or for what reasons are they academically resilient?

These questions have been constructed in response to a pilot study (VanderLind, 2017) in which stigma and resilience emerged as themes that merit further investigation and development. The educational field's understanding of what it means to be a college student with mental illness is mostly limited to quantitative studies that do not capture the lived experiences of these individuals. Hence, qualitative research is desirable in answering these questions of how students are both stigmatized and resilient.

Overview of Studies

This dissertation will investigate the issues of identity development, stigma, and academic resilience across three studies: a university-wide survey with metaphorical data, a duoethnography, and an autoethnography. Three studies with differing amounts of participants have been selected to build a telescoping approach to answering the research questions. This will provide breadth and depth to the datasets, giving insights into the experiences of the many to the more nuanced detail provided in the individual experiences delved into in the autoethnography. The duoethnography, with an *N* of two, forms the bridge between these two studies as it gives the juxtaposed experiences of two individuals, narrowing the scope of data beyond the university-wide survey but providing more information than the autoethnography. It should be noted that, due to the differing genres of the studies, the tone of writing will differ vastly across findings chapters. In

particular, the survey with metaphorical data will have a more analytical tone, the duoethnography will have a more narrative tone with analysis and discussion woven in, and the autoethnography will have a tone more representative of creative writing alongside analysis and discussion, so this chapter will have more intermingling of different tones of voice.

Beyond painting a rich picture of what it means to be a college student with a mental illness, this dissertation will provide insights for faculty and staff who may interact with individuals from this population. The better the supports we can provide and the deeper our understanding of the needs of this population, the better we can serve them and help them achieve academic success through to degree completion.

Theoretical Framework

The theoretical framework driving this dissertation is built upon three constructs: I will be using a mix of Abes, Jones, and McEwen's (2007/2011) Multiple Dimensions of Identity framework, a developmental education framework (based in the theoretical underpinnings of developmental education), and a representational literacy framework (Cope & Kalantzis, 2009). Although these constructs mainly relate to identity, resilience and stigmatization are also present in the interactions between the work of Abes, Jones, and McEwen (2007/2011), the developmental education lens, and that of representational literacy.

Multiple Dimensions of Identity

Abes, Jones, and McEwen (2007/2011) posit a theory of multiple dimensions of identity, building upon the work of Baxter Magolda (2001), Kegan (1994), Abes and Jones (2004), and Jones and McEwen (2000). This theoretical framework uses these

four theories to build a sense of how students identify in a myriad of ways; according to Abes, Jones, and McEwen (2007/2011), students develop socially constructed identities that are contextually driven. Based upon Jones and McEwen's (2000) model of identity development, this framework examines how students have a core identity and multiple additional ways of identifying based on demographic characteristics such as socioeconomic status, culture, race, and gender. Jones and McEwen's (2000) model posits the core identity comprises personal attributes, personal characteristics, and personal identity and the other facets of identity (i.e., those based on demographics) circulate around this central sense of identity. All of this is situated within the context of experience and sociocultural influences. After a study into identity development of lesbians conducted by Abes and Jones (2004), this model was revised by Abes, Jones, and McEwen (2007/2011) to incorporate what they call the meaning-making filter through which the contextual influences move to have an effect on students' conceptions of identity. This means that there are different degrees to which the context affects identity conception; for example, some identities may be more foregrounded than others in certain contexts, such as gender being more prevalent than an identity based on race/ethnicity.

Adding the component of the meaning-making filter, Abes, Jones, and McEwen (2007/2011) argue, influences how students make sense of their identities in particular circumstances and to what degree these identities are stable or intertwined with other ways of identifying. It also highlights the differences between personal and socially constructed identities, noting that students have both core identities and those based on sociocultural influences (e.g., identities of race/ethnicity, gender, sexual orientation).

Although this framework does not discuss the implications of academic versus nonacademic identities, the logic follows through that students are developing both during their academic careers.

The theory of multiple dimensions of identity has a focus on student development: it provides a framework for examining how students' identities develop based on context and sociocultural influences (Abes, Jones, & McEwen, 2007/2011). This framework will be used to inform this study in examination of how college students with mental illness develop multiple identities: those as people with mental illness (which may be posited to represent the core identity) and as college students with mental illness (a contextual shift from the personal, or core, identity to a socioculturally constructed one). In response to Abes, Jones, and McEwen's (2007/2011) assertion that researchers of identity development be wary of how the sociocultural context influences the meaning-making process of identity conception, I used a survey that included items addressing both parts of identity I want to assess separately: that of people with mental illness and that of college students with mental illness. This provides the context for the participants, giving them the structure needed to explore the meanings of their specific identities. This will foreground the identities I wish to examine, eliminating the potential for students to perceive some aspects of their identities as less salient than others. Both the identity as an individual with a mental illness and the identity as a college student with a mental illness will be presented separately, making each contextually grounded for the respondents.

Developmental Education

The second component of my theoretical framework involves the developmental education perspective. For my purposes, this framework is based in my earlier definition of developmental education using the field's theoretical underpinnings. I am focusing the lens on student development as learners and individuals. Using the NADE motto of developmental education, I am framing this dissertation as one that aims to access information about the development of college students at all levels of study, extending from first-year students to doctoral students. This view of developmental education is further echoed by Arendale (2005), who advocates that developmental education's focus is on all students because "all college students are developmental" (p. 72). Arendale (2005, 2007) further argues that developmental education focuses on both the cognitive and affective domains, not solely the learning aspect of the educational process. This dissertation undertakes the notion of developmental education as laid out by both NADE and Arendale: something that encompasses more than developmental coursework and delves into multiple aspects of student development. For example, proponents of the field posit that developmental education focuses on helping develop knowledge and skills in college students encompassing both the cognitive and affective domains (Arendale, 2005, 2007; Boylan, 1995; Boylan & Saxon, 1998; Casazza & Silverman, 1996; Clowes, 1980; NADE, n.d., 2015), something that may be conceived of as relating to identity development. This link lies in the skills component: learning a new identity or developing identities in disparate or interconnected ways may be conceived of as a skill students are gaining over the course of their studies as they come into their own as individuals and learners.

A component of developmental education that should not be overlooked in the context of this study is its focus on helping learners succeed academically (Arendale, 2005, 2007; Rubin, 1991; NADE, n.d., 2015). When considered in light of the research that indicates college students with mental illness experience academic struggles (Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Keyes et al., 2012; Thompson et al., 2013), it becomes clear that the developmental education community extends beyond learners in developmental coursework. This portion of the developmental education framework will address the fourth research question addressed in this dissertation: whether college students with mental illness are resilient in their studies, and if so, how?

Another element of developmental education that will be incorporated into this framework is the potential for stigma as identified by Maxwell in an interview with Piper (1998). Maxwell argues that the connotation of developmental education lends to stigmatization of learners placed into developmental coursework. I am extending this notion of stigma beyond the developmental classroom into the realm of identity development, tying together how stigma may affect college students with mental illness in their identity development and conception of self. Maxwell as interviewed by Piper (1998), Higbee, (2009), Higbee, Arendale, and Lundell (2005), and Koch, Slate, and Moore (2012) demonstrate that developmental coursework may carry a stigma for learners, something that has been mirrored in mental illness research (Hess & Tracey, 2013; Keyes et al., 2012; Leung, Cheung, & Tsui, 2012; Markoulakis & Kirsh, 2013; Mashiach-Eizenger, Hasson-Ohayon, Yanos, & Lysaker, 2013; Park, Edmondson & Less, 2012; Walker, Wingate, Obasi, & Joiner, 2008; Wang, 2012; Zychinski & Polo, 2012). If college students with mental illness make up part of the developmental

education population, this link in stigmatization seems crucial to understanding how learners develop a sense of identity or identities. This is the basis for the third research question in this study: if college students with mental illness perceive stigmatization, and if so, in what ways?

Representational Literacy

The third component of my theoretical framework is that of Cope and Kalantzis' (2009) concept of representational literacy. In their article about multiliteracies, Cope and Kalantzis (2009) define representational literacy in a variety of ways; the one I will be using is what they call "representation to oneself" (p. 179). They describe this kind of literacy as "tak[ing] the form of feelings and emotions or rehearsing action sequences in one's mind's eye" (p. 179), a representation of one's self that can be conceptualized as a representation of one's identity to both the self and the world. This piece of the theoretical framework will inform the ways in which I analyze the data for identity development: not only will I examine how self-concept develops in college students with mental illness, but I will also consider this development through the literacy lens.

Through this lens, all students are developing multiple literacies as they develop their identities (Cope & Kalantzis, 2009). My metaphor for identity development is that of literacy development: as students learn new ways to make meaning of the world around them, they simultaneously make meaning of what it means to be; they are using the meaning-making lens posited by Abes, Jones, and McEwen (2007/2011). In this light, developing identities as both individuals and college students with mental illness becomes a complex act of meaning making. Students are using the sociocultural cues to

filter experience into a sense of which identity to foreground (Abes, Jones, & McEwen, 2007/2011).

Using this analytical lens will allow me to access information about how college students with mental illness develop their academic and nonacademic identities in concert or in isolation. Thus, the representational literacy lens lends towards my first two research questions: how college students with mental illness develop (i.e., conceive of) their identities as both people and college students with a mental illness.

Theoretical Framework Synthesis

Stigmatization occurs within identity development. More salient aspects of an individual's identity will be foregrounded based on contextual factors (Abes, Jones & McEwen, 2007/2011), making it possible that a student with mental illness may choose to place that kind of identity in the background if experiencing stigmatization or threat to identity. This may also cause a shift in how the student decides to represent him- or herself to others (i.e., representational literacy), foregrounding the least stigmatized parts of their identity when trying to present the self to others. In this way, the developmental education, representational literacy, and multiple dimensions of identity come together to form a framework for understanding identity development and stigmatization. The construct of resilience comes through mainly from the developmental education perspective as students of developmental education may face issues of resilience. This intersects with identity development in that some research has shown issues of resilience for individuals who are maladaptive perfectionists, something that leads to poor mental health (i.e., depression) (Castro & Rice, 2003; Elion et al., 2012; Gnilka et al., 2013; Schrick et al., 2012; Stoeber et al., 2014; Walker et al., 2008). Although the construct of

resilience is most salient in terms of the developmental education perspective, it comes into the forefront of identity expression and development when students' self-conception does not meet their academic outcomes.

Summation and Preview

In this chapter, the definitions for developmental education and mental illness were established as was the case for including college students with mental illness under the developmental education umbrella (given its theoretical underpinnings). This chapter established the concerns facing both college students with mental illness and college students in developmental education in terms of identity development, stigmatization, and resilience. The following chapter contains a review of the literature on these three constructs as well as provides background on the issue of mental illness in higher education.

II. LITERATURE REVIEW

This chapter will explore how identity is developed during emerging adulthood and how both stigma and resilience function within college students with mental illness. It will begin with a brief exploration of the field of developmental education to establish the connection between the field and college students with mental illness.

Developmental Education

Given the NADE motto of developmental education provided in chapter 1, the field is concerned with lifelong learning, supporting the needs of students at all levels of study. It is also concerned with serving marginalized populations, such as students placed into developmental courses and first-generation students (Arendale, 2002; Boylan & Bonham, 2014; Higbee, 2009). In this way, developmental education is not limited to a focus on developmental coursework, but rather has theoretical underpinnings that expand the conception of who the developmental education population comprises and what supports developmental education includes. For the purposes of the studies in this dissertation, the lifelong learning aspect of developmental education (Boylan, 1987a, 1987b) will be foregrounded because the target population of this dissertation are not students placed into developmental courses.

All college students are along a developmental spectrum, from those placed into developmental courses to those pursuing doctoral studies, as they are continually in the process of developing as students and individuals, another primary concern of developmental education (Boylan, 1988a, 1988b; Boylan & Bonham, 2007). It should be noted, however, that these sources do not speak specifically to doctoral studies; I am using the NADE definition to extend who developmental education serves because these

students are also developing in some of the same ways students in developmental education do—they are developing new senses of identity as doctoral students, learning how to be successful doctoral students, etc. Developmental education, as conceived of for this dissertation, encompasses all students at a college or university because of the focus of developmental education on lifelong learning and recognition of necessary student supports to help them attain academic success (Boylan, 1987a, 1987b). All students, then, are somewhere along the developmental spectrum, rendering them members of the developmental education community writ large.

Another important factor to bear in mind about the field of developmental education is that it encompasses a myriad of student support services beyond those provided in the classroom: learning centers, writing centers, advising services, counseling services, and much more (Arendale, 2005; Boylan & Bonham, 2007). Therefore, based on the far-extending reach of developmental education, it becomes clear that the field is concerned with more than simply developmental coursework, although this is obviously a key component of developmental education. This umbrella of services under developmental education seeks to serve the whole student, keeping in mind we are in an era that focuses holistically on the student in developmental education (Arendale, 2005, 2007; Boylan, 1995; Boylan & Saxon, 1998; Casazza & Silverman, 1996; Clowes, 1980; National Association for Developmental Education, n.d.).

The Developmental Education-Mental Illness Connection

In the same way that students placed into developmental education may feel marginalized and stigmatized (Higbee, 2009; Maxwell, as cited by Piper, 1988), college students with mental illness may encounter these same concerns (Hess & Tracey, 2013;

Keyes et al., 2012; Leung, Cheung, & Tsui, 2012; Markoulakis & Kirsh, 2013; Mashiach-Eizenger, Hasson-Ohayon, Yanos, & Lysaker, 2013; Park, Edmondson & Less, 2012; Walker, Wingate, Obasi, & Joiner, 2008; Wang, 2012; Zychinski & Polo, 2012). Stigmatization and marginalization are not unique to any one population, but they may be more salient issues for different student populations such as those with mental illness or those placed in developmental courses. Self-conception is a large component of student development (Abes, Jones, & McEwen, 2007/2011)—the ways in which they perceive themselves can shape their classroom involvement and engagement—so it is crucial to understand (a) what kinds of self-conceptions these students have and (b) how to help them develop positive self-conceptions to avoid stigmatization and its negative effects.

At its heart, developmental education is about setting students up for success (Bettinger, Boatman, & Long, 2013; NADE, n.d., 2015). This dissertation aims to get at this piece (setting students up for success), only with a population not currently deemed part of the developmental education population in the literature, examining how students with mental illness construct identities that may not fit into societal norms as well as how these academic and nonacademic identities intersect with stigmatization and resilience.

Although the developmental education and mentally ill populations cannot, and should not, be equated, their members' needs in terms of academic support and experiences are parallel enough to suggest we should at least consider the possibility of students with mental illness as part of the developmental education community writ large. They may not be students placed into developmental education coursework, but they, based on the theoretical underpinnings of developmental education, at least merit

consideration as falling under the developmental education umbrella as students along a lifelong learning trajectory, students developing academic and individual identities, students who have difficulty with academic attainment, students who may benefit from skills instruction such as self-regulatory processes, and as students in a marginalized population.

Note that a student in developmental education is not the same as a student with a mental illness; although they may have similar needs or be on similar trajectories regarding factors such as identity development and facing stigma (Higbee, 2009; Piper, 1988), they are separate populations. My argument, then, is not so much that the two populations equate, but that the field of developmental education is not fulfilling its mission by not researching the needs of college students with mental illness. This is because developmental education focuses on serving the whole learner (Arendale, 2005, 2007; Boylan, 1995; Boylan & Saxon, 1998; Casazza & Silverman, 1996; Clowes, 1980; NADE, n.d.), and part of that picture is mental health status. If, as a field, we purport to support students in their academic and nonacademic needs, treating the whole student, we must consider the needs of those who have mental illness because it is both a component of the student and a factor that plays a role in academic success (Belch, 2011; Breslau, Lane, Sampson, & Kessler, 2008; Keyes, Eisenberg, Perry, Dube, Kroenke, & Dhingra, 2012; Thompson, Connelly, Thomas-Jones, & Eggert, 2013). The needs of college students with mental illness have been explored only partially in the literature and have been overlooked in the developmental education literature. This leaves a large knowledge gap to be filled.

Despite the call for inclusion of students with disabilities as part of the student population developmental education serves (Higbee, 2009), this has not extended beyond students with learning disabilities or physical disabilities, excluding college students with mental illness, which is a type of disability. If, as Higbee (2009) asserts, developmental education serves an increasingly diverse student population, college students with mental illness should be included in this population as they are a diverse population themselves. This is problematic in that developmental education researchers and theorists have not taken the needs of college students with mental illness into consideration as being included in those developmental educators serve. As will be discussed shortly, given the numbers of college students reporting mental health concerns, greater attention should be afforded to the needs of this population. This dissertation will fill some gaps in knowledge about how to best serve this student population through an exploration of identity development, perceived and self-stigma, and perceived academic resilience, none of which have been addressed in the developmental education literature.

Mental Health

Mental health, although not a new concern, has become increasingly acceptable to discuss in recent years. A growing body of research about college students' mental health concerns underline the need for educators to consider how mental health might affect students and what courses of action are available. This is imperative given how mental illness may hinder student success in terms of educational attainment (Belch, 2011; Breslau et al., 2008; Keyes et al., 2012; Thompson et al., 2013), educational attainment as related to perfectionism (Castro & Rice, 2003; Elion, Wang, Slaney, & French, 2012; Gnilka, Ashby, & Noble, 2013; Schrick, Sharp, Zvonkovic, & Reifman, 2012; Sironic &

Reeve, 2012; Stoeber, Schneider, Hussain, & Matthews, 2014), use of self-regulatory skills (Van Nguyen, Laohasiriwong, Saengsuwan, Thinkhamrop, & Wright, 2015), self-image (Crocker, Olivier, & Nuer, 2009), and use of mental health services (Cranford, Eisenberg, & Serras, 2009; Reetz, Bar, & Krylowicz, 2014). Even though mental health supports exist on many campuses, research shows that these are often insufficient to meet the demands of the student population (Novotney, 2014; Reetz, Bar, & Krylowicz, 2014).

Mental Illness in College Students

Postsecondary students are reporting a variety of mental health concerns (American College Health Association, 2014, 2015; Center for Collegiate Mental Health, 2013, 2015; Novotney, 2014). According to a 2015 study conducted by the American College Health Association (ACHA), 21.9% of students sampled reported anxiety as a factor impacting their ability to perform academically; 13.8% reported the same for depression, and 30% reported the same for stress. As shown in Table 1, from a representative sample of college students who reported having a mental health concern, anywhere from 90.3% to 1.4% reported some kind of mental health concern during the spring semester of 2015 (ACHA, 2015). Of most concern might be the percentage of students reporting feeling hopeless, overwhelmed (with or without anxiety), and so depressed they struggle to function; these numbers represent the most commonly studied mental illnesses in college students: depression and anxiety (Breslau et al., 2008; Castro & Rice, 2003; Cranford, Eisenberg, & Serras, 2009; Elion et al., 2012; Gnilka et al., 2013; Schrick, et al., 2012).

Table 1. College Students' Self-reported Mental Health Symptoms

Variable ^a	Male (%)	Female (%)
Hopelessness	40.7	50.9
Feeling overwhelmed	76.0	90.3
Very lonely	52.1	62.0
Very sad	54.2	68.5
Difficulty functioning due to depression	29.8	36.6
Overwhelming anxiety	45.4	62.3
Considered suicide	8.3	9.0
Attempted suicide	1.4	1.4
Engaged in SIB ^b	4.3	7.1

Note. Data represent a random sample of undergraduates from 140 schools. $N = 93,034$. Adapted from "Undergraduate Reference Group Executive Summary: Spring 2015," by American College Health Association, 2015.

^aSelf-reported as present within the past 12 months. ^bSelf-injurious behavior.

According to reports by the American College Health Association (ACHA), the Center for Collegiate Mental Health (CCMH), and the Association for University and College Counseling Center Directors (AUCCCP), statistics such as these have been steadily increasing (Novotney, 2014). As more postsecondary students grapple with mental health concerns, greater demands are placed on campus services, particularly counseling services; in 2013, AUCCCP reported that approximately one third of counseling centers surveyed reported needing waiting lists due to the volume of students seeking services (Reetz, Bar, & Krylowicz, 2014). According to the CCMH 2013 report, college students receiving on-campus counseling attended an average of five appointments. Across the 132 institutions of higher education surveyed, this added up to approximately 350,000 total individual counseling appointments (CCMH, 2013). Data from AUCCCP and CCMH emphasize the need for campus mental health services to address the increasing needs of students.

Table 2. College Students' Self-reported Mental Health Diagnoses

Variable ^a	Male (%)	Female (%)
Anxiety	9.6	18.6
Bipolar Disorder	1.5	1.5
Depression	8.9	14.9
Insomnia	3.6	5.0
Panic Attacks	3.8	9.1
Schizophrenia	0.5	0.2
Depression and Anxiety	5.9	11.3

Note. Data represent a random sample of undergraduates from 140 schools. *N* = 93,034. Adapted from “Undergraduate Reference Group Executive Summary: Spring 2015,” by American College Health Association, 2015.

^aSelf-reported as present within the past 12 months.

As seen in Table 2, ACHA's spring 2015 report of students' self-reported mental health diagnoses demonstrates the prevalence of anxiety and depression: when combined across genders, 17.2% of respondents reported a diagnosis of both anxiety and depression (ACHA, 2015). This equates almost 16,000 college students diagnosed within the calendar year prior to spring semester 2015. In addition, the CCMH 2015 report showed increasing numbers of college students reporting having attended counseling or taken medication for mental health concerns between the 2013-2014 and 2014-2015 academic years. They also found an increase across reported self-injurious behavior, suicide ideation, and suicide attempts (CCMH, 2015). This data is presented in Table 3.

Table 3. College Students' Self-reported Mental Health Concerns

	2013-2014 (%)	2014-2015 (%)	% increase
Attended counseling ^a	48.1	48.8	0.7
Taken medication ^a	32.6	33.1	0.5
Hospitalized ^a	10.2	10.2	0.0
SIB ^b without suicidal intent	23.8	25.0	1.2
Suicide ideation	30.9	32.9	2.0
Suicide attempt	8.9	9.5	0.6

Table 3 Continued.

Note. Data for the 2013-2014 academic year represent a sample of 140 institutions with 101,027 counseling clients; 2014-2015 data represent a sample of 139 institutions with 100,736 counseling clients. Adapted from “Center for Collegiate Mental Health 2015 Annual Report,” by Center for Collegiate Mental Health, 2015.

^aThese items are specifically for mental health concerns. ^bSelf-injurious behavior.

Firstly, we must note the prevalence of mental health concerns among college students.

Secondly, all these data point towards the increasing need for academic and nonacademic supports for college students with mental illness as there are insufficient counseling resources to support this population (Reetz, Barr, & Krylowicz, 2013) and mental illness has been shown to affect students’ resilience and GPA (Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Keyes et al., 2012; Thompson, 2013). This calls for an awareness by faculty and staff of how to best serve this student population, in particular because so little is known about their needs. Higbee (2009) calls for a curriculum that responds to the needs of students with disabilities, including invisible disabilities such as mental illness, addressing the needs of all students and increasing their participation through Universal Design. Although Universal Design may not have direct benefits for students with mental illness, as the focus of Universal Design is more on access for students with learning disabilities and physical disabilities (The Center for Universal Design, 2008), Higbee makes the point that we need to adjust the curriculum to serve marginalized student populations. For college students with mental illness, this requires both academic and nonacademic supports because they are facing challenges posed by their diagnoses and symptoms alongside their academic concerns. Ultimately, higher education professionals need to learn more about how to support college students with mental illness, something this dissertation purports to address.

Mental Health and Academic Success

Mental illness has been found to relate to decreased academic success and degree completion (Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Keyes et al., 2012; Thompson et al., 2013). The most frequently studied mental illnesses studied in connection to academic success are depression and anxiety, often as mediated by perfectionism.

Depression, anxiety, and perfectionism in women.

Perfectionism, defined in a multitude of ways, may lead to both depression and anxiety in women of all ethnic/racial groups who attend college (Castro & Rice, 2003; Elion et al., 2012; Gnilka et al., 2013; Schrick et al., 2012; Stoeber et al., 2014; Walker et al., 2008); it should be noted that the only extant research on this topic has females as the subjects, not males, even though males were part of my study's sample to fill this gap in the literature. Although women across ethnicities and races may feel pressure—either internal or external—to present perfectionism, the co-occurrence of perfectionism and depression or anxiety varies among these groups (Castro & Rice, 2003; Elion et al., 2012; Gnilka et al., 2013; Schrick et al., 2012; Stoeber et al., 2014; Walker et al., 2008). In particular, African American and Asian American women tend towards maladaptive perfectionism at greater rates than European American women (Castro & Rice, 2003; Elion et al., 2012; Walker et al., 2008).

Maladaptive perfectionism, the reluctance or inability to accept that one cannot always achieve perfection, relates to depression and suicide ideation in African American women in connection with acculturative stress (Elion et al., 2012; Polanco-Roman & Miranda, 2013; Walker et al., 2008). For both African American and Asian American

women, maladaptive perfectionism relates to depression and suicide ideation in connection with desire to please others such as family members (Castro & Rice, 2003). These findings have additionally been linked to lower engagement and academic performance as measured by GPA (Castro & Rice, 2003; Elion et al., 2012; Gnilka et al., 2013; Renshaw & Cohen, 2014; Schrick et al., 2012; Stoeber et al., 2014). Although these measures do not capture the nuance of the participants' educational experiences, they are indicative of the potential issues a subpopulation of female students could encounter.

Stigmatization in college students with mental illness.

A significant pool of literature has established the prevalence of both perceived and self-stigma in college students with mental illness (Jennings et al., 2015; Martin, 2010; Megivern, Pellirito, & Mowbray, 2001; Quinn et al., 2009; Tucker et al., 2013). In particular, investigations of stigma in college students with mental illness has been explored in connection with help-seeking behaviors, something linked to academic performance (Markoulakis & Kirsch, 2013). What the literature is missing is an analysis of whether and why college students with mental illness perceive stigma and self-stigmatize; my study purports to fill this gap in the literature.

Although stigmatization is generally discussed as one construct, Tucker et al. (2013) found that there are separate constructs for help-seeking stigma and mental illness stigma (self-stigmatization for having a mental illness). They found, in a factor analysis, that the two measured constructs are indeed different from one another (all factor loadings were significant, ranging from .52 to .86.). This is particularly significant in light of all the research on what Tucker et al. (2013) would call self-stigma and help-

seeking; many studies have indicated a correlation between college students' self-stigmatization or perceived stigmatization for having a mental illness and their willingness to seek help from campus or community resources (Jennings et al., 2015; Martin, 2010; Megivern, Pellirito, & Mowbray, 2001; Quinn, Wilson, MacIntyre, & Tinklin, 2009; Tucker et al., 2013). In short, students who experience stigma for mental illness are less likely to engage in help-seeking behaviors (Jennings et al., 2015; Martin, 2010; Megivern, Pellirito, & Mowbray, 2001; Tucker et al., 2013; Quinn et al., 2009).

It is also well-established in the literature that college students with mental illness do encounter stigma of some kind (Martin, 2010; Megivern, Pellirito, & Mowbray, 2001; Tucker et al., 2013; Quinn et al., 2009; Weiner, 1999; Weiner & Wiener, 1996). This encountering of stigma indicates a need to better understand the reasons for stigmatization and why it's related to lack of help seeking.

Another reason for stigmatization among college students with mental illness is a difference in cultures: students of varying racial/ethnic minority backgrounds are more likely to self-stigmatize and not seek help (Hsu et al., 2008; Leung et al., 2012; Sheu & Sedlack, 2004; Walker et al., 2008; Wang, 2012; Zychinski & Polo, 2012). The reasons behind this phenomenon are mainly linked to cultural beliefs about mental illness; they are often not supportive of traditional help-seeking behaviors (i.e., counseling services).

Resilience in individuals with mental illness.

Resilience has been found in multiple studies to relate to mental health (Adams, Sanders, & Auth, 2004; Aroian & Norris, 2000; Cohn, Frederickson, Brown, Mikels, & Conway, 2009; Dumont & Provost, 1999; Kapikirin & Acun-Kapiriran, 2016; Ong, Bergeman, Bisconti, & Wallace, 2006; Roy, Sarchiapone, & Carli, 2007; Rydén,

Karlsson, Sullivan, Torgerson, & Taft, 2003) and academic attainment (Allan, McKenna & Dominey, 2014; Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Hartley, 2011; Keyes et al., 2012; Koch, Mamiseishvili, & Higgins, 2014; Thompson et al., 2013). Given the impetus of the theoretical foundations of developmental education on student success, it is paramount to understand how resilience functions in college students with mental illness; there is, however, a dearth of literature addressing this specific population. Most of the literature in this section will deal with the issue of how psychological resilience relates to mental health.

Psychological resilience and mental health.

Psychological resilience may be defined as comprising the ability to deal with challenging situations (Dumont & Provost, 1999), make psychological adjustments to fit the situation (Ong, Bergeman, Bisconti, & Wallace, 2006), and being satisfied with one's life (Cohn et al., 2009). Although resilience may be defined in different ways or discussed in a slightly different manner (see, for example, the literature on grit; for an in-depth example, refer to Sanguras, 2017), for the purposes of this dissertation the definition used will be that for psychological resilience given the focus on mental illness.

Literature examining psychological resilience in relation to mental health has, overall, indicated that there is a positive relationship between psychological resilience and positive mental health, meaning the more resilient an individual is, the less likely they are to experience the effects of mental illness or poor mental health (Adams, Sanders, & Auth, 2004; Aroian & Norris, 2000; Kapikiran & Acun-Kapikirin, 2016; Roy, Sarchiapone, & Carli, 2007; Rydén et al., 2003; Vaishnavi, Connor, & Davidson, 2007). Self-esteem has been posited to be a mediator between mental health and psychological

resilience, something confirmed in Kapikirin and Acun-Kapirin's (2016) study of the relation between self-esteem, resilience, and depressive symptoms.

Most importantly, this literature points to the clear relation between resilience and mental health; the more resilient an individual is, the better they should cope with mental illness (Adams, Sanders, & Auth, 2004; Aroian & Norris, 2000; Kapikiran & Acun-Kapikirin, 2016; Roy, Sarchiapone, & Carli, 2007; Rydén et al., 2003; Vaishnavi, Connor, & Davidson, 2007). This points to a need for understanding how to build strong psychological resilience among the community of people with mental illness and students in developmental coursework, or perhaps whether such already exists. All of the studies cited thus far have been quantitative studies examining correlations, path models, and factor analyses; none are qualitative, so none probe into the lived experience of resilience in people with mental illness.

Resilience and academic attainment.

As stated above, mental illness has been shown to interfere with academic success (Allan, McKenna & Dominey, 2014; Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Hartley, 2011; Keyes et al., 2012; Koch, Mamiseishvili, & Higgins, 2014; Thompson et al., 2013). In short, studies have found a positive relation between resilience and academic success (e.g., Allan, McKenna, & Dominey, 2014), meaning that individuals who exhibit greater resilience are more likely to experience academic success in terms of GPA and retention (Koch, Mamiseishvili, & Higgins, 2014). In Koch, Mamiseishvili, and Higgins' study (2014), using a national dataset with 350 college students who identified themselves as mentally ill, the researchers found that only 76.6%

persisted to the second year of study; that number dropped as the years progressed towards degree completion.

In a study focused on GPA, Hartley (2011) found that students who scored higher on the resilience scale (here, the Connor-Davidson Resilience Scale) were more likely to have higher end-of-year GPAs. This further indicates a positive relation between resilience and academic performance in people with mental illness.

Another study on the relation between resilience and mental health found that internal locus of control was a predictor of resilience (Edwards, Catling, & Parry, 2016). This all comes together to paint a rather complex picture of the factors that go into student resilience and positive mental health. There is a clear need to parse out the different constructs that play a role in resilience, preferably through the eyes of people with mental illness, as this will provide a more in-depth look at the issue.

Identity Development

Identity development in college students has long been theorized about, particularly in relation to emerging adulthood (the period from 18-25). Perhaps the most seminal work in identity development is that of Erikson (1968), who posited that adolescents undergo a process of identity development. Since then, researchers and theorists have built upon his eight-stage theory of identity development, in particular focusing on the shift from identity development during adolescence to emerging adulthood. Arnett (2000) argues that emerging adulthood is a period for identity development and exploration. He focuses on three main areas for identity development: love, work, and worldviews. In his discussion of identity development during emerging adulthood, Arnett (2000) explains how individuals aged 18-25 undergo processes of

refining their identities by reflection and encounters with others. He particularly notes how worldview may shift during this time as individuals are faced with values that may counter their own; in addition, Arnett notes how this process may not be comfortable for college students, as they may encounter worldviews very contrary to their own.

In a similar vein, Houghton (2013), explaining the Intercultural Dialogue Model as based on Byram's (1997) intercultural communicative competence theory, posits that identity development begins with an analysis of the self in terms of personal values. It then progresses into analysis of the other's values and moves into a critical analysis stage in which students compare their values to those of the other. Next, identity development progresses to the critical evaluation stage in which students "[evaluate] . . . the values of the self and other with reference to a clear standard" (p. 312), and, finally, it moves into the identity-development stage; in this final stage, students evaluate their values in the context of others' values and decide whether or not to change based on these assessments. Although this body of work is particular to students who are English Language Learners, they may be members of the community of students with mental illness, rendering this information appropriate for this review of the literature.

Both Arnett (2000) and Houghton (2013) are referring to what Erikson (1959, 1968) called identity crisis and identity confusion. These are states in which individuals experience some kind of dissonance, whether spurred on from an external or internal source, related to how they identify (Côté, 2000). During these periods, individuals must go through a process of reconciling their self-concept to the new stimuli (internal or external), something that may be a difficult process, but that may result in shifting ways of identifying (Côté, 2000; Erikson, 1959, 1968).

Unlike Erikson (1959, 1968) posited, the process of identity development has found to be more recursive than linear (Côté, 2006). This implies that individuals may move forward or backward through the process of identity development, reacting to stimuli in a way that causes growth or a step backwards. This factor alone indicates a need for better understanding how individuals develop their multiple senses of identity, particularly when considering how individuals develop multiple identities (Abes, Jones, & McEwen, 2007/2009). It seems possible, then, that these identities might develop in tandem or in dissonance with one another, particularly in light of the recursivity of the process.

Erikson's (1959, 1968) conception of identity crisis stands particularly salient for the population of college students with mental illnesses who are in their emerging adulthood. If hypothesizing that a traumatic event such as diagnosis with mental illness may cause identity crisis, it becomes salient for people with mental illness and their identity development, which may move in any direction on the spectrum of development due to their experience of diagnosis. Diagnosis can bring about changes in one's self-conception, particularly as one has to re-identify as a person with a mental illness, and this may cause what Erikson calls the identity crisis (1959, 1968). People with mental illness may respond to their diagnoses in a positive or negative light, developing a stronger sense of identity or regressing to having a weaker sense of self.

This is significant in the nuances of identity development, as well. As asserted by Evans, Forney, Guido, Patten, and Renn (2009), social contexts determine the ways in which we develop and express our identities. When faced with oppression, for example, individuals may feel reluctant to express a certain facet of their identities. This is

particularly salient to the population of college students with mental illness, who may face stigma in their daily lives (Hess & Tracey, 2013; Keyes et al., 2012; Leung et al., 2012; Markoulakis & Kirsch, 2013; Masiac-Eizenger et al., 2013; Walker et al., 2008; Wang, 2012; Zychinski & Polo, 2012). Encountering stigma may make these individuals less likely to foreground their identities as people with mental illness, rendering it a more ancillary and less central facet of their personality. It is important to understand the processes behind identity development in college students with mental illness and if, in fact, identity crisis exists, alongside the question of whether these students have converging or diverging identities as both individuals and college students with mental illness. This last concept, whether the identities are conceived of differently, has yet to be explored in the literature.

If a goal of developmental education is to assist students in their development (Boylan, 1987a, 1987b, 1988; Boylan & Bonham, 2007; Higbee, 2009), it becomes crucial to understand the nuances of identity development in students with mental illness because the stigma they encounter, either imposed by the self or perceived from others, may affect how they present themselves and interact with the world (for example, whether they foreground their identities as people with mental illness or not). To help these students in their development, both academic and personal, means they need to come to terms with the identities they have tied to their mental illness in order to develop positive sense of self, insight, and the skills requisite to succeed in academia and overcome the hardships posed by their diagnoses and symptoms.

Summation and Preview

In this chapter, I explored the literature on stigma, resilience, and identity development in college students with mental illness. Gaps in the literature were identified and the impetus for this dissertation was established. In the following chapter, I will outline the three studies used in this dissertation—a survey with metaphorical data, duoethnography, and autoethnography—alongside an explanation of how the data will be presented.

III. METHODOLOGY

This dissertation's goal is to examine how students with mental illness construct identities that may not fit into societal norms as well as how these academic and nonacademic identities intersect with stigmatization and resilience. This dissertation will utilize three methodologies and data collection procedures across three studies: survey data including some metaphor analysis, a duoethnography, and an autoethnography. Each methodology will be driven by the same research questions but will be written up as its own study.

Positionality

Due to the nature of qualitative research, researcher experiences cannot be extricated from data collection and analysis. To minimize these effects as much as possible, researcher bias should be placed in epoché; in this study, however, placing my subjective experience in epoché would render parts of this study inauthentic. As an individual with a mental illness, I make meaning of the world through the lens of mental illness and what it means for my everyday life as an individual and a college student. I have an inherently emic standpoint as a member of the community I am studying.

My emic standpoint is the impetus for this study. I was diagnosed with mental illness while in middle school, and by the time I reached college, my symptoms were not under control enough that I could function very well as a student. I stopped attending classes due to a severe depressive episode. I did not seek help from any avenue until it was too late to rectify the situation: by the time I attended the counseling center, got on medication, and spoke with all my professors, the semester was almost over, and little could be done to help me salvage my grades. After three semesters in college, I dropped

out, largely due to how I mismanaged the symptoms of my mental illness. I was equipped to be a good college student, but my mental illness interfered with my ability to apply myself academically. My decision to drop out of college was additionally compounded by the university's response to an instance in which I shared thoughts of self-harm. Instead of receiving supports from the university, the Dean of Students threatened to kick me out of the university unless I was deemed not suicidal following two psychological evaluations. Between my struggles with my symptoms and this lack of understanding and academic support, I could not fathom persisting and staying enrolled in college.

Bracketing off this experience would render my analysis of the data inauthentic, something that should be avoided in qualitative research when working within methodologies such as duoethnography and autoethnography in which subjective experience is valued above all else (Chang, 2008; Denzin, 2014; Norris, Sawyer, & Lund, 2012; Spry, 2011). Because I am using these two methodologies within this study, my researcher positionality is that of the insider: a college student and individual with a mental illness who has undergone the processes of making meaning of what it means to be such an individual.

The Self as a Member of Developmental Education

Although I was not placed into any developmental education coursework, I was not unlike a student in developmental education in that I was a transitioning student seeking to understand a sense of self, in need of nonacademic and academic supports, and a member of a marginalized population (i.e., a student with a mental illness). I needed additional supports, such as faculty support and early interventions from the university

(e.g., an early alert system for students not attending classes), to assist me in maintaining academic resilience such as an environment in which I felt comfortable disclosing my mental illness when it interfered with my ability to perform the requisite academic tasks. I may also have been considered a member of the developmental education population in that I was seeking a way to understand how to be and succeed at the same time, and I was doing this with minimal guidance. By the time I returned to college, I had developed a strong resolution to finish my degree and adapted some strategies to help myself achieve my goals. Even so, I never stopped asking myself what would have happened if I hadn't dropped out of college. To this day, I wonder what my educational experience would have been like if I'd sought help sooner. Through my dissertation, I hope to achieve a better understanding of the issues facing college students with mental illness in order to build supports to help them achieve their academic goals and persist to degree completion. My experience in group therapy has taught me that the experiences of college students with mental illness are not all that different from one another, implying that there should be some supports available to address these common concerns. The impetus for this study, then, emerged straight from my own collegiate experiences. I believe this research will provide a foundation for finding supports for this unique population: I want to help educators and student support professionals help students stay enrolled and not find themselves asking the kinds of "what if" questions I asked myself after my first undergraduate experience. All of these experiences have led me to care deeply about this population of which I am a member.

Being considered a student in developmental education can also extend to how prepared an individual is for the demands of college, for example, in their self-regulatory

or metacognitive skills. I was not adequately prepared for the cognitive and emotional demands of higher education, particularly in light of my mental illness. Even though I had scored well on my ACTs and was not placed into a developmental education course, I could be considered a student in developmental education for the abovementioned factors. In addition to this, I was undergoing the process of learning how to identify as a student and as an individual with a mental illness. Growing into my emerging adulthood meant learning new ways of being and making meaning of the academic world I inhabited.

Organization

The organization of this chapter is not necessarily representative of a traditional dissertation setup. Instead of presenting the methodology followed by data collection and analytical procedures and then a nuanced reasoning of why the method is being employed, the rationale will be embedded in the narrative of what the methodology is, how data will be collected, and how it will be analyzed.

Survey with Metaphorical Data

The first study, a survey using metaphor analysis, was used with elicited metaphors constructed by surveyed people with mental illness who were college students at a Central Texas four-year university. This survey was used to assess students' perceptions of self as individuals and students with diagnosed mental illness, what metaphor analysis purports to accomplish (i.e., accessing the deeper thoughts, values, beliefs, and ideologies of respondents) (Armstrong, 2015; Kövesces, 2002; Lakoff & Johnson, 1980; Maslun & Cameron, 2010; Wan, 2015). By using participants' elicited metaphors, I was able to access the deeper meanings respondents assign to being

individuals and college students with mental illness; elicited metaphor enabled examination of the discourse respondents use and the implications of their chosen discourses, including the sociocultural influences thereupon (Kövesces, 2002; Lakoff & Johnson; Maslun & Cameron, 2010). There was also an accompanying survey to get at questions of identity development, perceived stigmatization, self-stigmatization, and academic resilience.

Metaphor Analysis

For my purposes, using a definition that differs from that of a traditional literary metaphor, a metaphor is defined as a comparison of ideas not necessarily related to one another, a way of “understanding one conceptual domain in terms of another conceptual domain” (Kövesces, 2010, p.4). For example, “being a college student with a mental illness is like. . .difficult” is not a metaphor because the provided elicited metaphor is literal, not figurative, whereas “an eyeball is like a camera” is a metaphor because “camera” is not a literal representation of a camera. Metaphors must be broken down into root constructs underlying the source domain. The target is the concrete, the literal, whereas the source must deal with a figurative concept, not a literal one. This definition is being implemented to both represent what constitutes a metaphor as well as what responses may not be included for analysis if they do not follow the metaphor form. There must be, for a response to be considered metaphorical, some comparison of ideas that are not necessarily related (Kövesces, 2002). In other words, there may be, and perhaps should be, some dissonance between the ideas as presented in words (Kövesces, 2002; Maslun & Cameron, 2010). The second step of this analytical process, however, requires an attention to detail in that the ideas should be relatable to one another through

metaphorical analysis (Lakoff & Johnson, 1980; Maslun & Cameron, 2010). These will be the exclusionary standards used to identify which responses qualify as metaphors and which do not, as all may not be presented as metaphors.

Data Collection

Data for this part of the study were collected via surveys (see Appendix A). These surveys were emailed out to all students at the university to gain as representative a sampling of the student population as possible. The email included a description of the study and notice that clicking the link to the study indicates consent to participate (see Appendix B). This survey was designed for circulation via Qualtrics, a survey creation and distribution online program. To focus the study on students with diagnosed mental illnesses, the first question asked whether or not the respondent had a mental illness (i.e., do you have a diagnosed mental illness?); those who responded “no” were directed to the end of the survey.

The survey had both open- and closed-ended questions, starting with metaphor construction. Respondents completed statements such as “Being a student with a mental illness is like. . .” and “Being a person with a mental illness is like. . .” in addition to answering questions about whether they viewed themselves as students versus people differently. Respondents were also asked how or why following the construction of metaphors to add to validity in analysis, allowing for a more nuanced and accurate analysis, for example, by providing more of the context behind the metaphor. Prior to the metaphor construction section of the survey came examples to help respondents understand how to go about constructing a metaphor (see Appendix A). This was to help ensure as many respondents as possible create viable metaphors.

How students view themselves as people versus college students was assessed by asking each metaphor twice: first, using the language of “being a college student,” then using the language “being a person.” Respondents were then asked if they perceived a difference between the two and why or why not. This was to ascertain whether students viewed themselves as having separate identities—whether they parsed out what it means to be a person with a mental illness compared to a student with a mental illness—or perceived themselves as only having one identity in order to ascertain if the findings match up with Abes, Jones, and McEwen’s (2007/2011) Multiple Dimensions of Identity framework, which posits that individuals possess a multitude of identities that are linked to their sociocultural surroundings. This analysis of the identity as a person with a mental illness alongside identity as a college student with mental illness facilitated an understanding of how college students with mental illness develop their identities, whether separate or in tandem, alongside how they view themselves as people with mental illnesses.

Respondents were also asked a short series of questions about whether they perceived themselves as academically resilient, whether they stigmatized themselves for having a mental illness, and whether they perceived stigma on campus related to having a mental illness. Each question was followed by the question “why/why not?” to get at the rationale behind the yes/no/unsure questions. To render these questions as clear as possible, brief definitions of “stigmatized” and “resilient” were provided in the questions themselves (see Appendix A). Data from this portion of the survey was used to assess (a) whether respondents viewed themselves as stigmatized and/or academically resilient and

(b) why they viewed themselves as such. This portion of the study provided much-needed data about self-conception and academic climate.

Data Analysis

First, metaphors were analyzed using an abbreviated metaphor analysis protocol (Cameron & Low, 1999; Lakoff & Johnson, 1980; Maslun & Cameron, 2010; Wan, 2015; Wan, Low, & Li, 2011) to look for trends and differences in respondents' perceptions of self as both people and college students with mental illness. The follow-up "how/why" questions to the metaphor construction questions were used to help analyze the metaphors and add nuance to the meaning made, something that added more internal validity and discourse context and access to the respondents' values, beliefs, etc. as are embedded in the language they use because of the sociocultural nature of language (Armstrong, 2015; Cameron & Low, 1999; Gee, 2013; Kövesces, 2002; Kucer, 2014; Lakoff & Johnson, 1980; Low, 2015; Maslun & Cameron, 2010; Paulson & Armstrong, 2011; Smagorinsky, 2001). Thus, the unit of analysis for responses were the elicited metaphors including the metaphor extensions. All participant-provided data for the metaphors were analyzed together (i.e., elicited metaphor and metaphor extension) in order to have a full sense of what the respondent intended. Although the unit of analysis could have been broken down into separate components—the elicited metaphor and metaphor extension—my approach was selected to best understand how the respondent intended the metaphor to be interpreted based on their metaphor extension.

Metaphor analysis allows for accessing information about how individuals experience the world and filter that experience through language (Kövesces, 2002; Lakoff & Johnson, 1980). To be considered an appropriate metaphor for this study, sources

“being a college student with a mental illness is like. . .” and “being an individual with a mental illness is like. . .” were evaluated to see if the respondents provided targets using metaphorical language or not (Lakoff & Johnson, 1980; Maslun & Cameron, 2010).

The specific mode of analysis used was that as laid out by Wan, Low, and Li (2011). This entailed first coding the metaphor in terms of how the target relates to the source. In this case, “being a student with a mental illness is like. . .” becomes the source, and respondents’ metaphors become the target (Kövesces, 2002). This is how understanding of one domain in terms of another was accomplished. This is only the first step employed by Wan et al. (2011), and it was the only step applied because the goal was not to conduct a full metaphor analysis as much as it was to glean the conceptual metaphors (for an explanation of what a full metaphor analysis entails, refer to Cameron & Low, 1999), as this is only one component of a larger dataset (the full survey is in Appendix A). Part of this analytical process also involved determining if the stem (also referred to as the source) and following text (also known as the target) differed in terms of subcategorization. This was important because metaphors access deeper cultural understandings, and to be considered a metaphor, a response should use metaphorical language, not that which strictly defines the stem (Kövesces, 2002; Lakoff & Johnson, 1980; Maslun & Cameron, 2010). Doing so allows for the analysis of what Lakoff & Johnson (1980) refer to as experiential gestalts, “which are ways of organizing experiences into *structured wholes*” (p. 81), which leads to understanding one concept, or domain, in terms of another, which is metaphor (Cameron & Low, 1999; Kövesces, 2002; Lakoff & Johnson, 1980; Maslun & Cameron, 2010).

For example, the conceptual metaphor “being a college student with a mental illness is like fighting an uphill battle” would be coded as “being a college student with a mental illness is struggle,” in which “struggle” is the generalized domain based on the target “fighting an uphill battle” (Lakoff & Johnson, 1980). Then, other metaphors that fit within this schema would be identified and appropriately categorized. Using the elicited metaphor and metaphor extension as the unit of analysis, coding was conducted by determining the best fit conceptual metaphor. This was done by associating the data with a concept it spoke most directly to—the conceptual metaphor—which was determined based on best fit and the first, most salient construct that came to mind. In cases where an elicited metaphor could have fit under multiple conceptual metaphors, the most appropriate conceptual metaphor was assigned based on what the data most spoke to out of the potential options.

This brings up the issue of subjectivity in metaphor analysis: other researchers may code the data differently based on their interpretation of the elicited metaphor and metaphor extension, but this fact should not render my analysis invalid (Armstrong et al., 2011; Low, 2015; Williams, 2015). Within the tradition of metaphor analysis, subjectivity is a recognized component of the method (Armstrong et al., 2011; Low, 2015; Williams, 2015). As Armstrong et al. (2011) note, language interpretation is highly subjective, leading to multiple possible interpretations of metaphor. Although there are steps to help minimize the subjectivity of analysis (Williams, 2015), some were not feasible because of respondent confidentiality (meaning I was not able to conduct member-checking), something Armstrong et al. (2011) note may not always be possible in metaphor analysis studies.

One step employed, however, was re-reading and reconceptualizing how the elicited metaphors and metaphor extensions fit their assigned conceptual metaphors, in line with techniques to minimize subjectivity (Williams, 2015). This entailed considering the range of possibilities for categorization and reading the data multiple times to determine the best fit when multiple conceptual metaphors could have applied to the response. Another step employed was elaborating on the process of analysis (see chapter four) using examples from the dataset to illustrate how the analytical protocol was applied (Williams, 2015).

Analyzing metaphors additionally provided access to whether or not respondents conceive of being individuals/college students with mental illness in similar or disparate ways. As each respondent is a member of the mentally ill community, it may occur that multiple respondents use similar language to describe their ways of being, which would allow for the building of metaphorical coherence (Lakoff & Johnson, 1980).

In addition to the use of elicited metaphor analysis techniques outlined above, metaphors were also analyzed in conjunction with whether or not the respondents perceived a difference between identity as a college student and identity as an individual. This portion of the study accessed information about how this population has developed a sense of identity or identities, something that can be compared and contrasted with Abes, Jones, and McEwen's (2007/2011) Multiple Dimensions of Identity framework.

Finally, the last set of questions about perceived academic resilience, self-stigmatization, and perceived stigmatization were categorized by Yes/No/Unsure responses and analyzed for trends within each category, building themes using emergent coding.

Duoethnography

Duoethnography is a type of ethnography in which two individuals function as co-researchers/co-participants in conducting a research study of self. This tradition emerged from *curre* (Sawyer & Norris, 2012), meaning one's living curriculum. This refers to the process of the study being recursive at times: our living curriculum, as is implied, is not static and continues to develop over time. As Norris and Sawyer state, "curre is an act of self-interrogation in which one reclaims one's self from one's self as one unpacks and repacks the meanings that one holds. Duoethnography does this with the [co-researcher/co-participant]" (2012, p.13). This means that meaning is built in tandem through the interactions with the co-researcher/co-participant. The important consideration in this methodology is that of authenticity on the part of both co-researchers/co-participants. It is also important to bear in mind that this is not representative of a linear narrative, rather a recursive, discursive act of refining meanings and illuminating new meanings and experiences as co-researchers/co-participants engage in the research process. Traditionally, duoethnography involves both co-researchers/co-participants in all aspects of the research process, from design to writing up the findings. This duoethnography will stray from this paradigm slightly, given that this is a benchmark project that should be conducted and authored by me alone. The co-researcher/co-participant took part in the design of the interview via the questions she focused on; in this way, she was co-researcher, addressing some questions I had designed while skipping over others. This, however, may be representative of the nature of duoethnography: fidelity to the interview protocol is not as significant as the conversation

itself and the natural turns it takes as new ideas emerge from the co-researchers/co-participants.

It should be noted that this study is not a true duoethnography; typically, two co-researchers/co-participants work in tandem to develop and analyze the research, eliminating hegemony and the privileging of one story over another. There is still some hegemony present in the study because I hold primacy as the main researcher. This will be minimized as much as possible through the data collection and analysis techniques I intend to employ.

A Note on Language

The language of co-researcher/co-participant is used to place both researchers/participants as equals within the process, not privileging one story over another. This also resists the othering that may occur during the research process if the researcher does not belong to the group being studied; in this case, both co-researchers were insiders of the bipolar community, rendering them equals with knowledge and experience of commensurate weight and value. Duoethnography works to subvert hegemony in this way, making the marginalized front and center as advocates for themselves. It is the marginalized who become the privileged and have their voices represented without the potential for othering that may occur if one researcher was not part of the bipolar community.

In this study, the language *co-researcher* was used instead of *co-participant* to emphasize that, although this is a non-traditional duoethnography in that I wrote up the findings alone, I am not to be given primacy as the researcher. This is implicit within the context of the document itself as a dissertation (that I am the primary researcher), and I

wish to place my co-researcher on equal standing as much as possible despite this study's straying from the norms of duoethnography. It is also worth noting the terms interview and conversation may be used interchangeably within this document, as the study was designed around a traditional interview protocol but was conducted more as a conversation.

Data Collection

Data were collected during the spring 2016 semester via two interviews held one week apart. These interviews were an hour and a half and two hours in length, respectively. Data was recorded for transcription purposes. Both co-researchers had the interview protocol as a reference point during the conversation (i.e., interview).

Questions were not answered in order, and the co-researchers took turns answering first as felt natural in the moment. Sometimes, I asked my co-researcher if she would prefer I go first. These interviews were conducted in the group counseling room of the university Counseling Center. To gain access to this space, I went through the bipolar support group counselor who knew of my project and knew both co-researchers through the group. The co-researcher was recruited via convenience sampling: we were familiar with one another through our participation in the bipolar support group.

The interview targeted three topic domains: diagnosis, academic life, and perceptions of mental illness; none of these constructs directly correlate to identity development, stigma, and resilience as the study was designed to explore the experiences of college students with bipolar disorder, but the three constructs did arise in the dataset. These were selected to assess the experience of students with mental illness writ large within academia. Although neither co-researcher was placed into developmental

coursework, both may be deemed belonging to the population of students in developmental education because they both required unique supports to succeed in college. Both co-researchers were graduate students at the time of data collection, one studying the social sciences and one studying the natural and biological sciences.

Graduate students were used for this part of the study because identity development does not cease upon the conclusion of one's undergraduate studies. Graduate students were also selected because of convenience sampling; I had access to another graduate student with bipolar disorder who consented to participate in the study. This time period is also relevant because, in particular, bipolar disorder is often diagnosed in an individual's emerging adulthood, a time at which identity development is still occurring (National Alliance on Mental Illness, n.d.; National Institute of Mental Health, 2015.; Abes, Jones, & McEwen, 2007/2011). This may, as with undergraduates, influence the academic experiences of graduate students, who, using this study's working definition of developmental education, may be deemed developmental despite their advanced coursework.

Data Analysis

The data first were analyzed using emergent coding during the 2016 pilot study (VanderLind, 2017). During this process, multiple themes emerged, including stigma, self-disclosure, and resilience. For this study, the data were coded *a priori* using the themes relevant to the research questions: identity development, academic resilience, and self- or perceived stigma. After coding the data, member-checking was conducted with the co-researcher to assess whether my data analysis accurately reflected what she said and meant during the interviews. This also led to collecting additional data, as our

conversations about the existing data added to the conversation about mental illness writ large. In this way, the co-researcher almost began to function more as a true co-researcher because her voice was represented in how the findings were written up. This is often an aspect of duoethnography, as new meanings and experiences may emerge at any stage of the study, representative of duoethnography's roots in *currere*.

Autoethnography

For this study, I conducted an autoethnography of my experiences developing an identity within academia as an extension of the duoethnography. This study highlighted my struggles and triumphs in identity development as an individual with bipolar disorder who is concurrently an academic. I explored topics such as individual resilience and resistance to stigmatization using archival data to analyze my journey over the past three years as a doctoral student. This study speaks to how developing an identity is like developing a new literacy: both involve learning a set of rules and knowing when to appropriately apply them.

Autoethnography as Method

Autoethnography is a method based in ethnography which examines the individual's life (Chang, 2008; Denzin, 2014). It can be defined as "reflexively writing the self into and through the ethnographic text; isolating that space where memory, history, performance, and meaning intersect" (Denzin, 2014, p. 22). Denzin (2014) and Spry (2011) also describe performative autoethnography as a form that takes traumatic experience as an impetus for social change in which the sting of experience is used to develop meaning.

Important in autoethnography is the use of varied source materials to help create a presentation of what is “real” (Denzin, 2014); Denzin (2014) and Chang (2008) argue for the incorporation of historical sources alongside personal experience to try to recreate experience and make meaning of the story being told, although they note the difficulties of creating a storied self who presents some kind of reality, as it is possible to recreate events without what Denzin (2014) calls facticity, “how those facts were lived and experienced by interacting individuals” (p. 13). Both Denzin (2014) and Chang (2008) problematize the issue of the subject because stories are not necessarily “true” recounting of experience but have been filtered through the meaning-making lens of the autoethnographer. Denzin (2014) notes that autoethnographers are creating a type of fiction and that this fiction may be falsified. This is why Denzin (2014) calls for using “sincerity, subjective truth, historical truth, and fictional truth” (p. 13) to create a *bricolage* of source materials and experience to create the performative-I. Spry (2011) and Denzin (2014) describe the performative-I as what the autoethnographer becomes in acting out experience, moving it from paper, to body, to stage.

Although this one study of the three in this dissertation does not use performative autoethnography, the methods are still relevant to this dissertation in terms of the theory behind performative autoethnography and how one transforms into the performative-I. Instead of being written up for performance, this autoethnography will be written using Hoppes’ (2014) methods: integrating analysis with narrative and stepping outside the self as researcher while remaining the participant with insider knowledge, creating a duality of meanings, the more subjective experiential to the more objective analytical.

Performative Autoethnography

Denzin (2014) and Spry (2011) additionally note the role of trauma and epiphany in performative autoethnography—traumas and experiences of oppression create a jumping off point for the story being told, and epiphany occurs when the autoethnographer culminates this trauma into an action or impetus for change, something that is also true in traditional autoethnography even without trauma as a jumping off point (Ellis & Bochner, 2006; Gonzalez, Stein, Shannonhouse, & Prinstein, 2012). Trauma is the basis for this autoethnography: the experience of being an individual and college student with a mental illness.

Denzin (2014) and Spry (2011) further elaborate upon the necessary pieces of performative autoethnography by asserting that there are three intersecting concerns an autoethnographer should pay attention to: performance, process, and analysis. This means a focus on how the autoethnography aesthetically works as a piece to be performed alongside considerations such as epiphanies (what Denzin calls process) and situating the story within a historical context (what he calls analysis). Denzin (2014) also notes the importance of triangulation within these concerns and across source materials to ensure validity of findings.

Also significant to the construction of an autoethnography is the consideration that individuals do not exist in a vacuum but rather have experiences shaped by cultural norms and discourses (Denzin, 2014; Spry, 2011). This pulls in the importance of recognizing social hegemonic structures that may represent oppression for the performative-I (Spry, 2011). Meaning-making is not devoid of sociocultural considerations (Denzin, 2014; Gee, 2013; Smagorinsky, 2001; Spry, 2011), rendering it

necessary to consider how one's story is situated within a sociocultural milieu and what the ramifications of the dominant discourse are upon the telling of the story.

This relates back to what Denzin (2014) asserted about situating oneself historically within a specific context; he and Spry (2011) note the ability of autoethnography to cause change in perceptions through the telling of the individual story that subverts social norms. Denzin (2014) notes that performative autoethnographers “perform painful personal experiences” (p. 67) to help cause this change in perspectives of the reader/viewer as well as in the autoethnographer (Spry, 2011). Denzin (2014) notes that we use this framework to “push against racial, sexual, and class boundaries in order to achieve the gift of freedom” (p. 67); what he neglects to include in this assessment of performative autoethnography is the consideration of other marginalized groups, including individuals with invisible disability. Nonetheless, one can expand upon Denzin's ideas to include these other special populations who might experience social injustice, as he has already pointed to factors that influence a person's experience of hegemony and othering. Spry (2011) builds upon this by asserting that performative autoethnography is political: it is an act of performance that places the self within a politicized realm of exploration in the context of self in relation to others.

For assessing the efficacy of performative autoethnography, Denzin (2014) created seven criteria:

1. Unsettle, criticize, and challenge taken-for-granted, repressed meanings
2. Invite moral and ethical dialogue while reflexively clarifying their own moral position

3. Engender resistance and offer utopian thoughts about how things can be made different
4. Demonstrate that they care, that they are kind
5. Show, instead of tell, while using the rule that less is more
6. Exhibit interpretive sufficiency, representational adequacy, and authentic adequacy
7. Are political, functional, collective, and committed (p. 78).

Important to this autoethnography is how Denzin (2014) describes using source materials to structure the text around a common theme; I will be using a variety of data sources that center on the theme of literacy learning.

Data Collection

I was be the main data source for this study, but I utilized archival documents via my medical records from three years of treatment under a psychiatrist. I also requested reports from my individual counseling sessions over that time to add detail to the medical rhetoric which may be short on rich details. Both of these records begin in the fall of 2013 and extend through the fall of 2016, but I only focused on the fall of 2013 and spring of 2016, the periods during which I underwent the most significant challenges related to my mental illness. Using the three data sources in concert allowed for a more nuanced analysis than using any one alone.

Beyond the medical and counseling records, other archival data was used in this analysis to provide as much depth and breadth as possible, adding layers of subjective truth to objective truth. These data sources were select emails sent during the spring of 2016. Although the autoethnography includes experiences from my entire doctoral career

to this point, its major focus will be on the time period surrounding the spring of 2016. This narrow focus was intended to highlight the largest challenges I encountered in identity development, stigmatization, and academic resilience. This was a time period in which I developed severe symptoms of bipolar disorder I had not previously experienced, which required a reconceptualization of self—what it meant to be bipolar and concurrently a doctoral student finishing her coursework.

Select emails from this period were included in the dataset as exemplars of (a) self-stigmatization and (b) struggles to maintain resilience. These were emails with professional colleagues during the period of spring semester 2016. Anonymity was maintained for the other parties involved in the communications, although their responses and initial emails were included in the study for contextual purposes.

Thus, I looked across source materials from the clinical to the personal to create a *bricolage* of experience, all situated within the metaphor of developing literacy skills like a student in developmental literacy. This metaphor serves as a guide for making sense of the data and organizing experience in the autoethnography.

Data Analysis

I analyzed across data sources for this portion of the study, *a priori* coding for instances of stigmatization (both self- and perceived), identity development, and academic resilience. This was constructed through a pastiche of sources—placing together the medical records, counseling records, and emails to create a rich sense of meaning. Each data source was used to enhance understanding of the others, forming a sort of internal triangulation.

Archival data was analyzed for trends in areas such as the alignment of reported stressors and medication changes. These data allowed me to add detail to the autoethnography to frame my experiences in what was objectively happening at the time (from a medical/therapeutic perspective) and what my subjective experiences were, whether reconstructed from the emails or from memory as triggered by the medical and/or counseling records.

I used the archival data to help reconstruct key events over the course of my academic career during my doctoral studies. These events were then be analyzed with a view towards how my identity as an individual with bipolar disorder may have been problematized as I learned the new literacy of having bipolar disorder, something I was diagnosed with at the beginning of my doctoral studies.

The intention behind including the autoethnography was to present one voice representative of what it means to be an individual with bipolar disorder, a sort of expansion upon the duoethnography. This extension of information provided in the duoethnography provided a deeper understanding of my experiences as a college student with bipolar disorder, although this data focused on my doctoral career rather than my undergraduate career. This was to show the progression of my identity development, initially discussed in terms of undergraduate studies in the duoethnography and extended into my current studies.

Summation and Preview

For each portion of this dissertation, I focused on conceptions of stigmatization, academic resilience, and metaphors for modes of being. All of this was filtered through the lens of Abes, Jones, and McEwen's (2007/2011) Multiple Dimensions of Identity

framework, allowing for a deep and broad sense of how college students with mental illness develop identities in conjunction with the issues listed above. All of this will then be tied back to the concerns of academic resilience and stigmatization the research questions aim to access.

In the following chapter, the first study, a survey with metaphorical data, will be presented. Findings, analysis, and implications will be explored.

IV. SURVEY WITH METAPHORICAL DATA

The first study of this dissertation is a university-wide survey with metaphorical data. As described in chapter three, and as presented in Appendix A, this survey contained questions about perceived academic resilience, perceived stigma on campus, self-stigmatization, and asked respondents to complete metaphors for being a person with a mental illness and being a college student with a mental illness. This chapter will cover the exclusionary criteria for removing responses from the dataset, the self-reported diagnoses to give a sense of what types of mental illness are represented, the findings for each construct being studied (academic resilience, stigma, and identity development), and a preview of the following study. As stated in chapter one, this study write-up will have a more academic tone due to the nature of the genre of survey reporting.

Because a full metaphor analysis was not conducted with the metaphorical data, the other survey data will be presented first. Then, a refresher of metaphor analysis techniques will be provided, followed by the analysis of the metaphorical data.

Recruitment

The survey was sent out to all students at the university via Qualtrics, totaling 36,076 potential respondents. Out of these, within the two weeks the survey was open, 1,056 responses were received. 350 reported no diagnosed mental illness, and as such, were directed to the end of the survey. 706 reported having a diagnosed mental illness; out of these, 34 responses were removed because no diagnosis was listed and 6 responses were removed because the diagnoses listed are not considered mental illnesses per the DSM-V. Once the exclusionary criteria described below were applied, this left a dataset of 219 responses.

Exclusionary Criteria For Metaphors

In line with solid metaphor analysis techniques, exclusionary criteria were decided upon before data analysis. Responses were removed from the dataset based upon the following:

1. Respondents indicated they were not diagnosed with a mental illness and were directed to the end of the survey.
2. The mental illness self-reported by the respondent was not categorized as a mental illness in the DSM-V (refer to chapter one for the operational definition of mental illness).
3. No metaphors were provided.
4. Metaphor extensions were missing.
5. The metaphor and/or metaphor extension did not fit the operational definitions in chapter one.
6. Only one metaphor was provided for one of the two targets (either for “being a person with a mental illness is like. . .” or “being a college student with a mental illness is like. . .”) without a response to whether the respondent considers these identities as similar or different because this renders cross-metaphor analysis impossible.
7. There was no response to the question asking if the respondent perceived being a person with a mental illness and a college student with a mental illness are different (because this renders it impossible to conduct a cross-analysis alongside the respondents’ perceptions of whether the two identities are similar or different).
8. There was no explanation of the how or why behind the question described above.

Diagnoses

To give a sense of what types of mental illness were present in the respondents, Table 4 presents the frequency counts for each self-reported diagnosis from the survey respondents. The inclusion of these data are simply to provide additional context for the findings. The number of diagnoses does not match the number of respondents ($N = 219$) because some respondents indicated having more than one diagnosed mental illness. Note that this study is inclusive of all diagnoses—no specific mental illnesses were selected as the particular focus of the study to allow for more generalizability.

Table 4. Reported Diagnoses and Frequency.

Diagnosis	Frequency
Panic Disorder (including panic attacks)	13
Generalized Anxiety Disorder	144
Major Depressive Disorder	26
Depression (type not specified)	89
ADHD/ADD	44
Bipolar I, II, and type not specified	27
Borderline Personality Disorder	4
Persistent Depressive Disorder	2
Post-traumatic Stress Disorder	23
Agoraphobia	1
Obsessive Compulsive Disorder	12
Anorexia Nervosa	3
Bulimia	1
Avoidant Personality Disorder	1
Psychosis	1
Social Anxiety Disorder	6
Chronic Depression	4
Clinical Depression	6
Dysthymia	1
Eating Disorder Not Otherwise Specified	1
Binge Eating	1
Schizophrenia	1
Seasonal Depression	1

Note. ADHD and ADD are classified as ADHD in the Diagnostic and Statistical Manual of Mental Disorders-V (DSM-V) (American Psychological Association, 2013), but respondents did not note this change in official diagnosis, so both were reported. Because they are the same diagnosis per the DSM-V, they have been collapsed into one diagnosis.

Findings: Academic Resilience

This section describes the findings pertinent to the following research questions: Do college students with mental illness perceive themselves as academically resilient?, and If so, in what ways or for what reasons are they academically resilient? Data were analyzed by examining the total responses for each category (“yes,” “no,” and “unsure”) and looking for trends in explanatory responses (respondents were asked “why/why not?” after whether they considered themselves academically resilient). The most frequent types of response were pulled out from the dataset as exemplars. The following table shows participant responses to the question “Do you perceive yourself as academically resilient?”

Table 5. Perceived Academic Resilience by Number and Percentage.

Response	Number of Respondents	Percentage
Yes	143	65%
Unsure	20	9%
No	14	6%
No Response	42	19%

N = 219.

The findings presented in Table 5 indicate that the majority of respondents perceive themselves as academically resilient. The most common reasons provided were that they are still enrolled in college, they perceive that they have no other choice but to be academically resilient, they are pushing themselves to achieve, they have dropped out and returned to college, and they have goals related to being in college. Those who reported they were unsure predominantly provided the rationale that they are resilient at times but not always. Finally, respondents who indicated they do not perceive themselves as academically resilient provided reasons such as giving up easily, letting

their symptoms get in the way of their coursework, and having dropped classes, projects, or out of college in the past.

Findings: Stigma

This section describes the findings pertinent to the following research questions:

Do college students with mental illness perceive themselves as stigmatized within academia?, and if so, in what ways or for what reasons are they stigmatized within academia? Analytic procedures follow those used for the academic resilience question. Findings have been broken down by self-stigma and perceived stigma, both of which respondents were asked about in the survey (see Appendix A) because the literature indicates these are separate constructs (Tucker et al., 2013).

Self-Stigma

Part of the survey asked respondents if they ever stigmatize themselves for having a mental illness. Of those who responded to this question, the majority (117 respondents, 53%, $N = 219$) indicated they do stigmatize themselves. Some of the reasons provided include holding themselves to higher standards than they can meet as a result of their symptoms and feeling less than their neurotypical peers. 26 respondents (12%) indicated they were unsure of whether they stigmatize themselves or not; the most common theme underlying their rationales is that they sometimes stigmatize themselves but try not to. 34 participants (15%) reported they do not stigmatize themselves. Some of the reasons provided include acceptance of their mental illness, perceiving themselves as no different than their peers, and recognizing that the diagnosis is not their fault. Finally, 42 participants (19%) did not respond to the question.

Perceived Stigma

Part of the survey asked respondents if they ever perceive themselves as being stigmatized for having a mental illness. Of those who responded to this question, the majority of respondents (107, 49%) indicated they do perceive stigma. The most common themes found among the “yes” responses were mental illness not being understood by neurotypical individuals, including peers and faculty, and mental illness being seen as an excuse. 25 respondents (11%) indicated they were unsure of whether they themselves as stigmatized or not; the most common theme underlying their rationales is that they do not self-disclose their mental illness. 45 participants (21%) reported they do not perceive stigma for having a mental illness. Some of the reasons provided include not feeling different than their peers (this response was most predominantly from individuals diagnosed with ADHD) and, as with those who responded “unsure,” not having self-disclosed. Finally, 42 (19%) participants did not respond to the question.

What Is Metaphor Analysis?: A Refresher

This section is intended to provide a brief refresher on metaphor analysis. For a full explanation of the method, please refer to chapter three.

As laid out by Low (2015), there are seven steps in the metaphor analysis protocol in educational research: (1) preparing participants, (2) eliciting the metaphors, (3) grouping into conceptual metaphors, (4) “attach[ing] metaphor to educational theories/philosophies,” (5) “infer[ring] likely actions/behavior from. . . categorization,” (p. #) (6) making suggestions for change in behavior or policy, and (7) evaluating the effect of the metaphors (as Low describes it, their impact). In this study, the first three steps

were carried out instead of the full set of seven, which would have entailed a full metaphor analysis, which was not the goal of this study because of the size of the dataset and varied foci due to the research questions. In the survey, respondents were prompted with an example metaphor (see Appendix A), asked to construct a source for two different targets (“being a college student with a mental illness is like. . .” and “being a person with a mental illness is like. . .”), and then, the resulting elicited metaphors were transformed into conceptual metaphors through thematic coding (Gibbs, 2007), one of several common approaches to metaphor analysis identified in a study of metaphor analysis techniques in education by Seung, Park, and Jung (2015).

Other common approaches to metaphor analysis in educational research include inductive categorization alongside an analytical framework, pre-determined categorization, and both quantitative and mixed-methods approaches (Seung et al., 2015). For this study, thematic coding was used, meaning common themes were looked for in the sources (using the metaphor extensions for clarity, as recommended by Armstrong et al., 2011). The other common methods described by Seung et al. (2015) were not used because they require either imposing a framework on the coding or using pre-determined themes, and I did not want to impose my own meanings onto the dataset as much as I wanted to let meaning emerge from what the respondents wrote. Although it is not always possible to remove one’s predetermined perceptions from the analytic process, I placed as much in *epoché* as possible and followed my instincts through the analytic process. For a refresher on the operational definitions to be used in this study, please refer to chapter 1.

Coding Procedures: Individual Metaphors

The third stage in metaphor analysis was applied to the individual metaphors: identifying underlying constructs for the conceptual metaphor (Low, 2015). Conceptual metaphors were identified by examining the content of the metaphor alongside the response to the question asking respondents to explain their metaphors. For example, one source provided for the target “being a person with a mental illness is like. . .” was “being a product that someone purchased but can't read the instruction manual.” This alone was insufficient for finding the underlying construct, so the participant-provided metaphor extension was examined. The extension for this metaphor was “When people find out that there's something slightly wrong with you, even if you can hide it really well, they automatically don't know how to react around you anymore. They judge what you do even though there isn't a reason to. They also know how they should treat you, but for some reason treat you like you're fragile and will break or explode at any minute.” Both the content of the metaphor and the metaphor extension were considered in concert to determine the appropriate conceptual metaphor. Looking at both responses indicated a conceptual metaphor of STRUGGLE would be fitting because considering that the respondent stated being a person with a mental illness relates to not being able to read instructions alongside the explanation that people don't know how to react indicated a sense of difficulty (or struggle). STRUGGLE was identified as the conceptual metaphor because the data spoke most to this notion, although other words could have been chosen, such as the above-mentioned “difficulty.” In brief, the elicited metaphor was mined for meaning, added to by the provided metaphor extension for clarity and depth of meaning, and then a conceptual metaphor was identified by the first, most salient term that came to

mind as I worked through the dataset. Once preliminary conceptual metaphors were identified, the rest of the elicited metaphors were appropriately categorized; if the elicited metaphor did not fit with any of the previously identified conceptual metaphors, a new one was identified through the same analytic process of examining the elicited metaphor and metaphor extension and assigning a conceptual metaphor. This procedure was applied to each elicited metaphor in the dataset.

Using this additional information (i.e., the metaphor extensions) allowed me to better fit metaphors to constructs (Armstrong, 2015; Cameron & Low, 1999; Gee, 2013; Kövesces, 2002; Kucer, 2014; Lakoff & Johnson, 1980; Low, 2015; Maslun & Cameron, 2010; Paulson & Armstrong, 2011; Smagorinsky, 2001), as some metaphors were not easily broken down into underlying conceptual metaphors without this rationale (for example, the metaphor of “drowning” came up in multiple instances, but was coded with differing conceptual metaphors dependent on the rationale provided). For example, the source “drowning” related to STRUGGLE, DIFFERENCE, BEING STUCK, NO CONTROL, INCLUSION, and HIDING (some of the conceptual metaphors identified through analysis). Examples of how these were categorized differently follow in the next paragraph.

Some examples of how “drowning” functioned differently follow. As noted above, the elicited metaphor of “drowning” was provided multiple times in the dataset, and using the metaphor extensions for categorizing into conceptual metaphors, it was found that “drowning” related to multiple conceptual metaphors. STRUGGLE was found to relate to drowning through the use of this source: “drowning. You don’t have time to keep your head above water.” in response to the target “being a college student with a

mental illness is like. . .”. The metaphor extension, “with school work, keeping up with relationships and financial responsibilities, oftentimes our mental health gets pushed to the back burner,” indicates a sense of STRUGGLE to maintain positive mental health while simultaneously meeting the demands of academics. In regards to the conceptual metaphor INCLUSION, the source “Drowning, but others are with you.” became an indicator of a sense of INCLUSION because of the metaphor extension “Everything can become really overwhelming. But you know you aren’t alone.” This indicated that the respondent felt overwhelmed, but also felt a sense of community, and, therefore, INCLUSION was the appropriate conceptual metaphor in this instance, although one may argue STRUGGLE is also fitting. When an elicited metaphor could fit into more than one conceptual metaphor category, the best fit was determined by following my first instincts. In this case, INCLUSION was more appropriate than STRUGGLE because the elicited metaphor and metaphor extension indicated a sense of community, something not inherent in the conceptual metaphor STRUGGLE. Hardship may be indicated in the metaphor extension (specifically, “Everything can become really overwhelming”), but the sense of INCLUSION indicated in the data took primacy because STRUGGLE was more ancillary to the overall sense of belonging indicated by the respondent. It should be noted that several conceptual metaphors were found to be related, so there are instances in which such decisions about the most appropriate categorization had to be made. In all cases, I examined the elicited metaphor and metaphor extension for the most predominant idea presented.

Once initial conceptual metaphors were identified for all elicited metaphors, they were sorted by concept for both sets: “Being a person with a mental illness is like. . .”

and “Being a college student with a mental illness is like. . .”. Conceptual metaphors were assigned to each metaphor, even if that conceptual metaphor only appeared once in the dataset. For example, the conceptual metaphor OVERWHELMING was only found once in the dataset, in the “being a person with a mental illness is like. . .” metaphor, with the elicited metaphor “A baby given a can of soda for the first time.” with the metaphor extension “When given a baby a can of soda, their little bodies are not used to that amount of sugar in one sitting before, and they can’t control their excitement or being hyper (sugar rush).” This elicited metaphor did not fit into the conceptual metaphor categories that had multiple responses, but it was still analyzed as an exemplar of identity conception. Although it could have fallen under the more frequent conceptual metaphors of STRUGGLE or NO CONTROL due to the nature of not being able to “control their excitement,” this elicited metaphor was determined to be more representative of the notion of OVERWHELMING because it was indicated that this would be a first-time experience and “their little bodies are not used to that amount of sugar,” something that overwhelms the system in a “sugar rush.”

Coding Procedures: Cross-Metaphor Analysis

In addition to coding the metaphors individually, cross-metaphor analysis was applied to assess whether participants perceived their person and student identities as different, similar, or the same. Respondents were asked whether they considered these identities different and why or why not; this data was coded by comparing the constructs for both metaphors to identify if they were the same, similar, or different. Then, this was checked against the response of “yes,” “no,” or “unsure” to discover if their use of constructs matched their perceptions. Several examples follow.

When a respondent indicated they perceived the identities as different, the conceptual metaphors for “being a person with a mental illness is like. . .” and “being a college student with a mental illness is like. . .” were compared to determine if the conceptual metaphors were the same, different, or related to see if the respondent’s perceptions were reflected in their conceptual metaphors. For instance, the “being a person with a mental illness is like. . .” elicited metaphor from one respondent was “Limbo” because “I never know what’s going to happen and I’m in a constant state of apathy, which gets confused for being relaxed.” This was categorized as NO CONTROL because the respondent indicated a sense of lacking control over “what’s going to happen” and being stuck in a state of limbo (although this could have been categorized as BEING STUCK, NO CONTROL was selected based on the language of “never know[ing]” in the metaphor extension). When a response such as this could have fit into multiple conceptual metaphor categories, I determined the best fit based on my interpretation of the response, selecting what I deemed the most apt conceptual metaphor. Although, in this case, apathy presents a sense of not caring more so than not being in control, I placed primacy on the language of “never know[ing] what’s going to happen,” something that indicates a lack of control over one’s situation on a daily basis. I also categorized this elicited metaphor as NO CONTROL because the respondent indicated being “in a constant state of apathy,” something that appears to not be under the control of the respondent because of its constancy. Thus, I determined the main concept behind the response as tied to the conceptual metaphor NO CONTROL more so than BEING STUCK. “Limbo” indicates being stuck, but the metaphor extension gave a fuller sense

of what the respondent intended, which I interpreted as indicating a lack of control over the respondent's circumstances or identity conception.

The elicited metaphor for “being a person with a mental illness is like. . .” was then compared to the “being a college student with a mental illness is like. . .” elicited metaphor from the same respondent, which was “Watching a movie with your favorite characters.” because “You want the best for them, but they obviously can’t hear you. When I can’t get out of bed to go to class I’m watching myself fail and I can’t do anything about it.” The conceptual metaphor for the student identity was also determined to be NO CONTROL because of the language “they obviously can’t hear you” and “I can’t do anything about it.” These findings were then compared to the response to the question “are these different?” following the metaphor construction part of the survey (see Appendix A), to which the respondent said “yes,” indicating they perceive the person and student identities as separate, yet they used the same conceptual metaphor for each identity, indicating a disconnect between their conception of how the identities overlap or intersect and how they actually conceive of themselves per the elicited metaphors.

Findings: Identity Development

This section describes the findings pertinent to the following research questions: (1) How do college students with mental illness conceive of their identities as people with mental illness?, and (2) How do college students with mental illness conceive of their identities as college students with mental illness?

“Being a Person with a Mental Illness” Metaphor

In analyzing the “being a person with a mental illness is like. . .” metaphors, 18 conceptual metaphors were identified. Some examples for each of the most frequent ones can be found in Table 5; five have been selected for each to give a sense of what types of metaphors were constructed. The responses provided are verbatim from the survey. No wording or punctuation has been changed or added. The elicited metaphors selected are intended to give a sense of the range of unique responses, thus those that were repeated (such as “drowning”) were not included as examples, but the full dataset can be found in Appendix C.

Table 6. Conceptual Metaphors and Elicited Metaphor Responses for Person Metaphor.

Conceptual Metaphor	Elicited Metaphor Responses
STRUGGLE	Trying to fit a triangle block into a square shaped hole. Being stranded in the ocean without a life jacket drowning in the middle of the ocean with passengers on boats passing you. You beg the other passengers to throw you a life vest or save you, but they either laugh, thinking you’re joking, or tell you to swim or tread water. walking through rapidly setting concrete. being in a room full of people who speak a different language and trying to get directions to somewhere unfamiliar
DIFFERENCE	being superman. Being a dull, grey color amongst the rainbow. Seeing other people walking on clouds when I’m stuck in quicksand A plant with a strange mutation Being a lightbulb in a room full of lights that flickers and strains itself to stay lit like the rest.

Table 6 Continued.

Conceptual Metaphor	Elicited Metaphor Responses
INSTABILITY	<p>Depression is like the seasons of the year.</p> <p>Well, it's kind of like being a balloon. There are days where we're inflated (this can be happiness or anxiety respectively), days where we're deflated or deflating (often depression or days of extreme self-depreciation), and days where we unexpectedly pop (examples include hysteria). It's like being a balloon that's always in motion.</p> <p>Being on a roller coaster.</p> <p>A person walking on the slippery bank of a river the ocean.</p>
BEING STUCK	<p>drowning</p> <p>Being trapped inside an invisible box</p> <p>going through life hanging on to the side of a hole and praying you won't fall in</p> <p>Being a person with depression is like being stuck in a deep dark pit. You look up and you can see everyone around you enjoying themselves but you can't figure out a way to climb up out of the pit to join them.</p> <p>Being trapped in a open cage. You can see the escape but just cant leave</p>

A full list of conceptual metaphors can be found in Table 7 along with the frequency count of metaphors for each one.

Table 7. Person Conceptual Metaphors.

Conceptual Metaphor	Frequency
STRUGGLE	49
DIFFERENCE	41
BEING STUCK	35
INSTABILITY	34
HIDING	18
NO CONTROL	15
BROKENNESS	13
EMPTINESS	4
EXCLUSION	2
INVISIBILITY	1
NEGATIVITY	1
CONFUSION	1
FEAR	1
COMPLIANCE	1

Table 7 Continued.

Conceptual Metaphor	Frequency
OVERWHELMING	1
EXPOSURE	1
AWE	1
SECRECY	1

As can be seen in Table 7, the most frequent conceptual metaphors were STRUGGLE, DIFFERENCE, INSTABILITY, and BEING STUCK, indicating that identity as a person with a mental illness is tied to a sense of hardship, being marked as different from those who are neurotypical, lacking solid ground, and having little choice, the implications of which will be discussed in the final chapter of the dissertation.

“Being a College Student with a Mental Illness” Metaphor

Table 8, which follows, includes examples for the two most common conceptual metaphors; again, five are provided, verbatim, to give some sense of the conceptual metaphor.

Table 8. Conceptual Metaphors and Elicited Metaphor Responses for Student Metaphor.

Conceptual Metaphor	Elicited Metaphor Responses
STRUGGLE	drowning. You don't have time to keep your head above water. Trying to to run a race with your legs half chopped off Folding a fitted sheet. You have tried to understand different ways to do it, you have even watched videos, but you still cannot grasp the concept of folding it. Coming into a movie late and the movie is in a language you don't understand. trying to stay afloat in an ocean with heavy clothes
DIFFERENCE	being a skittle mixed in with M&M's Being a black sheep Being a puzzle piece with no puzzle to fit into A penguin trying to fly within a flock of oversized intellectual crows. Walking up a mountain only to realize you had more weight to carry than others, and no one else believed you.

In analyzing the metaphors for “being a college student with a mental illness is like. . .”, 23 conceptual metaphors were identified. A full list of constructs can be found in Table 9 along with the number of metaphors for each construct.

Table 9. Student Conceptual Metaphors.

Conceptual Metaphor	Frequency
STRUGGLE	49
DIFFERENCE	42
INSTABILITY	23
NO CONTROL	16
HIDING	15
EXCLUSION	14
BEING STUCK	13
INCLUSION	8
OVERWHELMING	2
FEAR	2
PERSEVERANCE	2
ENDLESSNESS	1
DOUBT	1
STRATEGY	1
FRAGILITY	1
THREAT	1
DISTRACTION	1
UNCERTAINTY	1
NEWNESS	1
NAVIGATION	1
DISTRACTION	1
BROKENNESS	1

The most frequent constructs were STRUGGLE and DIFFERENCE. It is worth noting that BROKENNESS, which had 13 metaphors in the other set (for the person identity), was only present once for the student identity metaphors, which may indicate that a sense of being broken is more tied to being a person with a mental illness than a college student with a mental illness. This may indicate a stronger sense of self, in general, as related to being a college student with mental illness because BROKENNESS was only present once in the student conceptual metaphors. In addition, a greater number

of conceptual metaphors were identified for the “being a college student with a mental illness is like. . .” metaphor than the “being a person with a mental illness is like. . .” metaphor, indicating that there is variation between the perceptions of these two identities. Furthermore, a greater number of conceptual metaphors were created for “being a college student. . .” than “being a person. . .”, indicating a larger range of ways of identifying as a college student with a mental illness than as a person with a mental illness. There appears to be greater nuance in the student identity metaphors as compared to the person identity metaphors given the difference in number and the amount that only had one response.

Cross-Metaphor Findings

As described above, the two sets of metaphors were cross analyzed to identify if respondents perceived their identities as people with mental illness and students with mental illness as the same or different. This entailed identifying which constructs were similar to one another as this would allow for a more fine-grained analysis than looking only for same or different constructs for the two metaphors. This was accomplished by determining which conceptual metaphors shared characteristics; for example, STRUGGLE was found to relate to BEING STUCK because, in nature, being stuck is a type of struggle, not an easy process. The following table shows which conceptual metaphors were determined to be similar in nature when considering all the conceptual metaphors and their relation, not through the cross analysis, but by comparing conceptual metaphors before conducting the cross analysis.

Table 10. Similar Conceptual Metaphors.

Conceptual Metaphor A	Conceptual Metaphor B
BEING STUCK	EXCLUSION NO CONTROL DIFFERENCE STRUGGLE DIFFERENCE
STRUGGLE	PERSEVERANCE INSTABILITY DIFFERENCE HIDING NO CONTROL EXCLUSION BEING STUCK
DIFFERENCE	EXCLUSION NO CONTROL BEING STUCK STRUGGLE HIDING BEING STUCK
NO CONTROL	DIFFERENCE EXCLUSION BEING STUCK STRUGGLE INSTABILITY BEING BROKEN

Out of the 219 responses, 80 had different conceptual metaphors, 48 had the same conceptual metaphors, 71 had similar conceptual metaphors, and 20 could not be compared because only one elicited metaphor had been included in conjunction with a “no” or “unsure” to the question “Are these different?” in regards to the college student identity and person identity. This indicates the underlying perceptions of respondents were not consistently using the same conceptual metaphor for both “being a person with a mental illness is like. . .” and “being a college student with a mental illness is like. . .”,

although this is representative of my analytic process, not any indication of the respondents themselves beyond the data provided. The majority, then, used similar or same constructs to describe being a person with a mental illness and a college student with a mental illness; this is reflected in the responses to “Are these different?”: 94 reported “no,” 40 reported “unsure,” and 85 reported “yes.”

These findings are being broken down into an analysis of how many who responded “yes,” “unsure,” or “no” accurately represented that perception in their conceptual metaphors. This is to give a picture of whether respondents’ perceptions of whether these two identities (person with a mental illness and student with a mental illness) are reflected in the conceptual metaphors identified from their elicited metaphors and metaphor extensions. As such, each following paragraph will address each response (“yes,” “unsure,” and “no”) alongside a breakdown of how many responses were found to have the same, similar, or different conceptual metaphors for both identities.

Of those who answered “no,” 34 used different conceptual metaphors, indicating they perceived the two identities (person and college student) as different despite their response that they were the same; 20 used a similar construct, indicating that the identities may share certain characteristics but are not identical; 21 used the same construct, indicating that they perceived their two identities as the same in alignment with their response; and 19 could not be compared because of a missing metaphor as described above (meaning one elicited metaphor was provided and the respondent answered “no” or “unsure” to the follow-up question “Are these different?”).

Of those who answered “unsure,” 13 used different conceptual metaphors, indicating they perceived the two identities (as a person and as a college student) as

different; 19 used similar conceptual metaphors, indicating they perceived the identities as containing overlapping or related characteristics; 7 used the same conceptual metaphor, indicating their perceived identities do not differ; and 1 could not be compared because only one elicited metaphor was provided (as described in the previous paragraph).

Of those who answered “yes,” 34 used different conceptual metaphors, indicating they did perceive the two identities as different in alignment with their response; 32 used similar conceptual metaphors, indicating a relation between the two identities; 19 used the same conceptual metaphors, contrary to their perception that their identities are not different (per their response to that question); and, in this case, no responses fell into the category of not able to be compared.

Brief Discussion

The findings from this survey indicate, overall, that the majority of respondents consider themselves academically resilient, perceive stigma or self-stigmatize, and have differing, yet often similar when compared across the person and student identity metaphors, conceptions of what it means to be a person with a mental illness versus a college student with a mental illness. The metaphors explored in this chapter demonstrate the overwhelming hardships faced by these students—they often have troubling conceptions of self. Very few respondents demonstrated positive self-conception through the conceptual metaphors (specifically, those who indicated INCLUSION for the STUDENT metaphor, 8 out of an *N* of 219).

These findings indicate that faculty and staff could help college students with mental illness develop their sense of identity more positively, finding their strengths, such

as academic resilience, and integrating them into their sense of self either, or both, as a person and a college student with a mental illness. Part of this may entail direct conversations probing into a students' perceived strengths and, perhaps, the strengths they do not recognize (for example, in the case of students who do not perceive themselves as academically resilient).

Furthermore, work can be done to reduce stigma, both provided by the self and perceived as coming from others. As the majority of respondents indicated experiencing both kinds of stigma, it is clear that stigma exists for this population. One step towards helping this population may be to help them destigmatize themselves by exploring what it means to be an individual or college student with a mental illness alongside what is inside and outside of their control, such as the manifestation of their symptoms, as this was a predominant reason for self-stigmatizing. Finally, perceived stigma can be reduced through steps like educating faculty, staff, and students about the nature of mental illness, for example, to illustrate that it is not an excuse for needing academic supports or inability to keep up with the demands of coursework.

This brief discussion is intended to give a snapshot of the findings of this study in isolation. A more detailed discussion comes at the end of the dissertation. In that section, the findings from all studies will be compared by research question, and practical suggestions for supporting college students with mental illness will be provided.

Limitations

The primary limitation of this study is that it was a self-report measure. Although the first question of the survey asked respondents whether they had a diagnosed mental illness or not, there is no way of verifying that those who responded "yes" actually had a

diagnosis given by a medical provider. It stands possible participants may have self-diagnosed, which would skew the data because it is easy to self-diagnose without fully understanding the nature of the mental illness.

A second limitation of this study is that the full dataset collected was not analyzed. Identity claims and demographic data were also collected as part of the survey, but these components were not included in the analysis; therefore, some more nuanced understanding of the data may have been achieved through using the full dataset, for example, considering how identity development relates to type of diagnosis or length of diagnosis.

The final limitation of this study lies in the abbreviated metaphor analysis. Conducting a full metaphor analysis would have allowed for a deeper and clearer understanding of the elicited metaphors. Furthermore, it would have allowed for more validity and reliability in the findings.

Summation and Preview

In this chapter, identity development, stigma, and academic resilience were explored through a university-wide survey including metaphorical data. Overall, findings indicated that respondents perceived themselves as academically resilient, perceive stigma on campus, self-stigmatize, and have troubling conceptions of self as both people and college students with mental illness. In the following chapter, the research questions will be investigated through the lens of a duoethnography, narrowing the scope of participants to two. This is the next step in the telescoping approach used in this dissertation: moving from the broadest dataset to the most narrow.

V. DUOETHNOGRAPHY

What follows are excerpts and analysis from two interview conversations (there was an interview protocol, but the interviews were structured more like a conversations to follow the conventions of duoethnography [Norris, Sawyer, & Lund, 2012]) about mental health diagnoses, mental illness in academia, and public perceptions of mental illness. The tone of this chapter varies vastly from that of the previous chapter due to the nature of the genre of duoethnography versus reporting on a survey with metaphorical data. The tone is much more narrative in nature, in part to mimic the casual tone of the interview conversations. For a refresher on duoethnographic methods, please refer to chapter three.

Procedures

Two interview conversations, based in an interview protocol (see Appendix D), were conducted in the group counseling room of the campus Counseling Center because it was a safe space for discussing issues pertinent to mental illness and each co-researcher felt comfortable there. The interview conversations were recorded and transcribed following data collection. For the pilot study, the origination of this study, which occurred in the spring of 2016, data were emergent coded, and themes of resilience, stigma, and self-disclosure were found to be predominant in the dataset (VanderLind, 2017).

The themes discussed in this study are identity development, perceived and self-stigma, and academic resilience in the experiences of two graduate students diagnosed with bipolar disorder. These themes were arrived at after emergent coding a pilot study (VanderLind, 2017), an earlier version of this study not analyzed in full, in conjunction with the constructs addressed by the research questions, and these data were *a priori*

coded based on those emergent themes and the construct of identity development from the first two research questions driving the study:

1. How do college students with mental illness conceive of their identities as people with mental illness?
2. How do college students with mental illness conceive of their identities as college students with mental illness?

The themes that were used for *a priori* coding that came from the pilot study (VanderLind, 2017) were resilience and stigma, which have been reframed through the exploration of the literature into examining both perceived and self-stigma, and the theme that came from the research questions was identity development as a person or as a college student with a mental illness..

After the full dataset was transcribed, it was *a priori* coded for academic resilience, perceived and self-stigma, and identity development. Exemplars for each theme were pulled from the dataset to demonstrate how the themes are present in the experiences of the co-researchers. Following analysis, member checking was conducted with Violet via email. She was sent this chapter, asked if she felt her words were accurately represented, and she agreed that they were, so no adjustments to the analysis were necessary.

As stated in the methodology chapter, the co-researchers, Violet and Ren, were both graduate students with diagnoses of bipolar disorder at the time of this study. Violet was studying the natural sciences and Ren the social sciences. Violet was recruited through convenience sampling (Luborsky & Rubinstein, 1995) due to our familiarity from our experiences in the bipolar support group offered by the university.

What follows is an intermingling of our conversations and analysis, following the models set forth by Rose and Montakantiwong (2018) and Spencer (2014), both of which included analysis of the data following exemplars. Because the conversation is not presented in chronological order, but by theme, the analysis has been woven in to provide additional context and give the reader a sense of what themes emerged from our words. Although this inclusion of content beyond what was stated in the interview conversations is not traditional to a duoethnography, the analysis, discussion, and implications have been woven throughout the text to meet the genre expectations of a dissertation. Thus, following each exemplar comes a narrative explicating the findings, providing analysis, and, where appropriate, including discussion of implications. The exemplars will read as disjointed from one another because the conversation is not presented chronologically—the only connection between exemplars exists in the themes that were identified, so there will be a lack of transition between exemplars, as they should be taken individually (because they were not analyzed in conjunction but in isolation). A more nuanced analysis that crosses exemplars will be provided in the final chapter of this dissertation.

The findings and analyses are broken down into five sections, each relevant to a theme or overlapping themes: identity development, perceived stigma, self-stigma, academic resilience, and overlapping themes/constructs. The sections are broken down by theme to address the research questions individually as much as possible. The research questions driving this study are as follows:

1. How do college students with mental illness conceive of their identities as people with mental illness?

2. How do college students with mental illness conceive of their identities as college students with mental illness?
3. Do college students with mental illness perceive themselves as stigmatized within academia?
 - a. If so, in what ways or for what reasons are they stigmatized within academia?
4. Do college students with mental illness perceive themselves as academically resilient?
 - a. If so, in what ways or for what reasons are they academically resilient?

Identity Development

What follows are exemplars from the interview conversations in which Violet and Ren addressed issues of identity development. This section addresses the research questions How do college students with mental illness conceive of their identities as people with mental illness? and How do college students with mental illness conceive of their identities as college students with mental illness?

Identity as an Individual with Mental Illness

REN: It's a weird feeling. So, what do you think caused, or I'm sure I probably know this, but what happened that brought about the re-diagnosis?

VIOLET: Um, really, I just asked my psychiatrist because I knew I was on mood stabilizers, so I think that it was suspected when I was in the hospital and first diagnosed with Major Depressive Disorder 'cause I had a manic reaction to one of the meds they put me on . . . I was just super manic, and they started me out at like a regular dose, so I think it was suspected, and I have bipolar in my family, so when I finally asked five years later, it's like, okay, I know I'm on meds for mood stabilization, what is my status? And she's like, because it's in your family history, and you do have symptoms, we would call you . . . bipolar type one, but bipolar tendencies, is kind of what she first said, and kind of segued into bipolar type one. So that was the first time that I felt like a doctor was straight

with me. I had been seeing the doctor from the hospital for those four years in between, and I didn't really care for him, and I didn't feel like he was honest with me about my diagnosis and my meds and everything. He had an idea that I was bipolar but did not share that with me.

This instance (not the conversation, but the content of the statement) was the start of Violet's identity development as an individual with bipolar disorder. As Violet stated, she had been misdiagnosed, so it was not new to her to be an individual with a mental illness, but she now had to shift her lens from having Major Depressive Disorder to having bipolar disorder. She was, then, per Cope and Kalantzis (2009), developing a new literacy (representational literacy, that of identity construction) as she shifted her sense of self as tied to her diagnosis.

REN: I almost had myself hospitalized in college, when I still was just diagnosed with depression and anxiety, that would have been, what, 2004, million years ago? My boyfriend wouldn't do it. I got in my car with him, and said take me to the hospital, and he tried to drive me home, two hours away, and would not take me to the hospital. Yeah. And then I continued being misdiagnosed, for a long time.

VIOLET: Yes.

REN: Then I got here, and the summer before I came here, I felt like I was losing my mind. I couldn't sleep, so I was up half the night. I didn't leave the house, I wasn't talking to people, I felt like I was going bat shit crazy, then we moved here, and it felt like it was even worse. Like I swear to you, I didn't hear things talking to me, but I felt like the universe was trying to tell me I need to be among the trees, and to do that, I would have to jump off my balcony, and if I hadn't tried to do that, I wouldn't have gone to the doctor here, to try to figure out what was wrong. It was actually a TV ad that made me think I might have bipolar.

VIOLET: Oh.

REN: They were running mental illness awareness ads on CBS, and there was one talking about the symptoms of bipolar and misdiagnosis, and I was like, that's interesting. That seems like it might describe how I feel, and I started furiously Googling, and no one believed me, that I was actually bipolar, thought I was making it up.

VIOLET: I felt removed from bipolar, because my uncle, who was bipolar, was surely type one, and possibly with delusions. He was the black sheep of the family, that my mom wouldn't talk about. And after Vietnam, which he was drafted for, he got really bad. That's when his symptoms really manifested, and was on and off drugs, in and out of shelters, homeless, rehab, jail, so I felt very removed from that, 'cause that was nothing like my experiences. And I still haven't told my mom straight out, 'cause I'm worried she will associate his disease with my disease, which obviously they're related, but our circumstances are very different.

REN: Right.

VIOLET: So yeah, it never even occurred to me, and after I was diagnosed, my best friend's boyfriend was like, well duh. People were like, oh, yeah.

REN: But that's the exact opposite—

VIOLET: And he's bipolar, so he was like, duh.

REN: I didn't know any people who were bipolar until I moved here, then got my own diagnosis. I didn't know anybody. In fact, my family doesn't know anyone, except me, that's bipolar.

VIOLET: Oh, wow.

REN: At least that has been diagnosed. It's probably lurking in the family somewhere, we just don't know where.

VIOLET: And my first, so after the hospital, we would have required daily group, and it was everybody from the psych ward, basically, so bipolar, depression, anxiety, multiple personality.

REN: Dissociative Identity Disorder?

VIOLET: Yes. So there was like a hodge podge, but it was mostly depression and bipolar, and I was describing in some of my experiences, they're like, I have that, that sounds a little like bipolar, and that's kind of when I first started thinking about it, so I'd been thinking about it, knowing my meds, and knowing some of my symptoms, and just hearing from other people's experiences. I knew I didn't have hypermania, but that it was hypomania, kind of fit the description of my mood cycles, so that was actually like the best group I was ever in.

REN: That sounds like a really ... I don't know how to describe what that experience would be like, enlightening, but also like, holy crap, I just figured this out from talking to people, I don't know.

VIOLET: Yeah, but it was really nice to hear people who had, it's not disastrous thoughts, it's ... you know what I'm talking about, when you ... when you catastrophize.

REN: Yes.

VIOLET: So like that, would happen to me all the time, especially when I was depressed, and just cycle through my head, like I could just be driving, be like wow, that car almost hit me, and I'd take it all the way to a funeral. I just. . . I couldn't control my mind in the same sense that it felt like I should, and so I ran into people that were like, yes, that is catastrophizing. You know, like, I had that too, and I was like, wow, so I'm not alone, I'm not bat shit crazy, I'm not the only one who does this, so that was kind of a nice comradery feeling.

Ren had a shifting identity from misdiagnosis, much like Violet did, needing to develop a new identity literacy. Anecdotally speaking, this is a common occurrence with bipolar disorder—the symptoms typically do not manifest until the age of 18, so doctors are hesitant to diagnose people younger than that with bipolar disorder. This is something Violet mentioned in the conversations when discussing her misdiagnosis, as well, so it is not shocking that misdiagnosis occurred and that both Ren and Violet had to develop new identities shifting from individuals with one mental illness diagnosis to another, more severe mental illness diagnosis (i.e., bipolar disorder).

Something that Violet spoke to in terms of her identity development worth noting is how her interactions with others who had similar experiences helped her feel a sense of inclusion and provided her insight into her mental illness and her symptoms. Both Ren and Violet noted their experiences with group counseling: Violet after hospitalization and Ren during her Master's program. Although these were not groups specific to bipolar disorder, interactions with individuals who shared symptoms and experiences guided them as they explored what it meant to be an individual with a mental illness, even

though they had not yet received their proper diagnoses. This speaks to the power of belonging—having a sense of not being alone may help people with mental illness more quickly acclimate to their symptoms, understand them, and start to develop their identities as individuals with a mental illness, such as coming to terms with what it means to have a diagnosis.

It's also worth noting how Ren and Violet spoke about their identification with the bipolar diagnosis. In Ren's case, she readily identified with the diagnosis through her exposure to its characteristics via the popular media (the CBS ads), seeing how the portrayal of bipolar disorder matched what she was feeling. Violet, on the other hand, resisted identifying with the disorder because of her family history with bipolar. She did not perceive her illness as presenting itself as severely as it did in her uncle, so she did not identify comfortably with bipolar disorder like Ren did. This may be due, in part, to Ren not having a family history of mental illness. It stands possible that, if she did, she may have been more reticent to identify herself as having bipolar disorder.

In terms of literacy, it's clear that both Ren and Violet were developing new senses of identity, meaning they were demonstrating a type of literacy learning. Learning what it meant to be diagnosed with bipolar, although perceived in different ways by Ren and Violet, required a shift in conception of self. This, in turn, necessitated developing new identities, and thus, new literacies specific to the identity of being an individual diagnosed with bipolar disorder.

VIOLET: Yeah, so that [counseling group] was the first time I really talked to other people and heard other stories like mine, and that was nice, because I had been experiencing it my whole life, and not knowing what it was.

Again, Violet emphasizes the importance of interacting with others diagnosed with mental illness when shaping an identity as an individual with a mental illness. She notes the power of shared stories and how hearing the experiences of others can help one develop self-awareness, perhaps also providing tacit guidance on how to learn the new literacy of being diagnosed.

REN: Most people had problems with depression, anxiety, suicidal thoughts, substance abuse, but it was just such a big mix of people, and almost all of them were undergraduates, and I was a grad student at the time, so it felt very different. It didn't feel as much like, oh, you share my experience, you know what it means to be manic, or severely depressed, or we shared things in common, but it wasn't quite the same.

In describing her experience with group counseling, Ren states that she had a much different experience than Violet did. Whereas Violet found shared experiences with the members of her counseling group, Ren did not find as much benefit in terms of identity development. This may be due to the fact that Ren's counseling group wasn't limited to individuals with a diagnosed mental illness like Violet's was, limiting Ren's ability to use the experiences of others to help her develop the literacy of being an individual with a mental illness.

REN: I think that's the nice thing about the bipolar group, is that there's always going to be someone in the room, who was some kind of similar something going on, who has been—

VIOLET: Or has been there, at least.

REN: Yeah.

VIOLET: I try to do that in group. I don't know if it's appreciated always, but just share my past experiences. I've been through that, because I've found it really helpful to find other people who'd experienced the same symptoms, 'cause then you don't feel so alone, and you know you can get through it.

REN: Yeah, you're not just the lone crazy person.

VIOLET: Right, 'cause sometimes it's very isolating.

Here, Ren and Violet speak about a group they both participated in as graduate students that was specifically for individuals diagnosed with bipolar disorder. They both noted the direct benefits of speaking with others who share the diagnosis: knowing you are not alone and hearing about the experiences of others. This may help individuals with a particular diagnosis develop a sense of identity tied to their diagnosis more quickly because of the shared experiences and symptoms. And, as Violet noted, there are people who have had the diagnosis for longer periods of time who can help guide group members who are more newly diagnosed and may not feel a sense of inclusion or understand their symptoms. Groups such as these, then, may have an influence on the literacy/identity development of participants.

VIOLET: Right, so I feel like, as I've gotten older ... well, I've let my guard down a lot, and I'm much less jaded. I'm sarcastic, I'm still a little sarcastic.

REN: Aren't we all?

VIOLET: A little feisty, but I feel like I have let my guard down a lot, and more trusting with people, and getting to know people, and sharing with them. But at the same time, it makes it harder to mask, when I'm not doing well.

REN: Yeah. I know what you mean.

VIOLET: I think being married has something to do with that too, 'cause I try to hide certain things from. . .like if I'm doing really badly, I try to kind of hide it, but if I'm just having a bad week, a bad month, I let him know. I cry in front of him. I pace in front of him. I try to shield him a little bit, so he doesn't stress out, but at the same time, I feel comfortable enough to show symptoms.

REN: I feel like I had a follow-up to that, and I lost it.

VIOLET: Do you feel like being vulnerable with a person, in that way, in a serious relationship, like that kind of opens the door to. . .

REN: Yeah, I definitely think it can. I don't know. I've had conflicting experiences with my [husband] lately. When I told him how depressed I've been, he said, oh, well, I know. Well, why didn't you say anything? So it makes me kind of feel like I don't want to tell you things, 'cause you don't say anything about it anyway, but at the same time, if I can't tell him, who can I tell, except for maybe [my counselor]?

Once again, Ren and Violet speak to the value of a support system in dealing with a diagnosis. Violet explains how she has gradually become more open when expressing her symptoms, particularly around her husband; this may indicate that the length of time since diagnosis may lead to further identity development (here, expressing more openness) or that having a close relationship with someone else one feels comfortable letting one's guard down around may lead to a sense of identity that is not as tied to being closed off or hiding one's symptoms. Ren noted, however, that the support system provided by her husband was not always sufficient because of his reticence to reach out when he noticed she was not doing well. This may indicate that the type of support system is key: members must be receptive, intuitive (i.e., noticing the manifestation of symptoms), and ready to speak out when they notice something is off. Thus, identity development is not limited to the diagnosed, but extends to those in their support systems, as they have the power to influence the nature of developing representational literacy and have to develop their own senses of identity as a supporter of an individual with a mental illness. The main difference, perhaps, is that those who support people with mental illness, like Violet and Ren's husbands, is that they do not have to worry about constructing an identity to present to the world as related to this role, necessarily. Although they are developing new identities, they may not be as concerned with how that identity is perceived as the individual with the mental illness.

REN: There's one point about diagnosis that I wanted to ask, though, is how you

. . .I guess [question] number four, like how did you feel when you were actually properly told, hey, you have bipolar. What did that feel like?

VIOLET: I felt okay, really. By the time I was told I was bipolar, I'd kind of come to terms with it already, and it was still kind of hard to be labeled bipolar, I think, because I did associate with another level of crazy. It's one thing to be depressed all the time, it's another thing to be bipolar, so I kind of like, on a scale, it's a little further towards the crazy crazy.

What Violet expresses here is akin to a sense of fear due to the diagnosis with bipolar disorder: note the wording “crazy crazy.” Bipolar disorder is recognized as a more severe mental illness than depression, for example, as Violet notes, which may have led her to have an identity crisis when realizing that she fell towards the more severe end of the mental illness spectrum.

REN: Yeah. I feel that way a lot, not like I actively want to go out and kill myself, but if I died, meh, it doesn't matter that much.

VIOLET: Yeah, I grew up feeling that way. You know, like little kids say things like, oh, I wish my parents were dead, or I wish I was never born. I meant it. I would say, not that I meant my parents were dead, but people would then respond with, then you would have never been born. Fine. Five, six years old, little.

REN: I wished that I hadn't. I didn't see the purpose, in my life, if I was just going to be suffering all the time.

VIOLET: I didn't even think of it as suffering, I just didn't see purpose. It's like, when I was growing up, I didn't recognize that something was wrong, so I just didn't see purpose.

REN: I was convinced that I had been put on Earth for God to look down and laugh at me, and basically enjoy the fact that I was miserable. I was convinced of that fact when I was a teenager.

VIOLET: I was always very ... I would romanticize, like when we moved, it's a fresh start, I can be in the popular crowd, or I can do this, or I can do that, it's a fresh start. I can be anybody I wanna be, but I wind up right back kind of where I was, I'd fall into that niche, where I was comfortable. And it would frustrate me, kind of, you know, because I'd feel like a nobody, I'd feel like just kind of in the middle, and then it was like, oh, in high school, fresh start, and it's like, no, not really, kind of fall into the same

patterns, but I always kind of would romanticize about being more popular, being happier, being. . .getting the guy.

REN: Yes.

VIOLET: That would make everything better.

REN: I think I did the same thing. I think I even took that up to the point that I moved here. Everything will be better once I leave Michigan, I told myself, and in some ways it was. I finally got properly diagnosed.

VIOLET: You have to be worse before that.

REN: I had to be pretty bad, just to even get [my husband] to believe that there was something wrong, that I needed to see a doctor. And even then, when I had my diagnosis, it was so long to get adjusted on the meds, that he wanted me to go off them, because maybe it's not worth it, and it took a long time to get him to the point to see that it's not a check the box, flip the switch, you're done, you're fixed. It's a lifetime—

VIOLET: Adjustment.

REN: This is what it is, it's who I am, we're gonna have to deal with it. I can't turn off the manic. I can't turn off the depressed.

VIOLET: I think [my husband] had a harder time with the bipolar diagnosis than I did, 'cause I already suspected it, 'cause I was the one who kind of asked about it, and he was like I don't know, I don't think that's right, I don't see that. But other people close to me were like, yeah, okay, I can see that. And I explained the symptoms, we had a big talk, and I was like, I need you to help me watch out for symptoms, because I don't recognize them. I know I don't recognize them. I recognize depression, as I said before, more easily than mania, and so I'm like, these are things to watch out for, and I think that very real, serious conversation got to him. He was kind of in denial. And still, sometimes he's like, flip a switch, just don't be sad, because he suffers from emotional disturbances. It's not really depression. He goes through depressed times, but he was abused as a child, so he has his own mental issues that he battles, but for him, it is very much a situational thing, stress related. He can kind of push it down and move forward, and he kind of understands, it's different, when you have the chemical imbalance, that it's not triggered by a specific incident, so he had a hard time understanding where I was coming from, but then at the same time, he thinks I can just flip a switch and fix it, just suck it up, just push it down.

Here, Violet and Ren speak about their history of experiencing mental illness before college and how their experiences shaped their identities as people with mental illness. They speak of a reckoning when coming to terms with having a lifetime diagnosis; bipolar disorder never goes away, even though it can be managed with medication and therapy. This points to a heaviness in the sense of identity, almost a dread, of knowing this diagnosis will never change, and that they have to face a lifetime of symptom management.

Something else they point out is how perceptions of others, particularly those in their support groups (here, their husbands), affects their sense of identity. They speak about their difficulties getting their husbands to understand the nature of the illness, and this acts as a force counteracting their positive identity development. These members of a support system may not fully understand the nature of the mental illness, meaning they may inadvertently misinterpret what is going on or undermine the sense of identity being developed. This may indicate that having a support system may be key, but it is essential to positive identity development to have individuals in the system who have direct experience with the diagnosis.

VIOLET: No, and there's certain ... there are behavioral tools to help you kind of nip it in the bud, or keep it from getting worse. It doesn't get rid of it. You know what I mean? Like I'm learning, I'm 36, and I'm learning still, on how to stop the anxious cycle, and how to stop the catastrophizing, and all of those things, and it's still a struggle to do that, because your mind just runs away with it, and you can't really control it. It's just not the same.

Although Violet's earlier words indicated that she may have developed a stronger sense of identity due to length of diagnosis, here, she states that, despite her age, she still does not always recognize the mental illness at play in her life. This indicates that identity development when dealing with a mental illness is a continual process as

individuals continue to learn more about their symptoms, triggers, and management techniques. In other words, one does not simply develop an identity related to their diagnosis in a linear process, but rather continues to develop it over time in a reiterative process. Violet noted earlier how group counseling helped her understand her diagnosis and symptoms, but here, she speaks to how she does not always recognize how to manage her symptoms when they manifest.

VIOLET: I think after I was first diagnosed, I, I was constantly in fear of being suicidal and being at that lowest point.

REN: Hmm.

VIOLET: So it seems like I'm a little depressed. I just automatically would kind of jump into like, "Okay, we're going to stop this now before it gets worse." Which is not a bad thing.

REN: And having like a plan of action almost.

VIOLET: Right. Like if it's more than a weekend, I start to say like, "Okay."

REN: That's really good. I don't do that. (Laughter) Oh, I, I think this, this is evident in the fact that I went like two months without seeing the doctor and was not well during that time.

VIOLET: Well, and I think when you're really not well, it's harder to do that. I think when it's just the beginnings or that little bit, it's easier to step back and say, "Okay, I'm not doing so great. I need to stop this now." But when you, when you let-, not let it get farther, it only goes farther. It's a lot harder to stop back and say, "Okay, this is what I need to do for myself."

In this instance, Ren and Violet are speaking about their identity development following diagnosis in conjunction with recognition of symptoms. Violet notes the fear she felt when first diagnosed, but that she eventually developed a better sense of her symptoms, which seems to have abated some of the fear. Based on the exemplars thus far, it seems time does play a factor in identity development, although here, Ren notes that she does not always take action or recognize her symptoms as anything outside of the

normal range of emotions. It stands possible, however, that this is due to Ren being more newly diagnosed than Violet.

VIOLET: So I've always like admired you for being able to be kind of. . .but it, it . . .I, I was about to call you a poster child, but you don't want to be a poster child. You just want to be able to say, "Look, I have bipolar and I'm a normal person too." But I feel like you're a good representative and I don't feel like. . .I admire that, but I don't feel like I can do that.

REN: See, I feel like a terrible from like the fact that. . .like poster child comes into my mind sometimes. Like I'm. . .you know, like I put myself out there as someone who talks about what the experience is like and who's trying to be advocate. And yet, I'm not well all the time which makes me feel like I'm a terrible poster child, poster, you know, spokesperson whatever for the experience of mental illness in academia.

VIOLET: But I think that is an important message for people. You don't have to stop taking your meds to go through a hard time. You know what I mean?

Violet clearly perceives Ren as someone with a strong and clear sense of identity as linked to her mental illness, but Ren does not always perceive herself as such.

Interestingly, Violet states she "[doesn't] feel like [she] can do that [be an open advocate for people with mental illness]." Ren and Violet clearly have differing senses of identity as individuals with bipolar disorder; Ren perceives herself as somewhat forced into the "posterchild" identity because she acts as an advocate through her research, but Violet does not perceive herself as capable of doing the same. This may be in part due to her reticence to self-disclose (which will be discussed in-depth later in this chapter), but it also may indicate a sense of apprehension about being open with her diagnosis, meaning she does not have a fully positive sense of identity. Ren, on the other hand, sees herself in the "posterchild" role, despite not always wanting it, and is happy to be an advocate for others. Nonetheless, she perceives herself as not always living up to expectations

because she cannot always manage her symptoms well. This speaks to a conflicting sense of identity: that of ownership of one's diagnosis alongside a sense of shame.

REN: See, I, I wish that I had had that ability because that's the reason that. . . I mean like now that I'm not on Klonopin [a sedative], I am, I have no intention of ever taking another benzo[diazepine, a sedative] again. Just ever, because I've been there, done that and I don't. . . I don't know. I, like I could trust myself with the Klonopin, but it's so sc-, but, you know, it's so scary because of the long half-life that I wouldn't want to take it again. So I want something shorter acting like Xanax [a benzodiazepine], but Xanax is a little more habit forming because it's so quick release and. . .

VIOLET: Right.

REN: It's just. . .there's no good alternative once you start self-medicating.

VIOLET: No. And that's what, I mean, I'm afraid given my uncle's history. It makes sense that I am weary about self-medicating. When I say that and I have five cups of coffee a day because I quit smoking and probably just the minimum. Some days it's eight. (Laughing) But you know, I mean like no one talks about self-medicating when other people drink excessive amounts of coffee. You know, or like. . .I mean it's just. . .it's a double standard in a lot of ways. Like you have to look at every single substance that you put in your body as. . .it's like, um, a manifestation of a symptom. You know, like, "Oh, I'm overeating." "Why?" "Because I'm depressed." Or, "Oh, I'm not eating enough." "Why?" "Because I'm manic or because I'm depressed." So it's, it's kind of like you just have to think twice about everything.

REN: I know. It's like you never know. . .like we talked about last time, like "Am I really happy, or am I just slightly manic?" You never know.

VIOLET: No, and I was talking to my husband about it with the new job and I was like, "You know, since it turns out I was hypomanic the whole time I was there over the summer, am I really going to be happy there, or do I need to be manic to be happy there?" Like it's a scary thing to realize that you're basing a life decision on a period of time where you may not have been truly happy.

REN: Yeah.

VIOLET: And I mean, obviously, I was happy. I was hypomanic, but there had to be good things going on in order to like get me to that place is what I keep trying to tell myself like, there had to be positive motivators.

REN: If it wasn't good, you would have been probably. . .

VIOLET: I would have been. . .

REN: Depressed.

VIOLET: Depressed, right. Well, that and I'd gone off medication which makes it more likely to be hypomanic when you stop it. So the combination of being happy, of going off the medication that kept me from being hypomanic made me hypomanic. But it's such a scary thought to think like, "Well, what if when it's real life and I'm not hypomanic, what if it just totally sucks? What if?"

REN: Mm-hmm. I totally don't think it will, but. . .

VIOLET: I don't think it will, either.

REN: But that's not the point, though.

VIOLET: But, yeah. I mean, I think it will be fine. It's just, it's also scary. I'm very set in my ways, and I don't like change, and the thought of moving and changing jobs and cities and all of those things is very scary to me.

Again, Ren and Violet speak to a sense of fear tied to their identities as individuals with bipolar disorder, in this case, as related to their use of medication. Violet noted earlier in the conversation that she has a fear of using benzodiazepines to manage her panic attacks because of the possibility of chemical dependency. Ren echoes this in her first statement about her previous abuse of sedatives to self-medicate. A common theme emerging from these exemplars of identity development is fear: fear of a lifetime diagnosis, of not being capable, of not recognizing symptoms (such as Violet's fear of being hypomanic as stated in the above exemplar), and of the effects of medications such as benzodiazepines.

Taken as a whole, Ren and Violet had similar, although not identical, experiences of developing their identities tied to having bipolar disorder. Fear was expressed by both, both demonstrated the importance of a support system in the process of developing sense

of identity, and both indicated that identity develops over time gradually and in a continual process.

Identity as a College Student with Mental Illness

This section only contains one exemplar from the dataset. Because the original pilot study (VanderLind, 2017) was not focused on identity as tied to being a college student with a mental illness, this topic did not come up much in conversation. This was the only instance of identity as tied to being college student with a mental illness without any other themes present (recall that some themes overlapped in exemplars and these will be discussed later).

VIOLET: It makes everything harder, I feel like. I do. I feel like, when I had it. . . it's managed now, but I feel like all the meds then have their own issues with memory and focus and waking and just everything, that before, when I was kind of in denial, or masking it, it was so much easier. Everything was just easier, and I was younger, so I don't know how much of it was age, and how much of it is all the meds and the symptoms, but I feel like the anxiety, the stress, I didn't have a lot of anxiety when I was younger, and the older I got, the more anxiety I developed, so I feel like I'm on a huge disadvantage for tests, presentations, quizzes, anything where I have to perform, and you're being judged. You are constantly being judged on your performance, and that is very difficult. You're at a job, yes, you're being judged on your performance, but it's spread out. It's not like, on this one day, you will be judged, for the past three months. It's spread out over time, and it's easier to kind of show, yes, you're a good worker, whereas school, you are literally being graded, and I feel like. . . partly due to my age, but I feel like legit. I always worried, coming back to a Master's program, would I feel legit like I would not be able to do a PhD program, and it's not fair, and it's not right, but that's how I feel. And because I think it is the sciences, nobody cares. They don't. . .if you can't cut it, you can't cut it, it doesn't matter the reason, and I feel that way about undergrad, Master's, all of it.

Here, Violet first speaks about her identity as tied to being a college student. She notes how her symptoms interfere with her ability to meet the demands of college, and this proves problematic for developing a positive sense of identity as a college student

with a mental illness due, in part, to perceived stigma (for example, being judged or not being able to “cut it”). Her sense of identity as a college student with a mental illness, then, is one wrought with self-doubt: “I feel legit like I would not be able to do a PhD program, and it’s not fair, and it’s not right, but that’s how I feel.” Here, there’s a conflict between how Violet perceives her identity and how she wants it to be perceived by others, indicating that perhaps she strives to present her identity to the world in a way that does not resonate with how she perceives it—she is actively constructing an identity for the world to see, developing her representational literacy.

Perceived Stigma

What follows are exemplars from the interview conversations in which Violet and Ren addressed issues of perceived stigma. This section addresses the research questions Do college students with mental illness perceive themselves as stigmatized within academia? and If so, in what ways or for what reasons are they stigmatized within academia?

VIOLET: So, but for me, it was, again, it was seventh grade, I was severely depressed, but never diagnosed. And it only occurred to me, because we went, we had just moved, I'd had mono the year before, and I had mono like symptoms, where I was very fatigued, and didn't want to do anything, and very lethargic, and we went and visited Connecticut, where we had just moved from, and one of my friends had been diagnosed with depression. And we had all the same feelings, kind of, I hadn't really recognized it, but I was like, hmm, maybe, it doesn't sound too far fetched. But as they were narrowing illnesses down, and they had me see a psychiatrist, and I just lied. I knew what normal answers were, so I gave him the normal answers, and my mom still doesn't believe that I was depressed.

This is an instance of the effects of perceived stigmatization. Violet expresses how she knew the “right” answers to tell the psychiatrist to avoid being diagnosed, which indicates almost a fear of diagnosis, even though Violet was starting to recognize

symptoms of mental illness she saw in her friend. One might expect that having a friend diagnosed with depression would allow Violet the space to feel safe having a similar diagnosis, but had she wished to be diagnosed, she likely would have been honest with her psychiatrist instead of giving the answers she knew she needed to use to avoid diagnosis. That Violet knew the “right” answers demonstrates there is a literacy to psychiatry appointments—certain questions will be asked, and differing answers will indicate different issues to the psychiatrist. Violet was an insider on this literacy and knew what to say to avoid proper diagnosis.

REN: Yeah, I didn't know anyone. No, actually, I've never known anyone directly, who has taken their life. The sad thing is, what feels sad to me, is that I was friends with all of the "crazy people," all the people who were depressed, and on the outside, and even they ostracized me eventually.

VIOLET: That's horrible.

REN: And stopped talking to me and. . .so I don't know, I just. . .I always had problems with friends, not lasting friendships, and I wonder how much of that is due to mental illness.

Ren perceived stigma from her peers, something detrimental to her well-being. Even though she thought her peers would understand (note how she referred to them as the “crazy people”), they eventually tired of dealing with her symptoms. Perceptions of mental illness can be powerful in this way—in a space where Ren expected to be included and safe, she was, as she stated, ostracized. This may indicate that even those who people with mental illness may expect to be part of their support system may stigmatize them and not understand their needs.

REN: It's just. . .it's nice knowing that there's someone that you can just be your crazy around, but I also don't want to be my crazy around him [my husband], 'cause what if I'm too crazy, and he wants to leave me?

VIOLET: No, I completely understand that. I hide how bad I am, but not my

mood. And to this day, even though. . .so that was 2005, when I was hospitalized, so it's been 11 years, he [my husband] goes back to that place of worry and stress, immediately, so when I'm having a hard time, especially if it's consistent, he automatically goes in to fix it, and stress, and worry. So I can't tell him. . .I don't feel like I can tell him how bad it is, but it hasn't. . .I would say it hasn't been. . .this fall was rough, but it wasn't nearly as bad as my senior year in college, my first year, well my only year at [university A], my year at [university A]. I'd reverted back to cutting, and just self harm behaviors, and was trying to hide that from him. He didn't buy my cat scratch story, though.

Violet and Ren both speak to their fears regarding being stigmatized by their husbands, cornerstones of their support systems. Ren expresses the fear of being perceived as “too crazy”—as if her symptoms will become too much for her husband to handle—and being alone as a result of it. Violet similarly speaks to her perceptions of her husband’s receptivity to her symptoms and an associated fear of telling him exactly what is going on. This may indicate that stigma can be perceived as coming from even the closest members of one’s support group, which is problematic because individuals with a mental illness should feel comfortable openly expressing their needs to the members of their support systems, not just a select few. Furthermore, that Violet and Ren both fear the perceptions of their husbands demonstrates that stigma can be perceived as coming from anyone, even those closest to the individual with a mental illness.

This ties back to representational literacy: both Ren and Violet wish to present an identity that is not “too crazy” (as Ren stated) to those around them, including members of their support systems. Even in what should be safe spaces, representational literacy comes into play in an effort to overcome perceived stigma.

VIOLET: The only time I had scars, when I was teaching water aerobics at the time, and I had my bathing suit on, I didn't have shorts on, or I was in the dressing room or the locker room or something like that, and I realized, I looked down, and so I always cut on my upper thigh, very high up, so that

nobody really noticed, I mean [my husband] could theoretically notice, but he never did, 'cause usually I wasn't naked in bright lights, or anything like that, so unless it was bleeding, he wouldn't notice. So I was aware that I had scars, and I'd known people with scars, and you always kind of wonder, what is that history, what is that story behind it, and I'm sure nobody else noticed, but I was just aware, and kind of. . .not embarrassed, but just—

REN: Hoping people wouldn't say anything.

VIOLET: Yeah. Yeah, because at the time, I wasn't cutting. It was kind of in between times.

Here, Violet speaks about fear of stigmatization for a common coping technique for people with mental illness: self-injurious behavior. Violet cut herself as a way of coping with her mental illness, and she feared people would see the scars. This fear may stem from the questions that would arise: what are the scars from? This is especially poignant if the scars look like those of self-harm, having characteristics such as being evenly spaced apart or being located on often-hidden parts of the body. That Violet feared others would notice her scars demonstrates the tension of representational literacy as related to stigma: she sought to present herself to the world in a way that minimized the potential for stigmatization from others.

VIOLET: Um, so, I mean I feel like it's [self-disclosure] easier in an academic setting than in a workplace setting perhaps. Um, I don't feel comfortable with it in my field though. I don't feel like, um. . .it's, it should be better understood you would think, the science behind it in a science field, but it's not. It's kind of just seen as a weakness. So it might have been viewed as a weakness. It's also kind of seen as an excuse I think.

REN: Hmm.

VIOLET: And I think some people probably try to. . .we've seen people use it as an excuse and abuse that. So, I feel like those people kind of give legitimate claims of bad reputation. So I don't know. It's probably most of the people and there's individuals I would feel more comfortable disclosing with than others, but at the same time, I know that it's, it's, um. . .ethically, they should not disclose to anybody else. But legally, they can.

You know, you go to our professor and disclose. They're stopping, stopping them from telling the whole department. Ethically, they should not.

REN: Oh, according to FERPA, they should not say a damn thing to anybody.

VIOLET: They, they shouldn't. But there's nothing really like with teeth to keep them from spreading it around the whole department. So I feel like that has always been a concern of mine as far as going to an individual and say. . .you know, like a mentor and saying, "This is my situation. Do you have advice? Can you help me out?" You know, "Can you just kind of be there?" Um, I've never felt comfortable doing that.

REN: Even after you, you did speak to your PI [supervisor]?

VIOLET: Even after I did self-disclose. Um, no. And I think part of that is a personality issue with, with that person. Um, uh, just not understand me and I, I felt like it was not understood. You know, so I, I just self-disclosed to my adviser. Um, I felt like it wasn't well understood. And I probably could have been clear. I did not say, "Hey, I'm bipolar." I said, you know, "I have a mood disorder." You know, "What does that mean?" And, and I just said, "I have a mood disorder and I've not been doing well." And I was I guess hoping that will be enough and that was not understood and it's like, "Well, what does that mean?" "Well, I've been very depressed." And, um, I may have already said this on record, but I've got the response, "Grad school isn't for everybody."

REN: Oh, I'm officially going, go on the record as saying, which I have many times, that that's a shitty thing to say to somebody.

VIOLET: And it wasn't the only thing said. It was one of the many things said. It was, you know, "I'm sorry you're going through a hard time. I'm sorry you're going through this." But it was also said that grad school isn't for everybody.

REN: And that's not the helpful thing to say to someone who—

VIOLET: No.

REN: catastrophizes and has depression.

VIOLET: No. (Laughing)

REN: And it's like the worst thing you could say.

VIOLET: It is. And after having been through having to leave grad school

because of my mental illness essentially. Um, and I don't think that was the only factor, but it was definitely a big factor. That's not what you need to hear because you already feel like your mental illness is keeping from you achieving.

REN: Yeah.

VIOLET: So, um, no, I don't feel like I can go to that person and talk to him about it at all.

REN: That blows. . .it's just. . .

VIOLET: And I did go back and say. . .you know, realized that I didn't maybe explain it well enough. I mean, he doesn't know enough about mental illness and particularly bipolar disorder, which as I've said I didn't tell him I had. Um, I went back and I said, "Look, you know, I don't see you doing this, but if you ever have questions, now that you know, I'm happy to talk to you about it." And it's never been brought up again. I've never gotten a sincere, "How are you doing?"

REN: I want. . .I have kind of the opposite experience, because all. . .pretty much everyone in my program knows or at least should know. I'm pretty sure that my former supervisor doesn't because he doesn't remember things very well.

VIOLET: My adviser does not remember. . .he's very much in his head. Does not remember things like this and I don't think he really wanted to remember it. And I don't know that I want him to remember it because it was a point of weakness.

REN: Well, I don't, I don't know that I want all of them to remember either. Like our new program director. And I, I think if it weren't for stigma attached to and me wanting to be viewed as not attached to this mental illness that I would think that it's just, it's very nice and it's very reassuring every time she sees me. She checks in like, "How are you doing?" And it's a very loaded how are you doing. Like, "How. . ."

VIOLET: Which to me is just as bad.

REN: Yeah, it, it, it's like, "I'm glad that you care, but at the same time, I want to be more than [my mental illness]."

VIOLET: When you want. . .which you do that to another student? No. Probably not unless they were going through some traumatic life events. And you want to be treated like the other people in your program. And I. . .so I mean, so on one hand, I'm, I'm happy that it hasn't come up again. On the

other hand, like looking at it, it wouldn't be so bad at every so often. He's like, "You know, you seem to be doing better."

Ren and Violet are speaking to their experiences self-disclosing to faculty, in Violet's case, her graduate assistantship supervisor. Both perceived stigma from the individuals they spoke with in different ways. Although Violet mentions she did not fully disclose her mental illness by saying "mood disorder" instead of "bipolar disorder," this was in part due to her perception that mental illness is not understood in her field of study, meaning it may carry stigma in the sciences. She wanted her supervisor to understand why she hadn't been meeting his expectations, but she did not receive the most positive response when she self-disclosed (for example, she was told "grad school isn't for everyone"). This may indicate a lack of understanding about what mental illness is and how it can affect one's academic performance on the part of faculty.

In Ren's experiences, she encountered a sense of stigma even though her faculty member meant well by checking to see how she was doing. The repeated inquiries made her feel like she was perceived as nothing more than her mental illness, perhaps indicating the faculty should be aware of how their actions may make students with mental illness feel stigmatized.

REN: I honestly. . .I, I feel like I've hit a point at which I saw (chuckle) people leave me the hell alone, because. . .I mean it was pretty obvious that I wasn't doing well when I go from being on campus like every single day to not being there for weeks.

VIOLET: Right.

REN: People are going to notice.

VIOLET: Right, and that happened with me, as well. People did notice.

REN: And it's like it's nice that they care, but after a certain point, I don't want to talk about it with you. If I wanted to, I would tell you.

VIOLET: Right.

REN: You know, like just. . .I, I don't feel the need to, to ask you how you're doing constantly and look at you like you're some fragile, wounded thing, you know.

VIOLET: Oh, man, my husband does that sometimes. The fragile, wounded thing. I'm not. . .that is. . .it's just as bad.

REN: Just. . .I mean, either way, it's like I am more than bipolar.

VIOLET: Right.

REN: I am more than the symptoms that I'm feeling right now, please recognize that I am a person.

VIOLET: Right. It was normal feelings in addition to the bipolar.

REN: Yes. This is just what it is now. This is just a part of me or this, you know, small stretch of time, but it's going to pass.

VIOLET: An I guess that's part of why I'm worried about self-disclosing. Because I worry that that is how people will view me. And, you know, if I don't turn something in on time or if I don't do well on an exam, it—"Oh, it's just because of that." Or, you know. . .

REN: I worry about that in the profession. Like I gave a presentation about what it's like to be a graduate student with bipolar at a conference last year. And there were fa-, like full-time faculty from different institutions saying, "That's very brave, but I don't know that I would disclose any of that stuff if you're looking for a job."

VIOLET: Right.

REN: And so, I mean, I'm still terrified that people are going to look at the work that I'm doing and go, "We don't want to hire you because you're the crazy chick."

VIOLET: Have I told you about my. . .I've told you not on record about my experience at my post-graduate program and I don't remember if I heard it from a faculty member or a student to be fair. I don't remember if a faculty member disclosed the situation, but there was a former graduate student who was Mastered out, he failed his comps three times. He said, "I let him leave with a Master." And, um, he was suing this department because he was not given a fair chance he says and he was bipolar and not on his

meds but everybody was worried he was going to come in the building with a gun or do, you know, some horrible things. Blow up the lab or, you know, just. . .he, he was not right. He was not on meds and he was obviously not right. And, you know, the department very strongly thought they did everything they could for him. And really like if you fail your comprehensive three times to let you leave with a Master's is very nice. It's, it's not nice, you know, in the field, but it's not a bad resolution.

REN: Right.

VIOLET: And I heard all about it from. . .and I, I did talk to professors about it. I know and like they should have never disclosed that. Um, but you know, this was also just a great, angry, jaded person. Um, and so, how can you go to a department who thinks that bipolar is associated with angry, violent people who will sue you if they don't succeed and do-, disclose to them? Say, "Look, this is fine. I've been having such a hard time. There's not anything I can do because of this. Can I do Office of Disability Service? Is there something that I can do to kind of come out of this hole that I have made for myself and stay in the program?" How do you go to a department and, and tell them that?

REN: Yeah.

VIOLET: So I think that kind of put the nail on the coffin like not to self-disclose because hearing, hearing that.

REN: Yeah. I-, someone actually told me. . .um, I think it was during my first year here, but actually be careful about who I tell about my personal problems. Um, mostly related to mental illness because maybe they would take my, my job away.

VIOLET: Yeah.

REN: They didn't. I mean, ethically, they, they can't for that reason. But. . .

VIOLET: I try to be careful about friends I tell, even. Um, and I've probably disclosed to more people here than I should have, but I felt like it was, um, not one sided. I was hearing about some of their mental illness problems, and so I disclosed mine. And you know, we have very honest, frank conversations about it. But I, I do believe. . .there are tiers of mental illness, and bipolar is right underneath schizophrenia essentially to people. It is not the same as, "Oh, you're depressed." "Oh, you're having a rough time."

REN: Well, I mean it's, it's not really talked about nearly as much.

VIOLET: It's not. And, and so, like I s-, you know, people's view of bipolar is the view of people that they see in the news, and the people that make the news are the ones that shoot up offices. So that's how people view bipolar I feel like, you know.

REN: Yeah.

VIOLET: It's like, "Oh, that drug addict." You're like that drug addict over there. You're like the guy who shot up the office.

REN: Yeah, I f-, I fortunately had a more positive experience just because I happen to work with people who know people who have bipolar or, you know, like, I'm not the only person they've ever encountered who is in an academic setting or who is taking care of his- or herself. So in that way, it's been really fortunate on my end.

VIOLET: That's nice.

REN: Um, either they have no idea what bipolar is and I have to explain like with my mom or, you know, they have some kind of tangential experience.

VIOLET: See, I'm the opposite and you know this, but I've never self-disclosed to my mother. (Laughing) So I mean I'm just really shy about disclosing to people.

REN: And based on the experiences that you've seen the people in your life have or the attitudes they have, I can totally understand why.

In this exemplar, Ren and Violet speak about perceived stigma from faculty, peers in the field, their classmates, the popular media, and even their families. Violet had a particularly difficult experience in her academic program because someone else with bipolar disorder had been perceived to be a physical threat to the department, and this had been disclosed to her. This disclosure led her to feel uncomfortable asking for help when she needed it because of the perceived stigma coming from her faculty, which proves problematic for representational literacy, again because she desired to be perceived differently than she actually was. This may demonstrate the power faculty have to shape student perceptions of campus climate: had this not been disclosed to Violet, she may

have been comfortable asking for help. Ren, on the other hand, had a more positive experience of being a student with a mental illness in her academic program because the faculty were more aware of mental illness, although she did experience perceived stigma when a faculty member asked about her wellbeing too frequently for Ren's liking. Clearly, awareness of what mental illness is and is not and what it causes in people (here, violence) may need to be built on college campuses to allow students with mental illness a safe space to seek out assistance when they need it due to their symptoms.

Perhaps not surprisingly given the attitudes of faculty (at least, on Violet's part), when Ren shared she was intending to pursue a career in academia, she was discouraged from self-disclosing because the faculty at her conference presentation perceived that she would not get a job if she did. This was also echoed in how a student in her program advised her against disclosing her mental illness to faculty lest she lose her assistantship. All of this indicates a sense of stigmatization on college campuses even at the level of being a peer faculty member, not just a student. If faculty caution against self-disclosure, how can students with a mental illness know they have safe spaces to share their needs? This may lead to developing a literacy of hiding one's true self from others in order to appear more stable, capable, or to "pass" as neurotypical.

Self-Stigma

What follows are exemplars from the interview conversations in which Violet and Ren addressed issues of self-stigma. This section addresses the research questions Do college students with mental illness perceive themselves as stigmatized within academia? and If so, in what ways or for what reasons are they stigmatized within academia?

VIOLET: Yeah, I feel like I was a little sarcastic, let's say, in high school, and

jaded, and probably in middle school too. I was pretty jaded, even in middle school, but I feel like I masked the depression pretty well, and then I think it just exhausted me, but through high school, even my late teens, early 20s, so it wasn't until I was probably 21 or 22, before I just like, I knew I had a problem, that I couldn't handle it anymore, I couldn't mask it anymore.

REN: I'm trying to think if I ever tried to. . . I guess, probably more later in life, I tried to hide symptoms when I'm not well. Like recently, when I went off of Klonopin and Lamictal [a mood stabilizer], and got severely depressed, I tried to hide it by literally hiding from people.

VIOLET: Yes.

REN: Not a great idea. They're gonna notice you're not there, duh.

VIOLET: And I feel like I'm just not as good at it anymore, like one of my lab mates noticed, after I sat down with my advisor, and had a talk, and we'll probably get into this later, he texted me, and was like, I've noticed you've been a little down lately. And I wasn't actively trying to hide it, but at the same time, I didn't think it was that noticeable, but part of me felt validated that it was noticeable.

REN: Yeah, I know what you mean.

VIOLET: I didn't like that outsiders, you know, this person's not a close friend. Close friends, okay, they can notice, I open up to them a little bit more, but as far as just a colleague. . .

REN: Yeah, I don't like that feeling, that other people can tell things.

Here, Ren and Violet speak to their fears of having their symptoms manifest in noticeable ways. For both of them, manifestation of symptoms should be avoided if possible to keep others from becoming aware they are not doing well (again, note the link to representational literacy and the disconnect between sense of identity and what Violet and Ren want to be perceived as in addition to how they perceive themselves). This is, perhaps, because it draws attention to the mental illness and takes focus off Ren and Violet as people who are more than a mental illness. In this way, they both self-stigmatize. They feel shame when certain people—but not all, as Violet notes—become

aware of their manifested symptoms. Although this is something outside their control, Violet and Ren seem to feel responsible for letting their symptoms show to those around them, particularly individuals who are not close to them.

VIOLET: They [my parents] were not abusive. They were healthy, well adapted, they got along with each other, they loved each other, they never fought, at least not in front of us, like we never heard them fight, so not even behind closed doors, and by all reason I should be healthy and well adjusted, and I wasn't. [My husband], on the other hand, did go through a traumatic event, and has a reason for not being well adjusted. So, I would feel guilty, which would make the depression worse, 'cause I would just get in the cycle of, all these people in the world have it so much worse off than me, and just why me, why am I feeling this way, why do I feel like I deserve to feel this way, why is this. . .this isn't justified. This isn't. . .no logic behind it.

REN: I have a similar thing with shame, feeling like, recently, part of the reason, I think, that I pulled away from so many people, when I wasn't doing well, over break, is because I'm ashamed of the fact that I am supposed to be . . .I feel like I'm supposed to be in control of my mental illness. It's what I do, I research it, hello, I should have my shit together, is how I feel. And when I don't have it together, I feel horribly embarrassed, completely ashamed, that like, whoa, what kind of mental health researcher, blabbity blah, am I, if I am so severely depressed, that I can't get out of bed, or take care of myself, or bathe, eat.

In this case, Violet and Ren continue to express a sense of shame tied to their symptoms becoming unmanageable. Violet compares herself to others, most notably her husband, and does not feel her symptoms are any worse than anyone else's, indicating that she does not perceive her mental illness as possessing as much validity as it does in her daily life. Ren also notes shame when she perceives herself as not presenting the appropriate level of having everything together to the world (representational literacy), which may be a case of her holding herself to higher standards than she can feasibly meet. Struggles are not limited to people with mental illness, yet Violet and Ren stigmatize themselves for experiencing them.

VIOLET: I have the same feelings as well, though, I kind of feel like, if you can't

do it, you just can't do it, regardless of the reason. You get to a certain point, in your life, it's the real world, if you have dyslexia, you should guess, you should be given every advantage to compete on a fair level, but at a certain point in your life, you may say, maybe being an editor is not for me, or maybe ... Does that make sense? Doing something that your disability specifically impacts, is maybe just not for you. You may love it, but it may just not be for you, because you have to work around your disability. So I feel like, with the demand and the pressure, and the hours expected, it's not doable, with what's expected of you, and you start to think maybe it's just not for me. So I think it's discipline and disability specific. Does that make sense? If you have ADD [Attention Deficit Disorder], and you can't remember anything, then maybe law school is not for you. Does that make sense?

In this final exemplar of self-stigmatization in Violet and Ren's experiences, Violet echoes an internalized sense of what the popular conception of mental illness stands as: it is something to be pushed through or it is something that limits your capabilities. Bipolar disorder is categorized as a disability, as I have found out through applying to jobs, and so it makes sense that it would be seen as a potential limitation by the public. What is surprising is Violet's internalization of this message; it has become part of her identity and part of her representational literacy development. She does not perceive mental illness as something that can always be overcome; instead, to Violet, it is something that may hold you back, and rightly so. This is perhaps the most obvious case of self-stigmatization, and it aligns with research on perfectionism in female college students. Although it is not apparent in this passage, Violet is a self-proclaimed perfectionist, meaning she often holds herself to higher standards than she can meet as a result of the symptoms of bipolar. It makes sense, then, that she would perceive mental illness as a limitation in this way, but it still stands that she is perhaps unfairly stigmatizing herself for having bipolar because mental illness does not have to limit what people with mental illness are capable of achieving.

Academic Resilience

What follows are exemplars from the interview conversations in which Violet and Ren addressed issues of academic resilience. This section addresses the research questions Do college students with mental illness perceive themselves as academically resilient? and If so, in what ways or for what reasons are they academically resilient?

VIOLET: You know what I mean? I almost didn't make it through my senior year for undergrad. I finished in spite of my mental illness. I was in a very poor mental place at that time, and yet I somehow scraped through.

REN: Yeah. Like somehow, right now, to me, it's a success that I did not drop out this semester, because I thought I was going to. I was pretty close to thinking I would have to be hospitalized or drop out of school.

VIOLET: You can take a leave of absence and not leave the program.

REN: Well, I didn't even get that far in my brain. It was just, if this continues another week, I'm gonna have to. . .

VIOLET: No, I was really nervous in the fall. I mean, I didn't skip class, but that's all. I was like, I made it out of the house today. I missed one class, but I was physically sick as well, and was like, I made it out of the house today, yay for me. I made it to class today, but that's all I can do, and now I'm gonna cry and go home.

REN: Like this week, my success, I have left the house every week day.

VIOLET: See, that's fabulous, but see, it's in spite of your mental state, not due to your diagnosis.

REN: And it's a very small thing, that most other people would probably have been like, so?

In this passage, Ren and Violet discuss both academic and personal resilience. Ren was discussing a time at which she thought she might have to drop out of school because her bipolar symptoms were too much to manage on top of attending classes, working on her comprehensive exams, and attending to her graduate assistantship duties. Note, however, that she does not use language that implies she perceived herself as

academically resilient for continuing in her program despite this. The only resilience Ren perceived was in her ability to leave the house every day that week, something Violet applauded as an accomplishment. This may indicate that personal achievements such as attending to daily concerns like bathing, doing housework, and even leaving the house are perceived as demonstrating resilience, but academic resilience is not perceived in what Ren considers a smaller accomplishment (not dropping out of her program).

Violet, on the other hand, notes how she managed to push through during her undergraduate program despite her symptoms. She does not know how she managed to be academically resilient, but she still considers it as such. This may indicate that not all college students with a mental illness perceive academic resilience in the same way.

VIOLET: Right. And my senior year, I turned in every single paper, at least a day late. I was like, it's worth the five points off. So I made that decision for me, mostly because I hadn't finished them, but I couldn't. . . I just couldn't make myself do it, until it was like beyond the deadline. Like I had a deadline, I work well under deadlines, typically, as far as writing goes, but hard time sitting down two weeks ahead of time, and starting the writing. As it gets closer, it flows a little bit better, but yeah I turned in everything late, and I just took the points off.

Violet demonstrated clear academic resilience during her senior year of her undergraduate career: even though she did not turn her work in on time, she still turned it in, which is an accomplishment. It is not clear if she considers this an act of academic resilience because this was in response to a discussion about experiences that held Ren and Violet back academically during their undergraduate careers. This does demonstrate, however, a sense that Violet understood how her symptoms were affecting her ability to meet deadlines, a type of self-awareness that may help one on the path of academic resilience.

REN: . . . I don't know, I guess like the advice that, that I usually give is to seek

some kind of help. Talk to somebody.

VIOLET: And I've, I've done the the same for students. You know, if they kind of express that they're having a hard time or, you know, try to get them into the Counseling Center, but I think before all, just give yourself a break. So what? So what if you didn't get the A? You're here, you're doing it. That's an accomplishment. And it's something that I don't take my own advice with. (Laughing)

REN: I know. How many sentences did you write this weekend? (Laughter) Five sentences, right?

VIOLET: And deleted them. (Laughter)

REN: But you wrote them.

VIOLET: But, but I think, I think it is important to kind of cut yourself a little slack and just say, "You know what? Not every presentation, not every paper is going to be perfect." And that's okay. Everybody has their own reasons for that. And, you know, having the mental illness is a very valid one whether you want to disclose or not, you need to give yourself that break.

REN: Yeah. That's like. . .and that's the hardest part I think. Like it's, it's easier to, to talk to someone, say, "Hey, I'm doing shitty work because I'm severely depressed," or whatever than it is to actually tell yourself, "It's okay."

Here lies conflicting perceptions of academic resilience. Violet and Ren note what advice they would give to newly diagnosed students but that they would not always follow their own advice. Violet speaks about not accomplishing anything despite having done so—even though she ultimately did not keep the part of her thesis she wrote, she made an attempt to work on it, which is an accomplishment and demonstration of academic resilience. Despite her struggles with her symptoms, she still set aside time to work on her thesis.

As Ren notes, it feels easier to give advice than to internalize it, so college students with mental illness may not always perceive themselves as academically

resilient even when they are. There is clear self-awareness in that both Violet and Ren would tell students with new diagnoses to give themselves credit and not hold themselves to unattainable standards, but they also state they do not apply that to their own lives.

REN: So, I mean, it's not like attendance is a problem. And, you know, like then, if I was just having a bad day or if I start having a manic episode in class or a panic attack, I can just, you know, let them know. You know.

VIOLET: Right.

REN: You know, step outside, send them an email that says, "Hey, I'm having a breakdown. I need to leave." We're good to go, but. . .

VIOLET: That's why I've never gone [to class] mad.

REN: Really?

VIOLET: Really. I've been crying and having panic attacks on the way to class. Sucked down a cigarette and gone to class, left crying and in a panic attack. And somehow I made it through class.

REN: Wow.

VIOLET: Um, I think this last fall was the first time. Not, okay, the first time in graduate school since I've been back. Let's, let's clarify all that. Um, so the first time the last couple years where I just. . .I couldn't, I couldn't get up in front of people. I couldn't. . .if I thought about anything, I was just going to break down and start crying. And the thought of going up for extra credit to write some stupid answer down that everybody knows paralyzed me, but I was there. That's all I did that day. (Chuckle) That's probably all I did that week.

REN: It's a pretty big accomplishment, though.

VIOLET: But I was there, you know what I mean? And like to try to describe that to somebody, like I just couldn't. . .like, "Why didn't you go get extra credit?" "I just couldn't today. I just couldn't." To try to explain that to somebody is very difficult. Very difficult.

REN: Yeah. I've. . .one of my poor [faculty] members has a, had me for multiple classes. I think I've told you about this where I just like have full on breakdowns. Like in the computer lab, we're doing [coursework] and I'm just like freaking out and I don't know why bawling, can't stop. And I feel

so bad for him (chuckle) because he always sees me freak out. And he's like, "What do I do with this?" (Chuckle)

VIOLET: Yes, no. And I feel like. . .you know, part of me feels like, "Oh, I'm hiding it so well." (Chuckle) The other part of me is like, "Oh my gosh. You're doing this in public. You're hiding so well, it's like the tears aren't coming down. (Chuckle) You're so composed, tears."

REN: I, I, I don't b-, believe anymore that, that no one can, can tell. I'm like, "The whole world can tell that I am kind of crazy today." Like th-, like one time I had a breakdown and I think it was qual[itative research], intermediate qual, so that would have been like last year. And I was just like rocking back and forth like pulling on my hair. You know, like sitting all squinched up in a ball. And af-, after class, everyone came up to me and, you know, it's like, "Are you okay? Are you doing all right? Is everything fine?" Like, "Yeah, I'm okay." Still rocking back and forth, twitching.

VIOLET: I feel like too, over the years I've come up with what I consider are less obvious manifestations. However they're probably pretty obvious. If people were paying attention, I feel like people in my department don't care and don't pay atten-. . .not that they don't care, they don't pay attention. So let's you really draw attention to yourself. Nobody is going to notice if you're sitting there teary eyed. If you're bawling, they'll notice, but if you're just kind of crying a little bit, nobody is going to even notice. If you're sitting there digging your fingernails into your arms, nobody is going to notice. (Laughing)

REN: So not the case in my program.

VIOLET: It's very much, you know, like the majority of the classes are you have a professor at the front, you're all facing forward and you're sitting through a lecture. So it's not like you're working together in groups. It's not like you're facing each other. It's not. . . it's not as interactive. You know what I mean? So unless for some reason they're just drawn to you. They're not going to notice what they're doing. Which is kind of nice because then you can kind of disappear. So that is. That is so nice when you're having a bad day. You can just go sit in the back and just be like, "You know what? Today, I'm just sitting in the back."

REN: That is so never possible in our classes. Never. So it's. . .they're all seminar.

VIOLET: Right.

REN: So, it's like maybe 10 people. If it's a really big class, maybe 15.

VIOLET: Which is about the size of ours, I would say. We've had a couple that were closer to 17 or 18, but it's the same thing, probably between 10 and 15 people.

REN: But it's always discussion and activity based.

VIOLET: Yeah.

REN: Like always even in. . .even in stats. Even in-, when we had quizzes and stuff, we do them individually, but then we take it as a group and help each other try to figure out, you know, "Well, here's what I responded. What did you respond?" And so even in the more formal settings, there's really no anonymity in that classroom.

VIOLET: Yeah, I know. I wouldn't be able to handle that very well, I don't think. (Laughing)

REN: So like, everyone knows that I am crazy.

VIOLET: Yeah, I mean that also makes more sense why you would go ahead and self-disclose because they're going to notice, so you might as well tell them up front. Like, "Look, I have bad days."

REN: Mm-hmm. There's, there's just, there's really no. . .

VIOLET: Because I feel like I'm just like going to crawl out of my skin. I just kind of sit there and like, like I said, like take my finger and also to my arms over, just. . .

REN: Mm-hmm. Yeah. It's, it's just really, it's really obvious when I'm not having a good day because I don't talk as much. And you know me. I talk nonstop. When I'm in class, I just want to be a part of the conversation perpetually. And when I'm having a bad day, I don't speak as much. And so I feel like the whole world can tell because I'm suddenly very quiet.

VIOLET: Exactly. Like, if I'm talking too much, it means I'm manic. Unless I'm really comfortable around people. Then I'll, then I'm much more talkative, but, but I feel like in classes and stuff, I, I feel like I'm catching myself talking too much. I'm like, "This is, this is not right."

In this final exemplar of academic resilience, Ren and Violet discuss the differences in their academic experiences as related to the nature of their course structures. Violet notes how, in her field (the natural sciences), courses are more

formally structured and held as lectures, rendering it possible to attend class with a sense of anonymity despite manifesting symptoms as long as they aren't severe. This makes academic resilience more possible in Violet's case than in Ren's—in Ren's classes, there was much more exposure due to the seminar structure, making her symptoms more noticeable to her classmates. This forced her to self-disclose because her classmates would notice if she was manifesting symptoms of mania, in particular. Nevertheless, Ren did not allow this factor to influence her academic resilience; despite having obvious symptoms, she still attended class and participated to the best of her ability. Violet did the same, although her classes allowed for more anonymity if she chose to make herself less visible. What may be most noteworthy from this part of the conversations is that Violet notes how she would push through a class without knowing how she did it. This demonstrates immense personal strength: facing severe symptoms such as bawling and yet attending class.

Intersecting Constructs

What follows are exemplars from the interview conversations in which Violet and Ren addressed multiple constructs across research questions.

VIOLET: Right, but I feel like at a corporation, they may say, okay, so you don't handle deadlines well, well then we're not gonna give you projects with hard deadlines. If you don't get projects with hard deadlines, you're not gonna get promoted, so it's not a fair playing field, it's not going to be a fair playing field, so disclosing and expecting accommodations, I don't think it's necessarily disclosing, but it's the accommodation side, as far as Americans with Disability Act. It's not to your benefit, it's to your detriment. And that's kind of partly how I was raised, how I've taken on the thought process for myself. If I failed at something, it was just, I wasn't good enough. Maybe it was due to mental illness, maybe I just couldn't hack it, for whatever. . .but, whatever the reason, I failed, which is really not a healthy way to look at it, but like that's just not for me then. It's a horrible thing to say that you're gonna settle for something that was not your dream, or something that was your dream, and you're gonna settle for

something less than that, but the reality is, 100% of the population does not get to live out their dream, they have to adjust. Is that a horribly cynical way to look at things?

REN: I don't know that I'd say it's horribly cynical. I live on the, probably, far too optimistic side, where I want to succeed in everything, just as much as I would if I was not—

VIOLET: Oh, I want to.

REN: And I am bound and determined, damnit, that I am gonna freaking do it. It's where I live right now, because I think if I didn't live in that space, I wouldn't be here.

VIOLET: No, I want to, and I want to prove to myself that, again, I can do it in spite of mental healthiness, but having been in the situation where I did not succeed, took away that kind of confidence. Does that make sense?

REN: Yeah. Yeah, no, I feel you.

VIOLET: It was in large part due to my mental illness that I did not succeed. I don't feel like I got a fair shake.

REN: Do you want to talk a little more about. . .are you okay talking a little more about that?

VIOLET: I am okay talking about it. I'll get sad, but it's okay. It's still like ... I still have grieving over it, even though it's been six years, so yeah, in 2009, I started a PhD program at [university A], in the hard sciences, and did not do well. I wasn't doing well my senior year undergrad, mentally, my well being was not good, so I did not take any breaks, I went straight into the PhD program, and I didn't recognize that I really wasn't doing well, and so my grades suffered. I was not a good test taker, I felt like some of the material was a little out of my grasp, but for the most part, I felt like it was testing me. I didn't understand what was wanted out of the question, so I would skip it, or I would answer it differently. So then I was on probation, and then I felt completely homeless. I moved out of my office, I had no place to work, I lost my TA position, had to take out a loan to pay for my classes, and I was under the pressure to get all A's, in difficult courses, and I did not. But, once I was on probation, that's what stopped me. . .what triggered me to seek help, and realize that I was not doing well, 'cause I would be crying on my way to school, and turn around and go home. I just could not physically make myself do it. If the elevator was broken, I'd be like, I'm not carrying my backpack up four flights of stairs, turn around and go home. Any reason that was available, I would use to just hide at home. So I started new medication, but I feel like it was all too late. It was

midway through the spring semester, and I did not get my grades up high enough, and so I was dismissed from the program, but I was told, even before that, when I was first put on probation, that I may never find a place to work in the department, that nobody would want to pick me up, that I had to retake all my upper level, undergraduate courses to prove that I could do it, and basically jumped through hoops to stay in the program. I was given the choice to walk away at that time, or to give it a shot, and I thought, you know what, if I don't give it a shot, I will never know. And given my mental state at the time, I should have walked away. So it took from 2010 until 2014 for me to reattempt a graduate degree.

REN: What made you decide you wanted to come back?

VIOLET: I was sick of my job. I was sick of my job, I felt like a little bit of a robot. There's no room for advancement without an upper level degree, and really no room without a PhD, but I was too scared to attempt a PhD program, in addition to the fact that I would not be able to move, to attend a different PhD program, at a different school, due to my husband's job. And I think part of my failure at [university A], is it wasn't my first choice. It wasn't something I was truly invested in. I didn't feel like I belonged there, from the beginning. One of my grades my senior year brought my upper level GPA down, so I was accepted, but then it was conditional, so I had to repeat that class to bring my upper level GPA back up, but I did, but I felt like the whole year leading up to it, and during it, was I had to prove myself, I had to prove myself to them, and I was constantly under pressure to get an A, to get an A, and I couldn't handle it, that kind of pressure, so yeah, it took a lot. I was invited to come to this program here, about six months after I left [university A], and it made me cry just thinking about it, so I decided that it wasn't a good time. I felt like, coming back here, after doing my undergrad here, and then being so proud that I got into such a good program, was like coming back with my tail between my legs. I was embarrassed. I felt like I let everybody down.

REN: Sounds kind of. . . I mean, not really the same, but kind of similar to what I experienced as an undergrad when I dropped out. I'd only gone away. . . it wasn't even a great school, it was like two hours away, convenient where I went, and then I went back home, dropped out, decided eventually, because I hated my job, that I wanted to go back to school, and I was embarrassed to tell people where I was going to school, because it was the crap university, or at least that was the reputation back home. Oh, well, I was supposed to be so great or whatever, and then I wound up managing a Subway, and then I wound up going to teeny tiny university, that no one's ever heard of, has a crappy reputation.

VIOLET: I felt like that even coming here to [university B]. I was already

married. In high school, I got invitation letters from Harvard, from all kinds of Ivy League schools, to apply, and I decided not to go to college right away, so I ended up waiting a total of seven years before starting my undergrad. And I would say things like, oh, I'm just going to [university B], in jest, because when I graduated high school, [university A] was people's backup choice, where I went to high school. It was before the top 10% rule, granted, but it was people's fallback. Oh, I'm just gonna apply to [university B], just in case I don't get into the schools I want to go to. So, to be like a tier down from that, felt horrible. I felt like I'm not living up to my full potential.

There are multiple constructs at work in this passage: self-stigma, perceived stigma, academic resilience, and identity development. One of Violet's contributions demonstrates both identity development and academic resilience. Although Violet was facing many challenges in her PhD program, she persisted for a while. She ultimately dropped out, but, as she notes later, she returned to a graduate program, demonstrating academic resilience. The same is true in Ren's case—she dropped out of college as an undergraduate and returned to college after a brief leave of absence. Even though she describes the experience as humbling, much as Violet describes hers, she returned to school despite how she could have let her mental illness hold her back from continuing her education.

In regards to identity development, Violet's expression of her journey in her PhD program demonstrates how she had to develop a new sense of identity (again, an instance of representational literacy at work) as a student in light of the hardships she faced. She mentions not going to class, an indicator of a lack of academic resilience as well as a perceived identity as not capable of this level of study. This may also be a time at which Violet stigmatized herself because she mentions feeling shame for having to leave a prestigious program to attend another institution.

The most blatant example of self-stigmatization lies in Violet's first statement about achievements. She discusses how she does not perceive mental illness as an excuse for not performing at a high level regardless of the situation. Ren and Violet also stigmatized themselves for having to attend less-prestigious universities than they started out at despite the fact that it didn't impact the quality of their education. This is also an instance of perceived stigma because both Ren and Violet discussed how others viewed the programs they were in and how that impacted their perception of the schools as well.

REN: Okay. So, uh, could you tell me what it's like now and or in the past to be in college while managing mental illness? And that's a loaded question. Um, let's see. What is it like in one word, chaos?

VIOLET: I was going to say it sucks. (Laughter)

REN: Yes, it, it does suck. It's, it's like I'd expect it to be better now that I'm older and more in control. Like I think, "Oh, you know, I'm almost 31 and so I should be better at handling myself and my symptoms, and it's not any better." When it's bad, it's bad.

VIOLET: Yeah. I almost feel like it's worst sometimes as I get older.

REN: How so?

VIOLET: Um, I feel you don't handle it as well. And I think it's more me recognizing when I'm having a hard time to let myself have a hard time.

REN: Oh okay.

VIOLET: Whereas when I was younger, I would just push through it until, you know, disastrous things started (chuckle) happening. Like I pushed until the very limit, but I feel like I was able to get through my daily tasks more easily. Does that make sense? And now because I recognize it, like, "Oh, I need a day. I need a day just to be. . ."

REN: Yeah, I was going to ask that if you think it's more like. . .now that you know yourself better.

VIOLET: Yes. So it's giving myself a break which is good, but at the same time, part of me, wishes like 19 year old me was just oblivious, didn't recognize problems, didn't recognize the signs and just push through.

REN: Oh.

VIOLET: As I got more stuffed in. It felt like.

REN: Yeah.

VIOLET: Maybe that's not true.

REN: Huh. I guess I haven't, I haven't thought of it that way, but. . .well, I don't know. I don't know if. . .it's hard for me to remember if I ever did push through whether if I just kind of said, "Fuck it." And, you know, like when I was 19 and almost dropped out to school and basically said, "Fuck all this shit." And stayed in dorm all the time. I wouldn't do that now. I still wouldn't get my work done necessarily, but. . .

VIOLET: Right.

REN: Yeah, I don't. . .I guess I don't really know what's different other than now I know what's going on.

VIOLET: Yeah. And I'm definitely more aware. It's something that's scary because I see myself, um. . .and tell me if we're starting to get off topic again, but (chuckle), but I see myself sliding down or sliding up. And it's like I know and, and I'm afraid because I have been there before. I'm afraid of what's going to happen next.

In this passage, Ren and Violet discuss both identity development and self-stigma. Ren and Violet demonstrate identity development in their journeys from their 19-year-old selves to their present selves (both in their 30s). They note how they are better able to recognize symptoms now, which demonstrates that identity as an individual with a mental illness develops over time and shifts with gained experience.

Violet demonstrates self-stigma in her perceived inability to push through her symptoms like she did when she was younger. Although, as they mentioned, this may be due to experience and age, it still indicates that Violet compares her present self to her past self and sees herself in a negative light if her present self does not match up with the capabilities of her younger self.

Finally, they both address the issue of “pushing through”—academic resilience. Violet discusses how she was able to persist through her symptoms when she was younger but is not as able to do that now, perhaps due to her increased self-awareness, as she noted. This may indicate that increased self-awareness could lead to a decrease in perceived academic resilience; clearly, Violet has demonstrated much academic resilience throughout these exemplars, but she does not always perceive it as such. In contrast, Ren reflects on not knowing if she pushed through or gave up, a lack of self-awareness in her younger self. It is not clear, then, if this is an example of academic resilience or not. Ren does not appear to perceive it as such, particularly because she discusses dropping out, not emphasizing how she returned to school, in this passage.

REN: It's, it's hard to let go and accept the fact, but you can't do all the things that you necessarily want to, the way you want to.

VIOLET: Right. And I think that there's perfectionism I feel like ties in very strongly with mental illness. Because I know. I've had problems with it and it's, it's very hard to see what you think you could accomplish. . .what you should accomplish and not meet that goal.

This brief interaction demonstrates identity development, academic resilience, and self-stigmatization. Identity development is apparent in Ren’s mention of coming to terms with not being able to accomplish everything she wants to because of her mental illness, an indicator that self-stigmatization plays a role in how people with mental illness develop their identities. Violet echoes these sentiments in her contribution.

Academic resilience is related to this passage in a more negative light: the inability to accomplish goals because of the mental illness indicates, in some ways, a lack of academic resilience. Although Ren and Violet may try to meet their goals, they may not always be able to do so as a direct result of their bipolar disorder, so it stands that

mental illness symptoms may interfere with the ability to be academically resilient.

Nonetheless, Violet and Ren are academically resilient for trying to meet their goals, even if they do not.

VIOLET: So I had been through diagnosis and. . .well, not official diagnosis, but I've been through kind of the peaks and valleys and everything. And then to take seven years off from school and come back and not achieve what I felt I was capable of or not feeling like I was living up to my potential on having to kind of accept like, "Well, you're, you're different now." Like, "You didn't have all of these symptoms." They have now been triggered. They, you know. . .

REN: Yeah. It's almost like. . .whenever I stop and think back about when I dropped out as an undergrad, I can't help but wonder like, "What would my life have been like if I had been able to stay in school? Would I have stayed a music major? Would I be more successful?" Where, you know. . .I mean, I'm happy with where I am with my life. I'm very happy with where I am. Just, I just can't help but wonder the, the what ifs. What if I didn't drop out because of depression? You know, like, "What if I didn't spend three months just now in my house all the time? What if I've been able to get out and do more stuff, where would I be?"

VIOLET: I feel like you saying that though, like thinking, "What if I had gone to an Ivy League school straight out of high school or something like that?" I probably would have had to drop out due to depression. Like I don't, I don't know if the end result would be that different. It might have been worse because I might have been more discouraged for me, you know. Um, but given when like symptoms started manifesting and like the stress of school, I feel like would have mean that period of time worse. So I mean I see why, you know people have to take leaves of absence, people do drop out, people. . .you know, and not everybody has the guts to do it again and you did. You know, that says a lot.

REN: Well, we both did.

VIOLET: That's true. Yeah. I did come back. (Laughing)

REN: You did. You did come back in a very fabulous way.

VIOLET: Well, thank you. (Laughing)

REN: Like I, I like that you point out that it could have been worse or it could have been just the same, because my brain never goes there.

VIOLET: Mi-mine doesn't until like you. . .just now.

This final excerpt from the conversations demonstrates academic resilience and self-stigmatization. Academic resilience is apparent in how both Ren and Violet returned to school after dropping out due to mental illness symptoms, and, in the moment of the conversation, they both recognized this action as demonstrating academic resilience. It is worth noting that both stated they do not normally think in that way, however.

Self-stigma is apparent in the “what ifs” of this exemplar. Both Violet and Ren question what their lives would have been like if mental illness did not interfere with their academic plans. They place blame on the mental illness for holding them back despite their demonstrated academic resilience.

Brief Discussion

In this study, Violet and Ren demonstrated academic resilience in many situations, such as re-enrolling in college and staying enrolled despite difficulties posed by bipolar symptoms, but they often failed to recognize it as such. Violet, more so than Ren, was cognizant of her academic resilience. The reason why is not clear.

Both Ren and Violet perceived stigma and engaged in self-stigmatization, mostly because of the way they were treated by faculty and because they did not perceive themselves as strong enough to overcome their symptoms in academic settings. It should be noted that Ren and Violet had differing experiences with perceived stigma from faculty: whereas Ren's perceived stigma came from someone with good intentions, Violet's came in a manner that was not intended to support her needs as a graduate student with bipolar disorder. This may be due to the difference in their academic

disciplines, Ren belonging to the social sciences and Violet belonging to the natural sciences. This, however, cannot be generalized because of the *N* of 2.

Finally, Ren and Violet both explored their identity development, although most frequently as people with mental illness (rather than college students with mental illness). They indicated that support systems, particularly those including other people with mental illness, can be crucial in the initial steps of forging an identity related to the diagnosis, although, sometimes, individuals in those support systems may undermine positive identity development by unintentionally stigmatizing. Again, this cannot be extended to the larger population of college students with mental illness because of the small sample size.

Limitation

Part of the beauty of duoethnography lies in its potential to illuminate differences in experience (Norris, Sawyer, & Lund, 2012). This duoethnography does not always reflect difference as much as it reflects parallel experiences of being a college student and a person with a mental illness, but this itself may indicate that individuals diagnosed with a mental illness may undergo similar processes when developing identities, encountering stigma, and remaining academically resilient.

Summation and Preview

This chapter explored the experiences of identity development, perceived and self-stigma, and academic resilience in two graduate students with bipolar disorder. In the following chapter, my experiences as a college student with a mental illness will be presented alongside an analysis for the themes discussed in this chapter (identity development, stigma, and academic resilience).

VI. AUTOETHNOGRAPHY

What follows is an autoethnography that examines two semesters of my experiences as a college student with a diagnosed mental illness: the semester in which I was diagnosed, and the semester in which I underwent significant crisis related to the mental illness (the fall of 2013 and spring of 2016, respectively). The autoethnography focuses on these two time periods because they demonstrate the greatest amount of identity development as I was diagnosed with bipolar disorder in the fall of 2013 and experienced severe symptoms in the spring of 2016; the period of time in between the semesters covered was a relatively stable time in my life, so I have elected not to analyze those semesters excepting when knowledge of experiences during that time will enhance the ability to understand data for the semesters analyzed (fall 2013 and spring 2016). I am focusing on the time period that best exemplifies my identity development because of the first two research questions driving this study: How do college students with mental illness conceive of their identities as people with mental illness? and How do college students with mental illness conceive of their identities as college students with mental illness? The period of spring 2014 to late fall 2015 has not been included in analysis because I was, overall, stable during this time and did not undergo major struggles related to academic resilience, stigma, or identity development, the constructs this study examines, rendering this time period largely irrelevant to the study's purpose.

This autoethnography incorporates reconstructed experience, counseling records, medical records, and other archival data as appropriate to form a *bricolage* of experience in autoethnography (Chang, 2008; Denzin, 2014; Spry, 2011). For a refresher on autoethnographic techniques, please refer to chapter 3. When appropriate, the counseling

or medical records follow the account of the day/time period being explored. Medical and counseling records are presented exactly as written (with some bracketed explanations of terminology where necessary) in italics to separate them from the experiential data and analysis. Because they are intended as supplementary to the experiential data, which is the central data source for autoethnography (Chang, 2008; Denzin, 2014; Spry, 2011), they have been placed after it. The records are not represented in their entirety; rather, the relevant portions have been pulled out to give the necessary information to build upon the experiential data. Some of the information in the records, such as reports of vital signs, is not relevant to the story being told or answering the research questions driving this study.

I arranged the autoethnography chronologically to allow for following my journey as I experienced it: in a linear fashion. Where possible, dates are provided to give a concrete sense of when these events occurred; in some cases, this was not possible, so a general timeline has been provided instead of precise dates.

This autoethnography intermingles voices throughout—there is the narrative of events unfolding; the infusion of thoughts, feelings, and dialogue; the more clinical voice of the counseling and medical records, providing further insight into the events described; and the analytical voice, reflecting on the data and providing insight into the meaning behind the events as well as providing discussion and implications based on the data analyzed. This approach to autoethnography is referred to as a layered account (Charmaz, 1983; Ellis, 1991; Ellis & Bochner, 2000), using techniques typical of grounded theory, an account that includes data alongside the narrative and incorporates analysis, findings, and implications throughout.

Tense shifts should be noted before reading. In places, the tense will shift within a paragraph from present to past tense (or vice versa) because of time: present tense reflects what is actively going on, whereas the shift into past tense is to give a sense of what already occurred or has been established. This is to follow more of a creative type of style in the narrative, interweaving the past with the present in instances where it was deemed appropriate.

Finally, this autoethnography is written using *vignettes*, or small stories with no resolution, that are intended to form a larger picture of the issue of being a college student with a mental illness alongside identity development, stigmatization, and academic resilience. This style is based on the models of Markham (2005) and Vasconcelos (2011): that of what Markham calls the fragmented narrative.

Formatting Key

Italics: Archival data such as medical records, counseling records, and emails

Presentation of inner thoughts/feelings in narrative sections

Bolding: Present where bolding exists in archival data

“Quotation marks”: For reconstructed speech or emphasis

Underlining: Present where underlining exists in archival data

[Brackets]: Adding explanation or clarity or protecting anonymity

Although the double application of italics may be confusing, formatting requirements for this dissertation do not allow the use of varying font styles or sizes, so my options for differentiating between information presented is limited. Counseling records, medical records, and emails will always have a heading to separate them from the experiential data (e.g., “Counseling Records”), whereas the inner thoughts and

feelings will be limited to the narrative sections in which the rest of the text will be unitalicized.

It should also be noted that types of data will be separated by a blank line.

Headings will not be used to differentiate the data, narrative, and analytical sections under each date because the different voices are intended to be read in concert to form a snapshot of the date covered. Every section is by date, and all data underneath that date are relevant to it. The next set of data will come under the next date as a progression through the data, analysis, and implications.

Glossary of Medical Abbreviations and Terminology

Agor.: Agoraphobia (fear of situations that might cause anxiety)

Anx.: Anxiety

App.: Appropriate

Appoint.: Appointment

Aud/vis.: Auditory or visual

Avg.: Average

BID: Twice a day (in reference to taking medications)

BPD-NOS: Bipolar Disorder-Not Otherwise Specified

BPD-I: Bipolar Disorder-Type I

BZD: benzodiazepines such as Klonopin, which are sedatives

Ct.: Client

Cymbalta: An antidepressant also used for pain management in individuals with

fibromyalgia

DC: Discontinue

Depress: Depression

D/O: Disorder

Eval: Evaluation

f/u: Follow up (in reference to appointments)

GAD: Generalized Anxiety Disorder

Halluc.: Hallucinations

HI: Homicidal ideation

HPI: History of Patient Illness

IT: Individual therapy

Lamictal: A mood stabilizer used in treating bipolar disorder

Lamotrigine: The generic name for Lamictal

Mania: An elevated mood often associated with characteristics such as rapid speech or thoughts, grandiosity, impulsivity, and irritability

Medmgt: Medication management

MG/mg: Milligram

Mixed episode/mixed state: A mood state in which someone experiences symptoms of depression and mania at the same time

Mod.: Moderate

Paxil: An antidepressant

Persec.: Persecutory

Psych.: Psychiatric

Psychosis: A state in which one experiences thought disturbances such as hallucinations or paranoia

PTSD: Post-traumatic Stress Disorder

Pt.: Patient

Q: Every (in reference to taking medication)

QD: Once a day (in reference to taking medication)

QHS: At bedtime (in reference to taking medication)

Reg.: Regular

Risperdal: An atypical antipsychotic (atypical simply referring to the class of antipsychotic)

RX: Prescription

SI: Suicidal ideation

SIB: Self-injurious behavior (such as self-mutilation)

Sx: Symptoms

Tab: Tablet (of medication)

TID: Three times a day (in reference to taking medication)

VS: Vital signs

Semester One: Fall 2013

Date: October 15th, 2013

I sit next to the sliding glass doors to the balcony of my second-floor two-bedroom apartment. The trees have a shimmering quality as I stare out at the evening dusk. *Come join us. Live amongst the trees. It's where you belong.* I press my hands against the cool glass, staring at the trees. Opening the door, I step out onto the balcony, gaze still fixated on the green leaves surrounding the balcony. The warm air surrounds me, as does the darkness. *I have to be amongst the trees. It's where I belong.* I step onto

the railing, reaching out to touch the branches, feeling the waxy, green leaves. *I have to live amongst the trees.* I reach out, extending my grasp as far as it will go, pulling on the branches.

“What are you doing?” my husband asks, watching me from inside, the door still open.

“I have to live amongst the trees. It’s where I belong.” I begin leaning over the railing, trying to ascertain how I can get into the trees. Aware that I am leaning over the railing, grasping, reaching, my husband steps outside. I try climbing over the railing.

“What are you doing?”

“I have to live amongst the trees!” A desperate cry escapes my mouth. As I try to climb over the railing, my husband grabs me, pulling me back. “No! I have to live amongst the trees!” I begin sobbing. Desperate. Yearning. Hearing the voices calling to me from the woods below. My husband wrestles me back from the railing, and I fight him, lashing out my arms, gripping onto the railing, wailing that I need to be in the trees because it’s where I belong. Tears stream down my face as he forcefully pulls me down.

“What’s wrong with you?”

“I don’t know! I just need to be amongst the trees! It’s where I belong!” My memory fails as I reflect on this experience; how I got back inside the apartment is a mystery. The door is closed now, my husband holding onto me firmly, holding me back. I hear sobbing. It’s my own, yet foreign. I feel disconnected from my body.

“You can’t jump off the balcony!”

“But I belong in the trees! You don’t understand!” *Come join us. You’re better off in the trees. Nobody will judge you. You belong here.* “Just let me go! I need to be

in the trees! You don't understand!" More sobbing, tears, and struggling against his grasp. "I just want to die. Let me die!"

"No, I can't do that!" We continue to argue as I try to wrest myself free of his grasp. I feel his fingers digging into my arms. "Something's wrong with you."

"I know," I manage to shout out between sobs; "I told you something was wrong, but you didn't believe me. Just let me go!"

Date: October 17th, 2013

I sit at the university Counseling Center waiting for my initial consultation. "Lauren VanderLind?" I walk back with the counselor, feeling awkward, out of place. The standard protocol begins: a description of what's been going on and why I need services. "I tried to jump off my balcony a couple days ago. I've been to counseling in the past and would like to see someone." After a few minutes of conversation, the counselor informs me my case is too severe for them to address at the Counseling Center. "We can refer you to outside resources, though. Let me set up an appointment with our case manager for a referral." He sets up the appointment. I walk out of the Counseling Center, defeated. *I'm too crazy for them to see me. I can't afford to pay for counseling. My husband doesn't have a teaching job, we just moved to Texas, and we're short on money. Now what am I going to do?*

Date: October 18th, 2013

Today is the day of my meeting with the case manager at the Counseling Center. I do not bother showing up. I'm acutely aware that I cannot pay for counseling, so I don't see the point in going. I do not cancel the consultation.

Counseling Records

10/18/2013 Case Management Client No Show [Counselor] 4:30 PM

Date: October 21st, 2013

I'm at the doctor's office at the Student Health Center. Something is wrong, and I know it. I've known it for months. The doctor enters, asking why I've come in. "Something's wrong with me. I think I have bipolar disorder. I tried to jump off my balcony a few days ago." The doctor runs through the typical protocol, assessing if I'm a danger to myself.

"Can you tell me a reason why you shouldn't be hospitalized?" More sobbing and tears.

"I can't go to the hospital—I have too much to do! I have to teach, and I have to go to class; I'm a doctoral student. I don't have time to go to the hospital." I'm fighting to stay at home with my husband, my safety net, the one who keeps me safe from harm.

"I understand." The doctor concedes. She won't hospitalize me, but I need to see a psychiatrist. She refers me to one and helps me set up an appointment to see her.

This is an instance of resilience and self-stigmatization. As I told the doctor, teaching is a grounding force in my life. That semester, I taught two sections of Integrated Reading and Writing, a developmental-level reading course. Working with

students and knowing they depended on me to be there as their instructor made me want to be resilient and avoid hospitalization. I could not imagine missing my time with the students in my classes; they were part of my support system, whether they realized it or not. Teaching was, and has continued to be, a stabilizing force for me regardless of what was going on in my personal life. I had to stay out of the hospital to be there for my students, an example of my resilience in the face of crippling mental illness and suicidal ideation. I readily used teaching as an excuse to stay out of the hospital because I also self-stigmatized for being “crazy” enough to merit hospitalization. It was validating to hear the doctor tell me she agreed something was wrong beyond the normal cycle of depression, but I could not reconcile hospitalization with my self-concept. I was strong. I was desperate to avoid being committed. I did not want to be deemed “crazy.” Most importantly, I did not want to fall behind in my classes as this was my first semester in a doctoral program. Hospitalization did, and continues to, scare me. I perceived it as a sign of weakness, and I did not consider myself weak. I knew my husband would be there to help keep me safe; I didn’t need to be in the hospital. If I tried to kill myself again, I knew my husband would stop me. My identity at that time was of a strong but conflicted 28-year-old. I could sense deep inside that something was wrong with me—I was not my usual self, and my symptoms were not consistent with what I had experienced in the past. I was in a state of identity crisis (Erikson, 1959, 1968).

Medical Records

Depression screening:

Little interest in doing things—several days

Feeling down, depressed, or hopeless—more than half the days

Trouble falling or staying asleep—nearly every day

Feeling tired or having little energy—more than half the days

Poor appetite or overeating—several days

Feeling bad about yourself or that you are a failure, or have let yourself or your family down—

more than half the days

Trouble concentrating on things, such as reading the newspaper or watching television—nearly

every day

Moving or speaking so slowly that other people could have noticed; or the opposite, being so

fidgety or restless that you have been moving around a lot more than usual—more than half the days

Thoughts that you would be better off dead or hurting yourself in some way—more than half the

days (consider Suicide Assessment Risk)

Total Score 17

Interpretation: Moderately Severe Depression

Patient Concern – Panic attacks Depression Suicidal ideation – not today. A few days ago –

“felt like jumping off her balcony” she stopped because she couldn’t climb the railing.

Patient is married and her husband helps her a lot. Also her work is a positive force and relieves her depressive / suicidal ideation.

Duration: several years

Contributing factors: unsure what her stresses

Pertinent positives: Excessive sleep; Fatigue; Crying; Irritability; mild loss of interest in activities

Remedies: Currently taking Paxil 40mg x 2 years [Paxil is an antidepressant, something that

exacerbates symptoms of bipolar disorder, as I later found out.]

Current treatment: Would like to change therapies.

Safety concerns: Suicidal thoughts, no plan.

Follow up encounter: Depression. Anxiety. The current medical regimen needs to be changed.

Mental health: The patient responds well and appropriately to questions. The patient appears

depressed, yet exhibits appropriate judgement and insight to questions and treatment discussion, Alert and oriented x 3. There are NO obvious symptoms of mania, irritability, confusion or psychosis.

Plan:

- 1. Mood disorder*

Patient instructions: 1) Continue Paxil [an antidepressant/anti-anxiety medication] at present dose pending psychiatrist consult 2) Patient given the information regarding the

suicide hot line and crisis intervention. Patient declines hospitalization. Patient denies plan to self harm.

Follow Up: 2 Weeks

“How did your appointment go?”

“Well, she wanted to have me hospitalized, but I managed to talk her out of it. I’m seeing a psychiatrist in two weeks. The doctor said I might have bipolar disorder.”

This was an identity I was beginning to reconcile myself with, although I did not yet realize the full ramifications of being diagnosed with bipolar disorder. All I knew was that I very strongly felt I had it, and it started to become part of how I perceived myself. Despite my struggle with the doctor over hospitalization, I felt “crazy.” My symptoms were not consistent with those I had experienced in the past, and I suspected that I was not simply experiencing depression, but something more severe and complex. And, as I would find out later, I was right.

Date: November 1st, 2013

I sit in the waiting area of the Student Health Center waiting for my first appointment with the psychiatrist. I choose the chair in the corner, almost hidden from view. I feel safe there. Before long, I hear my name called. “Lauren?” I walk back towards the nurse, trepidatious, not sure what to expect. The nurse introduces herself; she is soft-spoken and has the appearance of a kind soul. We walk back to her office to take my vital signs and go through the standard questions: do I drink, do I smoke, do I use drugs, what medications am I currently taking? After this, the nurse directs me to the

waiting area. I sit, clutching my purse, waiting anxiously. A few minutes later, I see a middle-aged woman round the corner.

“Lauren?”

“Yes.”

“I’m the psychiatrist. Let’s go back to my office.”

The appointment is a blur. I recall telling the psychiatrist I thought I was bipolar, but I do not remember anything else. All I can do is reconstruct the events from the medical records.

Medical Records

Depression symptoms

The patient reports feeling sadness and/or irritability since the age of 12

Is the mood disturbance reported to be associated with disturbed appetite and sleep? Yes

Is the mood disturbance reported to be associated with decreased energy levels? Yes

Is the mood disturbance reported to be associated with decreased interest? Yes

Is the mood disturbance reported to be associated with decrease concentration? Yes

These occurred part of a day, more days than not in a week for more than one year Yes

Possibly

During the most severe time, these occurred every day, all day, for great than or equal to two

weeks Yes

Suicidal symptoms

Wanting to die or not be alive Yes

Last date experienced 10/18/2013

Wanting to harm oneself Yes

Last date experienced 10/18/2013

Plans to harm oneself No

Wanting to kill oneself Yes

Last date experienced 10/18/2013

Intent to kill oneself No

Are medications, if taken, helpful for these issues? Yes

How much? Slightly

Manic symptoms

The patient reports symptoms of mania including sustained periods of severe irritability?

Yes

*This will last for how long? For sure 2 days. Mood (irritability/elevated) unpredictable
for other*

days

At times feelings of giddiness or feeling too happy/good are present – No

Are there any mania-associated symptoms? Yes

Is there difficulty with insomnia? Yes

Is there difficulty with increased energy? Yes

Is there difficulty with increased activity levels? Yes

Is there difficulty with being distracted? Yes

Is there difficulty with increased rates of thought or speech? Yes

Is there difficulty with agitation? Yes

The patient describes – impulsivity, grandiosity, increased spending and sex drive Yes

Aggressive thoughts including wanting to harm others No

Aggressive thoughts include wanting to kill others No

If medications are taken, are they helpful? No

Anxiety symptoms

Does the individual worry more than others? Yes

This has been present since what age? 5 Painfully shy

Issues affecting worrying include Financial issues, Relationships, Medical/psychiatric conditions

academics

Worrying is associated with Decreased sleep, Decreased energy, Decreased concentration,

Increased fatigue

Are there muscle spasms or tightness in severe flares? Yes

Do symptoms of severe/more acute periods of anxiety occur? Yes

Is there a sense of doom? No

Is there chest pressure or pain? Yes

Is there increased heart rate or palpitations? Yes

Is there tremulousness or shakiness? Yes

Is there sweatiness and/or clamminess? Yes

Is there dizziness and/or lightheadedness? Yes

Is there shortness of breath or altered breathing? Yes

Is there numbness/tingling in the face, hands, or extremities? No

Is there nausea or vomiting? No

Do the more severe episodes occur spontaneously? No

The symptoms are triggered by situations in which escape would be difficult (ie crowds)

Yes

*The symptoms are triggered by performance in front of others with potential for
embarrassment*

No

The symptoms are triggered by specific places or objects? No

The symptoms are triggered by environmental factors related to past trauma Yes

PTSD symptoms

Are there symptoms of PTSD? Yes

*Are there nightmares? Yes specific to emotional abuse (in the past)/now of car accident
2006*

Are there flashbacks? No

Are there panic attacks? Yes

Is there avoidance of thoughts? Yes

Are there feelings and situations reminding of prior trauma? Yes

Are there symptoms of hypervigilance/startle Yes

Obsessive symptoms

Are there obsessive thoughts? No

ADHD symptoms

*Are there symptoms of ADHD? No If mood stable: pays attention/focus, not fidget. No dx
of*

ADHD

Eating disorder symptoms

Did the history obtained from the patient include disturbance of eating patterns and self image?

No Denies: binge/purge, diet pills/laxatives, over exercising/restricting food

Aggressive symptoms

Does the patient exhibit aggression towards others? No

Psychotic symptoms

Does the patient describe perceptual disturbances? No

Current Medications

Paxil 40 MG Tablet 1 tablet in the morning Once a day

Past Medical History

Depression

Anxiety

Assessments

- 1. Bipolar disorder, unspecified*
- 2. GAD (generalized anxiety disorder)*
- 3. Panic disorder with agoraphobia*
- 4. Posttraumatic stress disorder*

FORMULATIONS:

28 Year old female patient presenting with depression/manic symptoms (most consistent with Bipolar Type II), as well as anxiety (most c/w GAD, Panic Disorder with Agoraphobia, and PTSD). Separate attentional deficits/hyperactivity are not present.

Symptom onset sequence includes: early anxiety with worries/panic attacks, followed by depress/mania, then increase in anxiety due to PTSD symptoms after MVA [motor vehicle accident]. The patient has self medicated with Etoh/Recreational Drugs/BZD [benzodiazepines] (currently appearing to be in remission.) Use of these has not preceded the symptoms above. There is persistence of presenting mood disturbance/other symptoms despite periods of sobriety. The patient is intelligent, articulate and motivated for treatment.

Treatment

1. Bipolar disorder, unspecified

Stop Paxil Tablet, 40 MG, 1 tablet in the morning, Orally, Once a day

Start Paxil Tablet, 20 MG, Orally, Take 1 & 1/2 tabs daily for 5-7 days, 2. Then take only 1 tab for 5-7 days, 3. Then take only 1/2 tab for 5-7 days

Start Lamictal [a mood stabilizer] Tablet, 25 MG, as directed, Orally. 1. Take 1 tab daily for 14 days. 2. If no rash, may increase to 2 tabs daily thereafter

2. GAD (generalized anxiety disorder)

Treatment notes: same.

3. Panic disorder with agoraphobia

Start Klonopin [a sedative] Tablet, 0.5 MG, Orally 1. Take 1/2 tab twice daily for 7 days, then 2. If needed take 1 tab twice daily thereafter

4. Posttraumatic stress disorder

Treatment notes: same.

There it was. I had not one, but four, diagnosed mental illnesses. I was crazier than I thought. In some ways, it was a validating experience; I had known something was off for months, and I finally had the answers I was looking for. Nevertheless, it was frightening. I was to decrease my antidepressant and start a mood stabilizer and sedative. In that appointment, I realized I would be on medication for the rest of my life. I had another identity crisis. My mental illness was so severe I had to be medicated forever; there was no avoiding it, or my symptoms would likely continue to worsen. I had to reconceptualize my identity again: I was suddenly an individual with bipolar disorder, generalized anxiety disorder, panic disorder with agoraphobia, and posttraumatic stress disorder. It was an overwhelming amount of news to process. In a half hour, I went from being diagnosed with depression and anxiety to having a list of mental illnesses, bipolar being the most severe. I had somehow known I had bipolar disorder. I was right. Now my husband would have to believe me: I had a diagnosis.

I did not stigmatize myself for having four mental illnesses; I did, however, stigmatize myself for needing to take medication for the rest of my life. It required a drastic shift in how I saw my life progressing: I would forever be yoked to a regimen of pills. Maybe I really was too crazy for the Counseling Center to deal with. Either way, I was right, and I almost gleefully told my husband the news about my diagnoses later that day. *I was right. I knew I was right. I knew I was bipolar. He should have believed me.*

Date: Early to mid-November, 2013

I underwent a period of adjustment as my medications were changed from a 20-mg dose of Paxil alone to a slowly decreasing dose of Paxil (with the aim of cutting it out

completely), a slowly increasing dose of Lamictal (a mood stabilizer), and a low dose of Klonopin (a sedative). As we decreased the Paxil, I experienced periods of agitation, rapid thoughts, and feeling out of sorts: symptoms of hypomania, which is an elevated mood state related to bipolar disorder. The Lamictal was not working quickly enough to counterbalance the negative effects of the Paxil, and I felt immensely unstable. I recall many messages left for the psychiatrist about my dosing and symptoms, phone calls from her nurse with instructions, and adjustments to dosages. None of this is represented in the medical records, so the best I can do is reconstruct it from memory. I cannot recall how many times my dosages changed in this adjustment period; all I know is it was a difficult process that left me feeling drained and less than my best.

I vividly recall my first self-disclosure of my mental illness: I was in class and expecting a call from the nurse, so I had to explain to my instructor that I might have to step out of class. That day, we were working on a full-class assignment, and I had to take my turn at the computer to enter some of our data. I did not feel well. The room was spinning, and I felt exhausted. Nevertheless, I forced myself to focus on the task at hand, recording the information presented to me as instructed.

After class, my instructor asked if I was feeling okay. *Oh god, he noticed. Now what do I do?* Upon rapid contemplation, I decided I had to be honest. “I was recently diagnosed with bipolar disorder. We’re currently adjusting my medications, so I’m having some side effects and not feeling very well.” The look on his face said everything. Compassion. He thanked me for my work in class and said “I hope you feel better.” My first experience of self-disclosure, although nerve-racking, was a success. I had not been treated poorly or looked down upon.

This was a considerable step in my identity development: my identity as a doctoral student was shifting to become one as a doctoral student with bipolar disorder, and I was starting to openly share this new identity with my faculty and peers. It occurred rather by necessity, given that I was visibly not myself and did not see fit to make excuses or lie about why, but it was not as intimidating the second time I self-disclosed. It slowly became more natural as time progressed and I came into a fuller sense of identity as tied to my mental illness. This required developing a positive sense of identity related to the illness, however; were I not confident that I would receive, at a minimum, neutral feedback when I self-disclosed, I likely would not have begun destigmatizing myself for having bipolar disorder (among the other mental illnesses). Had my first experience with self-disclosure been less positive, I may have been more reluctant to explain my circumstances to those around me. This speaks to the power faculty have to influence how students with mental illness view themselves—upon self-disclosure by the student, the tone of the response of the faculty member shapes how the student may feel about self-disclosing in the future. I am grateful to have had such a positive experience with my first self-disclosure.

Nevertheless, when I shared my diagnosis with a peer in my doctoral program, she cautioned me against sharing it with the faculty. Her words of caution were to be careful about sharing too much lest I lose my assistantship. This filled me with a sense of fear initially, and, as a result, I avoided self-disclosing to my supervisor for over two years. Now, as I reflect on this experience, I feel a sense of anger that I was cautioned against self-disclosure. Why should having a mental illness that is considered a disability cause me to be fired if I was doing my job? Is that even legal?

This experience reflects perceived stigma. Because I thought I might be fired due to my diagnosis, I avoided disclosing to my supervisor until after I had been assigned to a new one. If anything, this may have held me back from developing a stronger rapport with my supervisor; once he was aware of my diagnosis, he was very supportive of my needs. Perceived stigma may have interfered with me fully benefitting from my time working under that supervisor. I will never know how things might have been different if I had not been so afraid of the repercussions of disclosing my mental illness. Just as my experience self-disclosing for the first time spoke to the power faculty have, this experience speaks to the power peers have, as well. Perceiving stigma from peers can be just as significant an influence on self-perception as perceiving stigma from faculty. Before speaking with this colleague, I had never considered that my mental illness might influence my ability to maintain an assistantship, and I had not given much thought to whether it would influence the relationship I had with my supervisor. Clearly, everyone an individual with mental illness interacts with has some kind of influence on how the individual will perceive themselves.

Date: November 20th, 2013

It is time for my first follow-up appointment with my psychiatrist. I cannot recall if this was the originally scheduled time for my follow-up as it does not fit the typical timeline for follow-up appointments (these usually occur after 2, 4, 8, or 12 weeks). As I mentioned, I was feeling out of sorts. I was not my “regular” self. Although I had no more instances of voices coaxing me to jump off my balcony, I still did not feel

“normal,” and the medical records reflect that I did have a short period of suicidal ideation, or at least wanting to die. Something was off, and it was due to the medication.

We followed what I would learn to be the standard protocol for follow-up appointments: rating mood and symptoms; answering questions about self-injurious behavior, suicidal ideation, and homicidal ideation; and discussing the side effects of my prescribed medications. Such appointments have a rather clinical feel to them: it’s as if there’s a checklist, and you’re simply going through the items as a matter of procedures rather than having a personal conversation about what’s been going on since the last appointment.

I recall that the reason for the follow-up was my poor adjustment to medications. As we tried to taper off the Paxil, I experienced an increase in hypomania. We couldn’t adjust the Lamictal more rapidly to try to counterbalance these effects and stabilize my mood because of one potential side effect: rash. If you do not slowly adjust the dosage of Lamictal, you are at increased risk of developing a rash. Once you develop a rash, you can never take Lamictal again. To try to minimize that possibility, the doctor was having me slowly increase the dosage by 25-mg increments (the smallest amount possible) until we reached the therapeutic dose. In summation, I was experiencing hypomania, and the Lamictal simply wasn’t strong enough yet to help stabilize my mood. Something had to be done in the meantime to help manage my symptoms.

Medical Records

Reason for Appointment

1. *F/U [follow-up] from 11/01/13 for BPD [bipolar disorder], GAD, PTSD*

History of Present Illness

Psych f/u:

HPI This patient is a 28 year old Caucasian female for a scheduled follow up regarding BPD, GAD, Panic D/O [disorder] + Agor. [agoraphobia], PTSD. At last f/u started both lamictal/klonopin.

Histories reviewed – None None Family Social Allergies Hospital/Surgical [indicating no change since the last appointment]

Stressors include – Financial, Academic, Relationships, Medical.

Medications, effects, and side effects –

Lamictal – initially helped/no side effects (no rash)

Klonopin – helped/no side effects except dry mouth (mild/increases fluids).

Depression sx [symptoms] – improved

Until decreasing paxil from 20 mg to 10 mg QD [once a day] had better: Sleep Energy Interest Concentration Appetite (more normal)/ Sadness, irritability.

Manic sx – improved Better until decreased from 20 mg to 10 mg QD Paxil.

Anxiety sx – worry Decreased until dropped dose of Paxil from 20 mg to 10 mg QD.

Anxiety sx – Panic attacks Decreased (as above).

Anxiety sx – PTSD same as above.

Perception symptoms – denies hallucinations, illusions, paranoia, or thought disturbance.

Destructive sx (suicidal/homicidal/mutilation)

Wanting to die or not be alive/ Wants to harm self – last this weekend on Friday 11/15/13

Denied wanted to kill herself.

Denied HI [homicidal ideation].

Current Medications

All Day Allergy

Lamictal 25 MG Tablet 2tabs Daily in am

Klonopin 0.5 MG Table 1/2 to 1 tab in am and 1 tab Q evening

Examination

Appearance Appears well, stated age, normal rate of speech and psychomotor activity,

Spontaneous speech.

Mood/Affect Appropriate mood and affect, affect normal range and intensity/, Euthymic mood.

Orientation/Memory Alert and oriented X 3; Concentration good via conversation;

Recent and

Remote memory intact.

Intellectual functioning Avg. [average]/adequate fund of knowledge, Vocab

app[ropriate] for

education level, App conversation.

Thought process/Cognition Coherent, logical, directed., Judgement/Insight/Abstraction

adequate, No aud/vis [audio/visual] halluc. [hallucinations], paranoia,

grand[iosity]/persec. [persecution] delusions.

Suicidal ideation No suicidal thoughts, ideation, plan, or attempts.

Homicidal ideation No homicidal thoughts, ideation, or plan.

Assessments

- 1. Bipolar disorder, unspecified*

2. *GAD (generalized anxiety disorder)*
3. *Panic disorder with agoraphobia*
4. *Posttraumatic stress disorder*

Not at imminent risk harm to self.

Treatment

1. Bipolar disorder, unspecified

Stop Lamictal Tablet, 25 MG, 2tabs, Orally, Daily in am

*Start Lamictal Tablet, 25 MG, as directed, Orally, Take 2 tabs in am, take 1 tab at noon,
30*

days, 90 [pills], Refills 1

*Treatment notes: Provider agreed that appeared to be more stable on low dose Paxil (20
MG
QD)*

*Rec[ommend] increase in lamictal to prevent mania if cont. [continue] this SSRI [Paxil]
(Pt stating she has enough Paxil for now).*

2. GAD (generalized anxiety disorder)

Treatment Notes: below.

3. Panic disorder with agoraphobia

Treatment notes: below/would benefit from IT [individual therapy]

4. Posttraumatic stress disorder

*Refill Klonopin Tablet, 0.5 MG, 1/2 to 1 tab in am, Orally, and 1 tab Q evening, 30 days,
60,
Refills 1*

Intermediary Period: Late Fall 2015

Date: unknown; sometime in early November 2015

It's the annual College Reading and Learning Association (CRLA) conference in Portland, Oregon. A friend and I have taken part of a day to explore the local area; we are currently in the woods near a waterfall, examining the brightly colored fallen leaves, wrapping up against the wet cold. It's sprinkling rain.

"So, there's a small possibility I might be pregnant. My period is really weird right now—spotty and light."

"Oh my God, Ren, that is so exciting! Do you want a baby?"

"Yes. I've wanted to be a mother since I got married, but I'm not sure this would be good timing. I'm starting comps [my comprehensive exams, which entailed running a pilot study] next semester, so I'm going to be really busy."

"But think about it—you won't be taking any classes, and next year, you'll just be working on your dissertation. That might be the perfect time to have a baby. You'll have more free time in your schedule."

"I guess you have a point. I'm not sure there's really an ideal time to have a baby as an academic. It's not like I want to wait until I get a job because who will hire a pregnant woman?"

We continue talking in this vein, exploring the pros and cons to having a baby during a doctoral program versus waiting until a job is in hand. I decide to call my husband, who is back home. My hands are shaking slightly.

"Hey, can we talk about something?"

"What?"

“I think I want to have a baby.”

“I knew you were going to say that.”

“Well, would it be so bad? I was talking to [my friend], and she thinks the timing might be right. I kind of agree. I mean, is there really a good time to have a baby when you’re an academic? I don’t want to be on the job search pregnant, and I don’t want to be pregnant and going up for tenure because what if they’re hesitant to give it to me because I’m pregnant, and I should have more free time next year when I’m working on my dissertation.”

“Do we have to talk about this right now?”

“No, I just got excited thinking about it and wanted to see what you thought.”

“Well, we can talk about it more when you get home.”

Although not tied to my mental illness, I was in a new stage of identity development, looking at adding a new identity: that of a mother who is simultaneously an academic and a college student. I had to consider potential future outcomes—what would perceptions be of me if I waited until I had a job or was on the job search to have a baby? What would that mean for my job prospects? For tenure? Maybe trying to have a baby before finishing the Ph.D. would be a good idea in comparison.

After I returned home from the conference, my husband and I discussed the matter in more detail. We both agreed that we wanted to have children and that perhaps this was the time. It wasn’t long before I set up an appointment with my psychiatrist to talk about what that would mean in terms of medication; most of my medications had warning labels about taking them when pregnant or breastfeeding, so I knew I would likely have to make some changes.

Date: December 4th, 2015

It's my first appointment with my psychiatrist since the conference. I bring up that I want to try to get pregnant. We launch into a discussion of what, precisely, that means for my medication regimen. The psychiatrist informs me that two of my three medications are in a class such that research shows they are not safe for pregnant/breastfeeding women. The main risk she highlights is spina bifida. I do not know precisely what it is, but the name makes it sound bad, so I am not resistant to her recommendation. Her plan of action: taper off the risky medications (Klonopin and Lamictal). I can stay on my antidepressant, something that was added to my regimen because of a recent diagnosis of fibromyalgia; this antidepressant, although it posed a risk in terms of exacerbating my mood swings much like the Paxil did, also functions as a pain reducer in patients with fibromyalgia.

Without considering the consequences, my husband and I did attempt to conceive between the conference and this doctor's appointment. After I reveal this, the psychiatrist urges me to make an appointment to find out if I am pregnant as soon as possible. (As a side note, it turned out I wasn't.)

Having made the decision to move forward with trying to have a baby, I had to go off two of my medications. This meant approximately one month of gradually reducing my dosage until I was no longer on the mood stabilizer or sedative. What I didn't know at the time is how difficult it is to come off these medications, particularly Klonopin. Trouble was coming, and I would have to adjust my sense of identity as a result. Despite the flare-ups of depression and hypomania I had been experiencing lately (which are

reflected in the following medical records), I left the appointment feeling positive and looking forward to this next stage in my life.

Medical Records

Reason for Appointment

Est[abolished] pt [patient] here today for psy[chiatric] f/u [follow up] from 09/14/15 for BPD [bipolar disorder], GAD [generalized anxiety disorder], PTSD [post-traumatic stress disorder].

History of Present Illness

HPI This patient is a 30 year old Caucasian female for a scheduled follow up regarding Bipolar D/O [disorder], GAD, Agoraphobia with Panic Disorder, PTSD. No changes last f/u.

Histories reviewed – Past Medical Family Social Allergies Hospital/Surgical

Stressors include – Financial, Academic, Relationships, Medical

(takes 9 cr. [credits]; Research Assistant, some finals).

Medications, effects, and side effects

Cymbalta [the antidepressant for fibromyalgia] – at this dose was not helping enough for depression; getting better now, but still has 2/7 very depressed days; no side effects

Lamictal – Helps with symptoms mania (maybe hypomania only part of a day for 3/7 days); no side effects (no rash)

Klonopin – Helps with symptoms anx[iety]; No known side effects

Mood changes since the last visit

sad/down/empty – worse (only improving recently/still as above)/GRADES moderate [meaning I ranked it as having a moderate level of effect on me out of the options mild, moderate, and severe]

anger/irritability (associated with hypomania) – worse (only improving recently)./GRADES moderate

euphoria/giddiness – deined [sic]

stress/anxiety – same (manageable)/GRADES mild

Sleep – Good (sleeping more).

Energy – Worse (since talking about having a child with husband)

Interest – Worse (improved in last couple weeks).

Concentration – Worse.

Appetite – Worse.

Manic symptoms

denies: impulsivity, grandiosity, increased sex drive,

Brief only: (with irritability) rapid speech/thoughts, or excess energy.

Anxiety sx [symptoms] – Agoraphobic symptoms Not significant (1 panic attack since last f/u)

Anxiety sx – Worry Increased/manageable; GRADES moderate.

Anxiety sx – PTSD No change/GRADES mild.

Perception symptoms – denies hallucinations, illusions, paranoia, or thought disturbance.

Thoughts of Harm/Death – (suicidal/homicidal/mutilation) Wanting to die or not be alive – last 1 week ago

Wants to harm self – last 1 week ago (had thoughts but husband stopped her)

Wants to kill self – last 1 week ago (no plan/act/or intent)

Denied: HI

Current Medications

Taking

- *Loratadine [allergy medication] 10 MG tablet 1 table Once a day*
- *Cymbalta 20 MG Capsule Delayed Release Particles 2 tabs Q am*
- *Lamotrigine [the generic name for Lamictal] 100 MG Tablet as directed take 1
Twice a day (am/QHS [at bedtime])*
- *Klonopin 0.5 MG Tablet as tolerated 2 TID [three times a day] (space \geq 8 hrs
apart)*
- *Prenatal Multi[vitamin] + DHA*

Examination

Psych:

Appearance Appears well, stated age, normal rate of speech and psychomotor activity, Spontaneous speech. No observable muscle tightness, stiffness, tremor, or spasms.

*Mood/Affect Appropriate mood and affect, affect normal range /, **Affect intensity increased/, Anxious – mild.***

Orientation/Memory Alert and oriented x 3; Concentration good via conversation; Recent and Remote memory intact.

Intellectual functioning Avg./adequate fund of knowledge, Vocab app for education level, App conversation.

*Thought process/Cognition Coherent, logical, directed.,
Judgement/Insight/Abstraction adequate, No aud/vis halluc., paranoia, grand/persec.
delusions.*

Suicidal ideation No suicidal thoughts, ideation, plan, or attempts.

Homicidal ideation No homicidal thoughts, ideation, or plan.

Treatment

1. Other bipolar disorder

*Refill Cymbalta Capsule Delayed Release Particles, 20 MG, 2 tabs, Orally, Q am, 30
day(s), 60, Refills 1*

Stop Lamotrigine Tablet, 100 MG, as directed, Orally, take 1 Twice a day (am/QHS)

Start Lamictal Tablet, 25 MG, as directed, Orally, 1). 3 BID [twice a day] X 5-7 days 2).

2 BID X 5-7 days 3). 1 BID X 5-7 days 4). 1 QD [once a day] X 5-7 days 5). DC

[discontinue]/stop (as tolerated), 30 day(s), 180, Refills 1

*Clinical notes: Discussed pregnancy management and her RXs [prescriptions]/Bipolar
Disorder:*

- 1. Identified FDA Pregnancy Category for all RXs/explained risks to fetus; handout
given*
- 2. Identified risks to her own safety/that of potential fetus should she abruptly DC all
RXs (and resulting increase in depression/SI/mania) – this would be higher than
that to fetus over next 1 month as we decrease her RXs*
- 3. Discussed importance of IT meanwhile – pt agreed*
- 4. Identified alt[ernative] TXs with potentially less risk harm to fetus should she
become manic: risperdal and lithium*

She prefers slow decrease lamictal & cont[inuation] of cymbalta for now (having failed to tolerate zoloft/proza and lexapro also Cat[egory] C)

Ideally she would like to increase cymbalta, but will need to hold for now.

2. GAD (generalized anxiety disorder)

Clinical notes: will need IT – minimally 1/wk.

3. Agoraphobia with panic disorder

Clinical Notes: Discussed FDA Pregn[ancy] Categ[ory] structured as above

prefers slow decrease klonopin – provide agreed given > risk harm to pt/potential baby should this RX be abruptly DC (incl SZ [seizures], suicide). Less risk to potential fetus over next month.

4. Chronic post-traumatic stress disorder (PTSD)

Stop Klonopin Tablet, 0.5 MG, as tolerated, Orally, 2 TID (space >= 8 hrs apart)

Start Klonopin Tablet, 0.5 MG, as directed, Orally, 1). 1 & ½ TID X 5-7 days 2). 1 TID X 5-7 days 3). 1/2 TID X 5-7 d[ays] 4). 1/2 BID X 5-7 d 5). 1/2 QD X 5 d 6). DC, 30 days, 90, Refills 1

Follow Up

6 weeks (Reason: medmgt [medication management])

Date: around Christmas 2015

I'm still coming off the Lamictal and Klonopin. The end is in sight—only a little while longer, and I'll be off them completely. Since my last doctor's appointment, I've been gradually adjusting to coming off the medications. The side effects are unbearable more often than not. I have flu symptoms—chills, nausea, lack of appetite, body aches,

fever, fatigue, fogginess of mind—and no remedy helps alleviate them. I'm in Michigan, visiting my parents and my husband's mother and step-father for the holidays. We're staying at my parents' house.

When I visit my parents, I usually spend a great deal of time with my mother, doing everyday household tasks and running errands. Occasionally, we go to a local coffee shop. This visit, things are vastly different. I barely have the energy to accomplish any of these tasks. Most of the week I'm there, I'm curled up on the couch, crocheting to keep my hands busy. On top of the flu-like symptoms, I'm agitated, a side effect of coming off the mood stabilizer while still taking an antidepressant. Agitation is a symptom of hypomania, and I no longer have therapeutic levels of Lamictal in my system to keep my mood stable and prevent the slide into a hypomanic state. I'm irritable, frustrated, and exhausted. I'd like nothing more than to sleep all day. Sleep has quickly become my only respite from the side effects of coming off the medications.

On one trip out of the house, I picked up a pregnancy test. The time was near, and I wanted to be prepared. At this point, everyone in our lives knows my husband and I are trying to have a baby, so there's no secrecy needed. When the time came, I got up early and eagerly tore open the box and inner packaging to get at the test stick. Waiting. Three minutes feels like thirty at this point. The digital test results pop up, and I see the words "Not pregnant." Tears start. I wanted a baby for Christmas.

I walk into the guestroom we're staying in.

"I'm not pregnant." Sobbing. More tears. It's becoming uncontrollable.

"I'm sorry." His tone is less than encouraging.

“Why don’t you care more? Isn’t this a big deal to you? Don’t you want to have a baby with me?”

“Of course I do. You just can’t expect it to happen right away. . .”

His words fade into the background. I’m not listening anymore. *Why isn’t he consoling me? Why doesn’t he care as much as I do? Isn’t he disappointed? I feel like such a failure. How hard can it be to get pregnant? I’m going through hell for this. What if I don’t get pregnant? What if I’m going through all this for nothing? I’m such a disappointment. I can’t do anything right.*

Here, I’m clearly stigmatizing myself. A big piece of my self-stigmatization was the difficult process I was going through trying to come off Lamictal and Klonopin. I had started exploring the new identity of a potential mother, but had to keep in check that I might not get pregnant. Weighing this against the hardships I faced coming off the medications, I was not sure if it was worth it in the moment. This is when I first started to question if I, as a person with bipolar disorder, could really be a mother. It appeared so easy initially: so many women get pregnant that it seemed like it should happen quickly. The seeds of doubt had been planted, and they would grow.

Date: December 25th, 2015

My husband and I are at his mother and step-father’s house for a Christmas gathering of his family. His half-sister, half-brother, their spouses, and their children will be there along with his aunt and her boyfriend. It’s going to be quite the event: his mother always puts out a large spread of unique foods (she’s not much for traditional holiday meals), and the whole family gathers together, sitting around the fireplace,

chatting, eating, and periodically going down to the basement to take a sauna, a staple of Finnish culture (I come from an area heavily influenced by this).

I'm wearing a new navy blue party dress, black tights, and a pair of gold gladiator sandals. I want to look put together even though I don't feel well. Everyone in his family has inevitably found out about my quest for a baby and knows that I'm tapering off my medications.

I spend the night picking at my food—I can barely keep anything in my stomach, so I can't eat much. I listen to the conversations around me, drifting in and out of my own thoughts. I'm consumed by a sense of failure and disappointment.

Most of the night has faded in the recesses of my memory; I recall feeling overwhelming fatigue and taking an extra half a Klonopin to try to quell the side effects. It didn't help. I eventually told my husband I did not feel well. We were supposed to spend the night there—we were alternating our time with each family—but I desperately wanted to be in my own house.

“Come here.”

“What?”

I lean towards his ear. “I want to go home,” I whisper. “I really don't feel good.”

“Alright. I'll ask my sister if she can take you when she goes.” He appears deflated. I know he's disappointed in me. We've had many a fight over my relationship with his mother and step-father. *Great. Now they're going to think I don't like them. I just want to be at home in my cozy bed. I want my mommy.*

I remember gingerly stepping into the car. Every movement was laborious and painful. I tried to make conversation on the ride back to my parents' house, but I know in retrospect that I did a poor job of it. All I wanted was to crawl into bed.

Date: a few days after Christmas 2015

It is our last day in Michigan. Because they live closer to the airport than my parents do, we are spending the night with my mother- and step-father-in-law. I still feel like death. Everything aches, and all I want to do is sleep. We're in the kitchen having coffee and chatting.

"So you're not feeling too hot still?" my step-father-in-law asks. He's a therapist who counsels individuals with addictions.

"No, I feel awful."

"Yeah, that Klonopin is a really hard one to come off of."

"Yeah, and when I was reading up on it, I noticed it's not something you're supposed to take long term. I've been on it for years now."

"It's really difficult to get it out of your system. Have you tried [product]? It's supposed to be good for coming off opioids. One of my clients uses it. He says it helps." He pulls out his cell phone and looks up the product on Amazon. It's expensive. It's more money than I'm willing to spend on something I don't even know will help the side effects of coming off Klonopin and Lamictal.

"All I know is I'm never going back on Klonopin after this. I feel like I know what it's like to go through withdrawals from hard drugs now."

Now, I'm starting to develop a new sense of identity, one that I wish I could hide from the world: that of the person with mental illness who will soon no longer be properly medicated. I'm acutely aware that my symptoms of withdrawal show to the world, and I desperately wish they didn't. I want to appear stronger than I feel that I am in the moment. I'm trying to construct an identity to project to others that does not match up with how I feel inside. Needless to say, it's a challenge and a time of conflict. I do not want to be stigmatized for not being strong enough to persevere through this hardship; inner strength is something I pride myself on, so to appear weak is mortifying to me. I'm actively trying to avoid encountering stigma by putting on the identity of someone who is strong, not someone who is suffering. I'm covering up my true self from the world around me, or at least attempting to do so. How successful I was is debatable.

Semester Two: Spring 2016

Date: January 25th, 2016

It's time for my next follow up with my psychiatrist, the first one since we decided to taper off my medications. I'm still not feeling well, and I'm not managing my mental illness symptoms effectively. I feel some resentment towards my doctor for putting me on Klonopin for so many years even though it's recommended as a short-term use medication. *She should have known better. Why would she do that? And why didn't she warn me about all these side effects when we started tapering off the medications?* The seeds of mistrust have been sowed, and they are beginning to grow into the fruit of resentment and desire to find another doctor.

Medical Records

Reason for Appointment

1. *An established 30yr old female presents today for a psych f/u from 12/4/15*

History of Present Illness

Psych f/u:

HPI This patient is a 30 year old Caucasian female for a scheduled follow up regarding BPD NOS [not otherwise specified], GAD, Agoraphobia, PTSD. AT last f/u pt requested decrease/complete DC of lamictal and klonopin (due to antic[ipation] of attempts at getting pregnant).

Has done so and feeling as below.

Histories reviewed – Past Medical Family Social Allergies Hospital/Surgical

Stressors include – Financial, Academic, Relationships, Medical

(passed last semester; 9 cr; works in assistantship).

Medications, effects, and side effects – Cymbalta – not managing residual level of anx/depression (no mania); no side effects

Mood changes since the last visit

Increased: depression (GRADES severe), anxiety (GRADES moderate);

denies rage/euphoria.

Sleep – Worse.

Energy – Worse.

Interest – Worse.

Concentration – Worse.

Appetite – Worse.

Manic symptoms – denies: impulsivity, grandiosity, increased sex drive, rapid speech/thoughts, or excess energy.

Anxiety symptoms – increased: worrying, panic attacks/GRADES mod/severe.

Perception symptoms – denies hallucinations, illusions, paranoia, or thought disturbance.

Thoughts of Harm/Death – (suicidal/homicidal/mutilation)

Wanting to die or not be alive – last yesterday (due to how she is feeling physically)

SIB: denied

Wants to kill self – last yesterday (no plan)

Denied: HI

Current Medications

Taking

- *Loratidine 10 MG Tablet 1 tablet Once a day*
- *Prenatal Multi + DHA*
- *Klonopin 0.5 MG Tablet as directed 1). 1 & 1/2 TID X 5-7 d[ays] 2). 1 TID X 5-7 d 3). 1/2 TID X 5-7 d 4). 1/2 BID X 5-7 d 5). 1/2 QD X 5 d 6). DC, Notes: Last: 2-3 weeks ago*
- *Cymbalta 20 MG Capsule Delayed Release Particles 2 tabs Q am*
- *Lamictal 25 MG Tablet as directed 1). 3 BID X 5-7 days 2). 2 BID X 5-7 days 3). 1 BID X 5-7 days 4). 1 QD X 5-7 days 5). DC/stop (as tolerated), Notes: Last: end Dec 2015*

Examination

Psych:

General VS and nurse intake reviewed above.

Appearance Appears well, stated age, normal rate of speech and psychomotor activity, Spontaneous speech. No observable muscle tightness, stiffness, tremor, or spasms.

*Mood/Affect Appropriate mood and affect, , **Affect range decreased/. Affect intensity increased//. Depressed – moderate alt , Anxious – moderate.***

Orientation/Memory Alert and oriented X 3; Concentration good via conversation; Recent and Remote memory intact.

Intellectual functioning: Avg./adequate fund of knowledge, Vocab app for education level App conversation.

*Thought process/Cognition Coherent, logical, directed.,
Judgement/Insight/Abstraction adequate, No aud/vis halluc., paranoia,
grand[iosity]/persec. [persecutory] delusions.*

Suicidal ideation No suicidal thoughts, ideation, plan, or attempts.

Homicidal ideation No homicidal thoughts, ideation, or plan.

Treatment

1. Other bipolar disorder

Stop Lamictal tablet, 25 MG, as directed, Orally, 1). 3 BID X 5-7 days 2). 2 BID X 5-7 days 3). 1 BID X 5-7 days 4). 1 QD X 5-7 days 5). DC/stop (as tolerated), Notes: Last: end Dec 2015

Stop Cymbalta Capsule Delayed Release Particles, 20 MG, 2 tabs, Orally, Q am

Start Cymbalta Capsule Delayed Release Particles, 20 MG, -, Orally, 1). 2 Q am and 1 Q noontime X 7-10 days 2). if no side effects, 2 Q am and 2 Q noontime thereafter, 15 days, 60, Refills 3

Clinical notes: Lamictal stopped 1 mo[nth] ago

no known current or recent mania

discussed following:

- 1. increase cymbalta (add slowly at noon time using 20 mg; not increasing faster than 7 days) – pt aware risk mania*
- 2. risperdal or Lithium to prevent mania – declined today – will need re-eval[uation] at f/u (concurred ; pt good candidate for IT to manage this, and reliable reg[ular] calling if needs move up appoint[ment]).*

2. GAD (generalized anxiety disorder)

Clinical notes: needs IT.

3. Agoraphobia with panic disorder

Stop Klonopin Tablet, 0.5 MG, as directed, Orally, 1). 1 & 1/2 TID X 5-7 days 2). 1 TID X 5-7 d 3). 1/2 TID X 5-7 d 4). 1/2 BID X 5-7 d 5). 1/2 QD X 5 d 6). DC, Notes: Last: 2-3 weeks ago

Clinical notes: above; needs IT.

4. Chronic post-traumatic stress disorder (PTSD)

Clinical notes: same

klonopin DC as directed.

7. Others

Reminded of benefits of IT: yes – needs restart with [counselor] at CC [Counseling Center]

Follow Up

4 Weeks (Reason: medmgt)

As is apparent in the medical records, I was experiencing increased depression, anxiety, and suicidal ideation as side effects of discontinuing the sedative and mood stabilizer. Without Lamictal, I had nothing to regulate my fluctuating moods, and I was falling on the depressive end of the spectrum. Without the Klonopin, I had nothing to regulate my anxiety and panic attacks, hence their increase since my last appointment. I also experienced a very recent episode of wanting to die (as noted in the medical records, because of my physical symptoms of withdrawal). These were a lot of symptoms to be facing at the start of a new semester in which I was taking a full course load (9 credit hours) and working an assistantship (which was 20 hours a week). This demonstrates some degree of academic resilience: even though I was not feeling well, I remained enrolled and kept my assistantship. I desired to persevere and do well academically even though I was going through a difficult time with my mental illness. Although I did not perceive it as such at the time, I was academically resilient in the face of my symptoms. I was strong, like I desired to be and present as to the world, but I did not feel strong, as will become apparent in the following passage.

Date: unknown; late January to early February

It's the middle of the afternoon. It could be any day of the week, and, in fact, this occurs almost every day if not every day. My husband is out teaching his two composition courses for the day. All the lights are off, and I am curled up on the couch, propped up by multiple pillows, wrapped tightly in an afghan and lap quilt, in my pajamas. I'm sweating, but when I take the blankets off, I get the chills, so I opt to keep them around me. The apartment is 72 degrees, but it feels like it's at least 80 (or 60 if I'm not wrapped in blankets). I have a bag of oyster crackers and a ginger ale nearby. My appetite has steadily been lower since I tapered off the Lamictal and Klonopin. All I can do is nibble on the crackers and sip at the soda to abate the nausea. Every joint in my body aches; it could be the fibromyalgia, but I'm taking Cymbalta to help with the pain, so I attribute it to coming off the medications.

I hear keys in the lock, so I open my eyes. My husband walks in.

"How are you feeling? Any better?"

I slowly roll my head to the side to face him, feeling dizzy the whole while. "Not really," I say, somewhere just above a whisper in volume. "I've just been on the couch all day."

"I'm sorry." He goes about putting his backpack, books, student homework, and laptop away. "Do you need anything?"

"No, I'm okay." Again, barely above a whisper. The pillows and blankets feel sticky from sweat. Now that my husband's home, I'm going to have to move to make room for him on the couch, the only place to sit in our living room. It's a slow process of adjusting blankets, pillows, and body parts to sit upright. It's painful and disorienting.

I'm able to spend all but three hours a week on the couch. Although I'm enrolled in 9 credit hours, only 3 of them are for a weekly class. The others are for directed research and an independent study intended to give me time to work on the pilot study for my comprehensive exams. Regarding my assistantship, there are weekly meetings I'm supposed to attend, but I've informed my supervisor about my physical state, and she concedes that I don't need to be there and can do my assistantship work from home. Given that I struggle to get off the couch, I am not making any progress on my assigned duties. I'm also not doing the assigned readings for class. I muddle through the weekly discussions as best as I can based on my background knowledge. This is a challenging feat given that I am one of only three enrolled in the course. I am starting to feel like a failure.

On one hand, I am demonstrating some academic resilience in that I still attend my weekly class, but on the other, I am not particularly resilient because I am not doing my homework or my assistantship duties. The symptoms I'm enduring are physically and mentally draining—every task seems insurmountable, regardless of how mundane or commonplace it may be. I cannot focus on my work because of how poorly I feel physically. It's as if I'm drowning and there's no one around to help me.

In addition to feeling like I'm not resilient, I'm starting to feel a sense of stigma. I stigmatize myself for not recovering quickly enough to be able to attend to my academics. I should be stronger according to my perceptions of self. Clearly, I'm engaging in self-stigma, considering myself “less than” for not being able to attend to simple tasks like leaving the house every day or complete my homework or assistantship duties. I also fear stigma from my instructor, peers, and supervisor. I do not want to be

perceived as weak, and I'm growing anxious that I appear that way to those around me. I'm both self-stigmatizing and encountering perceived stigma. Although no one is overtly treating me differently, I feel as though they perceive me in a negative light because of my inability to attend to my work.

Date: February 10th, 2016

Memo

To: *Lauren [Ren] VanderLind, Graduate Research Assistant*

[Supervisor]

From: *[Program Director]*

Subject: *GRA Accommodations for Lauren VanderLind*

This is an informal, written response to Ms. VanderLind's request for accommodations to her GRA position. The requested accommodations are due to a non-academic, medical issue that Ms. VanderLind self-disclosed.

I'm using this email as a means of describing the historical context of Lauren's GRA-ship for the spring 2016 semester. Lauren was assigned to work with [supervisor] for 20 hours per week for the academic year 2015-2016, and the scope of work for this assistantship generally involved analyzing [type of] data and working as part of a team to write up publishable results in journal manuscripts. In the fall term, Ms. VanderLind was ill and was unable to work for multiple weeks on the data; in an effort to allow Ms. VanderLind to catch up on her assistantship work, [supervisor] offered her the option of

substitute teaching for a fellow doctoral student in a RDG 1300 class since she was highly familiar with this class and material. [Supervisor] reports that Ms. VanderLind successfully made up for the hours with her teaching and grading. Ms. VanderLind has not yet been well enough to report for this spring term (January 18-February 5); she contacted [supervisor] during the week of February 1 to let her know about the prolonged illness. Ms. VanderLind does not believe she will be well enough to work for another two weeks (until the week of February 22). Because the team's work on the [type of] data continued through the holiday and the team is hoping to complete a publishable product by the end of February, it is too late in the process to bring Lauren back into that project. [Supervisor] will work with Ms. VanderLind, once she is sufficiently recovered, to rewrite the GRA scope of work, focusing on another study that will continue through the spring semester.

I had not been feeling well, and, as I stated before, it was interfering with my ability to work. I met with my supervisor to discuss a timeline for getting back to my assistantship duties when I thought I would be recovered from the withdrawals from Lamictal and Klonopin. This is an example of academic resilience: in a time of great struggle, I sought help and disclosed what was going on in my personal life.

Date: February 26th, 2016

It's my four-week follow up with the psychiatrist. I've now been off Lamictal for approximately two months and off Klonopin for about a month and a half. The side effects from coming off the medications still haven't abated. *Why didn't she warn me?*

And why isn't she doing anything to help me feel better? Doesn't she understand how much I have to do? I can't continue like this much longer. What good is she, anyway? Maybe I should switch to the other psychiatrist.

Medical Records

Reason for Appointment

1. 30 nYO F established and ENR [enrolled] here for psych f/u from 1/25/16

History of Present Illness

Psych f/u:

HPI This patient is a 30 year old Caucasian female for a scheduled follow up regard BPD, GAD, Agor. [agoraphobia] + Panic D/O, PTSD.

At last f/u increased cymbalta (and completed taper other RXs).

Histories reviewed – Past Medical Family Social Allergies Hospital/Surgical

Stressors include – Financial, Academic, Relationships, Medical

(1 class; is TA [this is inaccurate; I was a research assistant], working on comprehensive exam for grad prgm [program]).

*Medications, effects, and side effects – **Cymbalta – Helps with symptoms depress[ion], but still significant; no side effects***

Mood changes since the last visit

sad/down/empty – improved/GRADES severe

stress/anxiety – improved/GRADES moderate.

Sleep – Worse/more.

Energy – Improved/still low.

Interest – Same/still low.

Concentration – Improved.

Appetite – Improved.

Manic symptoms – denies impulsivity, grandiosity, increased sex drive, rapid speech/thoughts, or excess energy.

Anxiety symptoms

Improved: worrying, /GRADES mod

Same: panic attacks (1/week), PTSD (GRADES mild)

Perception symptoms – denies hallucinations, illusions, paranoia, or thought disturbance.

Thoughts of Harm/Death – denies wanting to harm or kill self or others.

Current Medications

Taking

- *Loratadine 10 MG Table 1 tablet Once a day*
- *Prenatal Multi + DHA*
- *Cymbalta 20 MG Capsule Delayed Release Particles – 1). 2 Q am and 1 Q noontime X 7-10 days 2). if no side effects, 2 Q am and 2 Q noontime thereafter*

Examination

Psych:

General VS and nurse intake reviewed above.

Appearance Appears wel, stated age, normal rate of speech and psychomotor activity, Spontaneous speech. No observable muscle tightness, stiffness, tremor, or spasms.

Mood/Affect Appropriate mood and affect, affect normal range and intensity /, Euthymic mood.

Orientation/Memory Alert and oriented X 3; Concentration good via conversation; Recent and Remote memory intact.

Intellectual functioning Avg./adequate fund of knowledge, Vocab app for education level, App conversation.

Thought process/Cognition Coherent, logical, directed., Judgement/Insight/Abstraction adequate, No aud/vis halluc., paranoia, grad/persec. delusions.

Suicidal ideation No suicidal thoughts, ideation, plan, or attempts.

Homicidal ideation No homicidal thoughts, ideation, or plan.

Treatment

1. Other bipolar disorder

Stop Cymbalta Capsule Delayed Release Particles, 20 MG, -, Orally, 1). 2 Q am and 1 Q noontime X 7-10 days 2). if no side effects, 2 Q am and 2 Q noontime thereafter

Start Cymbalta Capsule Delayed Release Particles, 20 MG, -, Orally, 1). 3 Q am and 2 Q noon X 10-14 days 2). 3 Q am and 3 A noon thereafter, 30 day(s), 180, Refills 1, Notes:

mid meal/addequate [sic] solid protein/increase if no side effects

Clinical notes: Discussed options:

- 1. add lithium or risperdal – declined for now (provider agreed given side effect profile of these RXs, lack mania and risk sedation)*
- 2. increase cymbalta slowly – pt preferred*

Risk to potential pregnancy less than risk untreated depression/potential later development of SI.

2. GAD (generalized anxiety disorder)

Clinical notes: IT.

3. Agoraphobia with panic disorder

Clinical notes: IT – avoid BZD while pt antic. getting pregnant.

4. Chronic post-traumatic stress disorder (PTSD)

Clinical notes: above.

7. Others

Reminded of benefits of IT: yes; will be seeing [counselor] at CC Mon[day].

Follow Up

4-6 Weeks (Reason: medmgt)

As can be seen in the next to last note, I did not follow through with individual counseling per the psychiatrist's urging at the last appointment in January. I went about a month without seeing anyone, which likely contributed to my difficulty managing my symptoms, such as the weekly panic attacks. Although most of my symptoms had decreased in severity over the past month, they were still present. The encouraging part of the records is that I did not report any self-mutilation or suicidal ideation or wanting to die. That marks an improvement since the last appointment; the reason behind it is unclear, as I am still experiencing the same side effects that caused my thoughts of death prior to the last appointment. Even though I was experiencing a slight decrease in mental illness symptoms, perhaps due to increasing my dosage of Cymbalta (the antidepressant),

I was still not managing them well. I was not seeking out the help I needed, either, by resisting individual therapy. The good news: I had an appointment with my individual counselor in a few days. This demonstrates that I was beginning to recognize that I needed help and was engaging in help-seeking behaviors, an indicator of slowly increasing academic resilience.

It's worth noting, from the medical records, that we decided to increase my antidepressant instead of adding in Risperdal (an antipsychotic that has mood stabilizing properties) or Lithium (another antipsychotic that's also a mood stabilizer). I was under the impression that I could manage my symptoms fairly well on my own, even though I was barely taking any steps to do so. I still spent most of my days on the couch, neglecting my academic obligations. As stated above, I was slowly demonstrating increased academic resilience, but I was not yet fully recovered enough to feel strong in my resilience. I still did not recognize it as such because I was ensconced in my suffering.

Part of that suffering was the emotional turmoil of trying to get pregnant. My attempts had been unsuccessful, and it was demoralizing. Even though the psychiatrist said we could add in Risperdal or Lithium to help with my symptoms, I resisted it because I did not want to see myself as "too crazy" to be off my medications. I was, once again, stigmatizing myself. I still wanted to portray myself as a strong individual even though I did not feel like one.

Date: February 29th, 2016

It's time for the counseling appointment I told my psychiatrist about a few days ago. Although I've been attending the bipolar support group, I haven't been seeing my individual counselor this semester. Even though I'm still physically and mentally suffering, I show up for the appointment early, check in, and situate myself in my usual chair in the waiting room. I even have my favorite drink from Starbucks at my side—a small sign of self-care.

I do not recall the conversation I had with my counselor accurately enough to reconstruct it. All I have to operate from are the notes from the counselor, which are presented below.

Counseling Records

Data: Client presented for one hour of psychotherapy to process concerns related to managing bipolar disorder. We discussed changes in functioning since our last session last fall. She reported that she has been “severely depressed” since titrating off of Klonopin and Lamictal.” She described not wanting to isolate herself but often does. She met with her provider, [psychiatrist], last Friday, and she increased her Cymbalta to the maximum dose. She described how titrating off of those medications was important to become pregnant in the future, and she and her partner are still hopeful to become so. She described some disappointment and frustration not becoming pregnant. She described sleep as having been a “refuge,” and she is now sleeping 12 hours a day. She used to sleep 8 hours a day but 10 is ideal. She is currently enrolled for 6 hours of comps and 3 hours in her last reading class this semester. We identified current mood and changes to mood. She noted a higher mood when leaving the house compared to not

leaving it. She endorsed having a few manic episodes that were shorter and less intense in duration. We discussed the possibility of planning for small but extremely satisfying dates with herself, e.g. going to her favorite coffee shop, getting breakfast, and reading for pleasure. We discussed continued self-care and normalized challenges in becoming pregnant. We highlighted continued self-care behaviors and compliance with her psychiatrist. We discussed interrupting unhelpful thinking through exceptions and challenging catastrophizing.

Assessment: Ct. [client] presented on-time, visibly tired in appearance, was motivated for therapy and displayed appropriate affect. She denied SI/HI with intent or plan. She reports a decrease in mood since our last session, and she identified mood at a 3 on average (0 = lowest, 10 = highest), at a 5 when leaving the house, and at a 1 when not leaving the house and isolating. She has developed some insight into relational distress with her family of origin. She was seeking support related to academic challenges and self-care. She may benefit from continued processing of academic, relational and mood related challenges. She may benefit from continued compliance and a follow-up with her medical provider.

Plan: We will process being strategic for self-care compared to emotional reasoning. We will follow-up on her use of self-compassion and exploring more satisfying alternatives to catastrophizing and isolation. We will process current mood including depression and mania. We will continue to explore relational functioning and becoming pregnant.

As my counselor describes, I am exhausted despite sleeping 12 hours a day. This is undoubtedly contributing to my inability to function academically and in my assistantship. I also noted how I was isolating—a trend in my life when things are not going well. As I stated earlier, I was only leaving my apartment when I had to go to class, see the psychiatrist, or attend counseling. Isolation was my method for preventing those around me from seeing through the façade of strength I was trying to project, the sense of identity I wanted to portray to the world. It was also a way to resist being stigmatized by those around me, as I feared they would perceive me as weak and crazy.

My mood was clearly low, despite periodic episodes of mania, and I was not engaging in self-care, self-compassion, or help-seeking behaviors. This was my first attempt at help-seeking all semester, and we were over a month in. I avoided explaining my circumstances to as many people as possible due to my shame. I shamed myself for not being strong enough to persevere, for experiencing symptoms of depression and mania, and for isolating myself. I felt as if everyone around me was beginning to pick up on the signs that I was not well, and I self-stigmatized as a result of fear of perceived stigma.

Going to individual therapy, per the urging of my psychiatrist, demonstrated some academic resilience, as I was beginning to engage in self-care and help-seeking behaviors. As my counselor noted, we discussed strategies for incorporating self-care into my week, something that can help with mood and overall functioning in people with mental illness. This was a beginning to demonstrating academic resilience enough that I would perceive it as such. I knew that if I isolated less, I would feel better, and I would resultantly be able to function better as a student and research assistant. I knew these

things, yet it was still challenging to start incorporating self-care into my daily life because I still felt so poorly from the withdrawals.

Date: March 10th, 2016

About a week and a half later, I was back at the Counseling Center for a follow-up appointment. Once again, I cannot reconstruct the conversation; all I can do is provide the records.

Counseling Records

Data: Client presented for one hour of psychotherapy to process concerns related to managing bipolar disorder. We discussed changes in functioning since our last session. She described experiencing a “week of rage.” She described how she was on the “verge of mania” yesterday, but she was able to pull it “back together.” She noticed that mania was increasing as twitching and a sense of energy increased. She found drinking water, having a snack, squeezing her duck pillow and social support from her husband who told her that she “is doing okay” as helpful. We discussed the possibility of providing her husband feedback on how helpful his words were. She described experiencing a number of academic demands that have increased stress including preparation for a conference in which she has 2 presentations and IRB [Institutional Review Board] work for her boss. We processed sitting with anger and frustration, resourcefulness and ways to self-care. She believes at this time that her overall functioning is better than it has been over the last couple of months, and we discussed her sense of happiness, application of self

compassion, continued social support, academic achievements, compliance with her psychiatrist and continued self-care as helpful.

Assessment: Ct. presented on-time, visibly tired in appearance, was motivated for therapy and displayed appropriate affect. She denied SI/HI with intent or plan. She has developed some insight into managing frustration and changes in mood. She has been seeking support related to academic challenges, interrupting self sabotage and increasing self-care. She may benefit from continued processing of academic, relational and mood related challenges. She may benefit from continued compliance and a follow-up with her medical provider.

Plan: We will continue to process being strategic for self-care compared to emotional reasoning. We will follow-up on her use of self-compassion and exploring more satisfying alternatives to catastrophizing and isolation. We will process current mood including depression and mania. We will continue to explore relational functioning and becoming pregnant.

This encounter demonstrates an increase in academic resilience. I was actively seeking help in the form of counseling, and, as indicated in the counselor's notes, in the form of academic supports (I cannot recall the precise nature of these, however). Despite facing challenges posed by mood (the manic episodes) and residual withdrawals (as demonstrated by my tired appearance), I was beginning to engage in greater self-care and self-compassion and identifying strategies for combating hardships posed by my mental illness.

I spoke of the stressors related to my assistantship duties and upcoming conference presentations, but I did not indicate these were compounding my stress levels more so than these usually would. This is another indicator of increasing academic resilience. I recall a sense of pride as I spoke with my counselor about my upcoming presentations, a sign that I was beginning to own my identity as an individual with mental illness again as opposed to constructing a façade of strength. Perhaps this indicates that my inner strength was reemerging.

Also of note in this counseling session is my discussion of rage and other related emotions; these are symptoms of mania and hypomania. Up to this point, these were the main symptoms of (hypo)mania I experienced: irritability, agitation, racing thoughts, and hyper-focus. I was likely experiencing an increase in manic episodes because the psychiatrist had increased my dosage of Cymbalta to the maximum, and antidepressants can contribute to the manifestation of these symptoms and mood states. Combating my depression meant risking an increase in (hypo)mania, and it appears this was happening. Nevertheless, I was engaging in self-care and using social supports in the form of my husband to manage these challenges as they arose.

Date: March 20th, 2016

I'm in bed, and my alarm goes off. I'm feeling out of sorts, as per usual. I turn the alarm off and go back to sleep. *So what if I miss the meeting? No big deal.* Today is our annual remote board meeting for a Special Interest Group (SIG) I belong to at a conference. I'm the board member in charge of our technological needs, so it's my job to

Skype everyone on the board for our meeting because not everyone (myself included) was able to attend the conference for an in-person meeting.

My phone rings, waking me up. I don't recognize the number. I do not answer. It rings again, this time from a different number. I still do not answer. I roll over, going back to sleep. My body hurts and all I want to do is sleep.

Date: March 24th, 2016

Email

Hi Ren,

[Another board member] and I tried to connect with you by phone and via Skype at the time of the Board meeting, but without success. Please let us know that you are doing well.

Best,

[name redacted]

I do not answer. I'm ashamed. I'm isolating.

Date: March 28th, 2016

I'm back from the conference, and it's time for my follow-up appointment with my counselor. As per usual, I arrive early, check in, sit in my usual seat, and sip on my Starbucks as I wait to be called back. Once again, I'm tired, but this is because I've

recently returned from a conference, and travel always causes me to feel tired for several days afterwards.

Counseling Records

Data: Client presented for one hour of psychotherapy to process concerns related to managing bipolar disorder. We discussed changes in functioning since our last session. She reported that she presented at a conference over the break [spring break] and found it “hard.” As she has not been taking Klonopin or Lamictal she has been trying to become pregnant, she reported increased worry when faced with social presentation. She reflected on how she has not experienced as much social anxiety in the past, and we discussed ways that she found support and engaged in self-care over the 3 days. She reported that she spent time in her room, spoke with her husband, and worked. She has an upcoming conference [American Educational Research Association] on April 8 (her last one for the semester). She reported an additional challenge in that she and her husband tried to celebrate her birthday upon her return, and they went to 3 restaurants trying to find a space to be seated. She described having a breakdown. She reported that she was able to accept the support of her spouse but was disappointed in herself. We highlighted how she had been stressed about the conference in the week prior, experienced significant anxiety during the conference, and was disappointed and stressed upon returning home; we used the frame of her not having had time to recharge. She reported an uplift in mood in that she went on a date with her spouse, and they had an enjoyable time for 2-3 hours. We discussed continued self-care, and we highlighted being intentional between work and play to find and relaxation. She reported that her coloring

book has been very helpful, and we discussed other helpful self-care activities that she could engage in to assist in creating a boundary.

Assessment: Ct. presented on-time, visibly tired in appearance, was motivated for therapy and displayed appropriate affect. She denied SI/HI with intent or plan. She has developed insight into managing frustration and changes in mood but has recently experienced increased social anxiety after stopping Lamictal and Klonopin. She had been seeking support related to academic challenges, relations and mood related challenges. She may benefit from continued compliance and a follow-up with her medical provider.

Plan: We will continue to process being strategic for self-care compared to emotional reasoning. We will follow-up on her use of self-compassion and exploring more satisfying alternatives to catastrophizing and isolation. We will process current mood including depression and mania. We will continue to explore relational functioning and becoming pregnant.

I recall, now having read through these notes, how I isolated at the conference. We had been working on strategies to keep me from isolating, but I found myself feeling out of place when surrounded by so many people at the conference. I was able to give my two presentations with success, but I did not attend a single presentation. The conference was in Orlando, and several of my friends decided to take a day to go to Disney World, but I could not fathom being surrounded by so many people as were bound to be at the park. I stayed in the hotel room that day, sleeping. I only left the room

to present and to go out to eat. If I could have afforded it, I would have ordered room service to avoid having to leave the room at all.

Without Klonopin, my anxiety levels were extreme. They prevented me from being a “good academic” and attending the conference I had paid at least \$1,000 to be at. I lost out on networking opportunities, and I began to question how having a mental illness could possibly be compatible with engaging in the types of activities expected of academics, such as attending conferences and networking. I started to doubt whether I was fit to be in academia as someone aspiring to become a faculty member after earning my doctorate. How would I be able to function at conferences? How would I be able to network well enough to help find a job? Was mental illness simply incompatible with being a professor? It seemed so.

Despite my difficulty functioning, I had planned ahead and brought my new coloring book and colored pencils. Coloring was something we regularly did in the bipolar support group, and I found it to be beneficial for mindfulness and self-care, so I took the initiative to buy supplies I needed to color outside of group. I recall coloring in bed at night after my roommate returned from her evening social activities, calming myself, quelling my anxiety. I was engaging in and resisting self-care at the same time: isolating yet coloring.

It shows some academic resilience that I managed to work while I was isolating in my hotel room, but a definite lack of perceived academic resilience in that I began to question whether I was cut out to be an academic. This caused an identity crisis, as well: if mental illness and academia were not compatible, what did this mean for my future aspirations? I began questioning my identity as an academic with a mental illness,

someone who wanted to devote her career to working in academia. Could I be both an individual with a mental illness and a faculty member? The two identities seemed at odds with one another. Clearly, I had some thinking to do, and I was undergoing further identity development.

Date: April 4th, 2016

It's time for my final individual counseling appointment before the conference. It's in D.C., so I'm excited and nervous at the same time. It's the largest conference I've ever attended, and I'm helping with a presentation. I've come to counseling today to do some processing before the conference. I'm anxious and want to work through it with my counselor, particularly because of my experiences of isolation and overwhelming anxiety at the conference.

Counseling Records

Data: Client presented for one hour of psychotherapy to process concerns related to managing bipolar disorder. We discussed the results to CCAPS [a survey asking how you've been feeling and behaving in the last two weeks] update, and we noted small changes in functioning as well as maintenance of overall functioning despite challenges with worry and anxiety. We process changes in mood and academic functioning. She shared that she has been feeling considerable academic stress and is preparing for a conference presentation this week. She has engaged in increased self-care and has been enjoying outside time on the balcony with her cat. She has also been dancing and stretching. She reported that she plans to also work on a proposal for a conference in

November. She expressed a desire to process ways to cope with anxiety at her upcoming conference. We highlighted practice, helpful self talk, part focused breathing and envisioning a positive outcome. We also identified helpful social support.

Assessment: Ct. presented on-time, visibly tired in appearance, was motivated for therapy and displayed appropriate affect. She denied SI/HI with intent or plan. She has developed insight into managing frustration and changes in mood but has recently experienced increased social anxiety after stopping Lamictal and Klonopin, She has been seeking support related to academic challenges, interrupting self sabotage and increasing self-care. She may benefit from continued processing of academic, relational and mood related changes. She may benefit from continued compliance and a follow-up with her medical provider.

Plan: We will continue to process being strategic for self-care compared to emotional reasoning. We will follow-up on her use of self-compassion and exploring more satisfying alternatives to catastrophizing and isolation. We will process current mood including depression and mania. We will continue to explore relational functioning and becoming pregnant.

As the counseling records indicate, I was making some progress in changes in functioning and mood, although I still appeared tired and reported experiencing symptoms of anxiety. I recall speaking with my counselor about my workload—I was feeling overwhelmed with everything I had going on (coursework, the comprehensive

exam, conferences, and my assistantship on top of managing my mental illness symptoms), and I needed solutions. He repeatedly emphasized the importance of self-care, so I told myself I would do something fun at the conference. At the end of the session, my mood had improved, and I felt positive about the upcoming conference. *I can do this. It's going to be okay. I'm rooming with Ashley [pseudonym] for part of the conference, so at least I won't be alone. That will help keep me from isolating.*

Date: April 6th-7th, 2016

It's time to get ready for the conference. I have an early morning flight on the 7th, and I have to pack. I carefully make my list of everything I need and systematically go through, line by line, packing my suitcase and carryon. *Okay, that's done. Next?* I go through the whole list until all I have left are things to pack in the morning after I've gotten ready for the trip.

I live about 30 minutes from the airport, and I don't have a car. This means I have to take a pre-arranged shuttle to the airport. It's cheaper than a cab. The latest pickup window they have is two hours before the flight leaves, and that makes me nervous. I select an earlier pickup time to ensure I'll have ample time at the airport. Because my shuttle is coming between 3:00 and 4:00 in the morning, I decide to stay up all night instead of sleeping for only a couple hours. Around midnight, my husband goes to bed, and I stay up watching *RuPaul's Drag Race*. At this point, it's worth noting that staying up all night is dangerous for a person with bipolar disorder. Our sleep cycles regulate our moods, so it can be risky to pull an all-nighter. Lack of sleep can easily propel an individual with bipolar disorder to either extreme: depression or mania. My

flight leaves early—before I’m scheduled to take my morning medications. I have to plan accordingly, deciding at what point in my trip I need to find time to get water and take my pills. I decide to take them on my layover. They won’t be on schedule precisely, but they’ll be close enough for my liking.

Eventually, the shuttle shows up, and I arrive at the airport. *I can’t wait to sleep on the plane.* Once I make it to the gate, I see I still have around two hours before the flight leaves. *What to do now? I’m kind of hungry. I guess I could get something to snack on now and finish at the conference.* I walk to a nearby snack shop and buy some crackers, a water, and a blanket. For some reason, I’m cold. I return to the gate and sit on the floor, first wrapping myself in my new blanket, then tearing into my crackers. I pull out my tablet and go online. I have a gift card for Barnes & Noble, and I want a book to read on the trip. After some searching for books about bipolar disorder (I’ve become a voracious reader on the subject since my diagnosis), I land on Marya Hornbacher’s *Madness*.

The time arrives to board the plane, and everything goes smoothly all the way to D.C. I manage to sleep on the flights, huddled under my blanket, and remember to take my medication.

Date: April 8th, 2016

It’s presentation day. A group of about four of us arrange to meet before noon, the start of the roundtable, to get prepped. We sit on the floor in the hallway outside the large ballroom where our roundtable will be, pouring through the massive conference

program to identify interesting sessions. Ashley is with me. We got ready, made a Starbucks run, and walked to the convention center together.

Something's off. It's not that I don't feel 100% because I started my period, either. It's not residual exhaustion from travel; I went to bed early the previous night and got plenty of sleep. All I know is that something is not right. I can't pinpoint precisely what it is yet.

The presentation goes smoothly. I engage with attendees, network with other presenters, and share my independent research ideas with them. Lots of business cards exchange hands. In all, it was a success, but once the presentation is over, I'm no longer putting forth a composed face. Whatever isn't right is starting to show through. I notice concerned glances from my co-presenters as we're making lunch plans and I leave to go to the bathroom. *I wonder what that's about? Did I bleed on myself or something? I don't get why they're looking at me like that.*

Date: April 9th, 2016

I've been reading *Madness*. It's a memoir of the experiences of a professional writer diagnosed with bipolar disorder. Her experiences resonate with mine until I encounter the sections in which she describes psychosis. I've never experienced psychosis; all I know is it terrifies me. I'm still feeling off, and I cannot figure out what's wrong. There's nothing concrete I can point to and say "Aha! I've figured it out!" At this point, I lack the insight to piece together what I feel with symptoms of bipolar. I cannot even put words to what I feel. I do not attend the conference; instead, I stay in the hotel room, lying in bed in the dark.

It's Ashley's last night in D.C. This means I'll be on my own until I fly home the morning of the 12th. *What am I going to do without her? Maybe I can get Olympia [pseudonym] to come stay with me instead of sleeping at her AirBnB. I can't be alone.* I'm on edge at the prospect. I remember all too vividly how much I felt anxious and how much I isolated at the last conference, and I do not want to repeat that here. I try to remember what my counselor said about self-care and combating negative self-talk. I've been given the tools to help me combat my anxiety, and now I have to see if I can successfully implement them.

Date: April 10th, 2016

Ashley is gone. Now it's just me in the hotel room. Olympia insists on staying at her AirBnB. *It's going to be okay. You can do this. Find people to do conference things with.* Easier said than done. The conference is massive, and it's unlikely I'll find a session to attend that someone I know will be interested in. Instead, I opt to spend the day alone, walking around downtown D.C. and going to the National Geographic Museum.

Before hitting the museum, I stop at Au Bon Pain for lunch. I've never been to one before, so I find myself asking a lot of questions of the one available employee. We strike up a conversation.

"Are you from here?"

"No, I'm just in town for a conference. I'm from Texas."

"Oh, so you need someone to show you around the city! Do you like wine? We could meet up tonight, and I will take you around. We'll have a good time."

“Um, okay.”

“Are you free around seven?”

“I think so.”

“Here, you can put your number in my phone, and I’ll call you later.”

Oh, holy crap, am I really doing this? What’s wrong with me? I type my number into his phone, hands shaking.

“Wonderful! I will see you then!”

I’m just finishing up my meal, so I stand up to leave. He opens his arms for a hug, and, not knowing how else to respond, I allow him to hug me. I smile and wave as I leave. *Oh God, what did I do? Why did I give him my number? He’s a stranger. I never do this. What’s wrong with me?*

Next stop: the National Geographic Museum. After looking at the exhibits, I stop at the gift shop to see what I can get to bring home. They have a plethora of stuffed animals of all species—I am drawn to the cats. I pick out a lion and a leopard, pay for them, and walk back to my hotel, contented.

Later that night, around 7:00, my phone rings. I do not recognize the number. I do not answer. I know it was him. When I call my husband at night, I do not tell him about my encounter; I’m too embarrassed.

The signs of mania were creeping in. I was impulsive, not thinking through the consequences of my actions, giving my phone number to a complete stranger in a strange city. As an introvert, this is not like me. I finally start to recognize the mania at play. I’m slowly developing some self-awareness.

I end the night in a frenzy: dancing around my hotel room, digging furiously through my suitcase in search of something elusive, talking rapidly to my new stuffed animals. I'm exuberant but agitated because I can't find what I'm looking for and I don't have anyone to talk to. Energy surges through my body, and my mind is racing so quickly I struggle to keep up with my thoughts. They begin to blur together, forming one incoherent line of thought. Clothes fly around the room as I continue digging, digging, endlessly, looking for something I must have at that exact moment. Chattering fills the room. I do not stop talking for a second. I must keep talking. The ideas are too plentiful to hold in my brain; they have to be spoken.

I eventually give up on my search. I cannot find what I'm looking for. In fact, I'm not entirely sure what I'm looking for anymore. Hopping from foot to foot, humming a tune of my own making, I jump into bed, stuffed animals in hand. I want my husband to see them, so I go about arranging them around me to take a selfie to send him. They're soft. I take picture after picture, arranging and rearranging the stuffed animals, trying to get the perfect picture. It's too tedious. It takes too much finesse for my body to handle. I need rapid, almost desperate or frantic movements to satisfy the energy I feel inside. I give up, pick the best picture, and text it to my husband.

As I'm going to bed that night, I read part of *Madness*. The sections describing Marya's experiences of mania and psychosis are starting to bother me. They make me uncomfortable, and I'm not yet sure why.

Date: April 11th, 2016

At Olympia's urging, I go in the morning to a session specifically for graduate students intending to become faculty. She arrives at my hotel around 7:30 a.m.—it's an 8:00 session, and we have to walk to the convention center. It's a dark, gloomy morning, rain sprinkling down as we walk. Of course, we make a quick stop at a Starbucks to grab coffee and pastries for breakfast. As we're walking, we begin to talk about how I've been doing. I can feel myself talking quickly, faster than I normally do. *Maybe I should have ordered decaf.*

“How are you feeling?”

“I think I'm manic. I probably shouldn't be drinking an Americano right now.” Energy surges through my body. I feel twitchy, electrified. As if my eyes are wide open, as open as they will go. My feet cannot move quickly enough; it almost hurts to walk at my normal pace. “It might be because I stayed up all night before coming here. I haven't felt right since I got here. I just feel on edge, twitchy, strange. And exhausted at the same time.” The exhaustion should have cued me in that I was experiencing a mixed episode, not mania. Mixed episodes are precisely what they sound like: an intermingling of depressive and manic symptoms. What, exactly, a mixed episode looks like depends on the person, but I've often heard it described as a state in which you want to claw your skin off or you're so depressed you want to die and actually have the energy to follow through with it. It's a dangerous state to be in.

Olympia and I arrive at the convention center. She's forgotten her conference badge, so we have to sneak around security to get to the session we want to attend. At first, the session is pleasant enough. There's food, and it's a small group of graduate students discussing their career aspirations with current faculty members. *Ask them*

about self-disclosure and working at a research institution. Ask them. Do it. I sit in silence, wringing my hands. Suddenly, I can't be in the room any longer. I quietly get up and go to the bathroom. When I return, the session is still going on. *I can't be here anymore. I need to leave. Why isn't this over yet? How much time is there left?* The minutes physically hurt. Sitting still is painful in a way I've never experienced before; it's different than fibromyalgia pain—it's a psychological pain as well as a physical urge to move. I keep checking my phone to see what time it is. The session finally ends, and I whisper to Olympia that I'll meet her outside by the bathrooms.

A few minutes later, she joins me.

"Are you okay? I thought you were fine, but then you got up, and you didn't seem okay after that. You didn't say anything the whole time."

"Yeah, I'm not feeling very good. I think I need to go back to the hotel and lie down. You can keep my badge if you want to go to more sessions."

"Do you want me to walk you?"

"No, I'll be okay. I just need to leave right away."

"Okay. I guess I'll see you back at school."

"Okay. Have fun. Safe travels!"

Escape. The cool air hits me as I step outside, brushing away some of the nervous energy. I start the short walk back to the hotel; it should only take fifteen to twenty minutes. As I walk down the sidewalk, I pull my hoodie around myself, zipping it up all the way to my chin, yanking the hood over my head, and shoving my hands tightly into the pockets. I feel twitchy. It's as if my body is shaking as I walk. I cannot walk fast enough. No matter how much I increase my pace, I feel like I need to walk faster. Too

much energy. My eyes dart frantically around, taking in the people, cars, and buildings. As I pass people on the sidewalk, I scrunch down into my hoodie, retreating from view as much as possible. I can feel my eyes are open wider than usual. *I look like a homeless person. I look like I'm crazy, too. Everyone can tell. I have to get back to the hotel where I'm safe and no one can see me. They know. They all know.*

I arrive at the hotel and swiftly walk to the elevator, trying to get to my room as quickly as possible. *I have to get where I'm safe. It isn't safe here. There are too many people.* I enter the dark hotel room, leaving the lights off and the drapes drawn closed. In the ambient light, I search for my tablet. It's going to be lunch time before too long, and I need to eat something, but I can't leave my hotel room. I look up places that deliver.

After lunch, I try sleeping to pass the time. It's not a successful endeavor. Instead, I wind up reading more of *Madness*. I'm on a section describing psychosis, and it's starting to resonate. *So that's what psychosis is like. Am I psychotic right now? I might be. I'm not having hallucinations, but it feels like people can look right into my brain. Is that why the psychiatrist always asks if I think people are reading or trying to steal my thoughts?*

Clearly, I was starting to develop an increased sense of awareness about my symptoms, but I was fearful of being psychotic. That would mean I was crazier than I thought. I always thought psychosis was something other people experienced, not something I would ever have to deal with. It's most commonly associated with Bipolar Type I, and I was diagnosed as Bipolar Not Otherwise Specified. Psychosis was not supposed to be one of my symptoms. This was the beginning of another shift in identity

caused by an identity crisis. I was no longer certain of who I was and what my bipolar was—I had never felt this way before. I felt terrified.

Date: April 12th, 2016

I'm returning home today. I feel out of sorts. I still feel like people can look at me and tell I'm crazy. I huddle in my seat, wrapping my hoodie and travel blanket around myself as tightly as possible to help hide myself from view, clutching my stuffed leopard.

We've boarded the plane, and I'm sitting by a window. Rain is rolling down it. *The world is crying for me.* I feel tears welling up and fight them back. *People will really know I'm crazy if I cry. I can't cry.* I put on my headphones to listen to music, selecting Toh Kay's *Streetlight Lullabies*. We sit on the runway for quite a while, long enough that I've reached the final track on the album, "A Better Place, A Better Time."

And so she wakes up / In time to break down / She left a note upon the dresser /
And she's right on time / You don't know anything / Right or wrong /
I say I know / And she says so / I wanna panic / Yeah, I've had it / I go /
"You don't owe anything / To anyone / But don't take your life /
'Cause it's all that you've got / You'd be better off just up and leaving /
If you don't think they will stop / And when you wake up /
Everything is gonna be fine / I guarantee that you'll wake in a better place /
In a better time / So you're tired of living / You feel like you might give in /
Well don't / It's not your time" / Looking through the paper today /
Looking for a specific page / Don't wanna find her full name /

Followed by dates / 'Cause when I left her alone / She made a sound like a moan /
"You're known / By everyone / For everything you've done" /
Fuck buying flowers for graves / I'd rather buy you a one-way / Non-stop /
To anywhere / Find anyone / Do anything / Forget and start again, Love /
She said she won't go / It hurts too much / To stand by /
You've gotta stop and draw a line / And everyone here has to choose a side /
Tonight / The moment of truth is haunting you / Don't forget your family /
Regardless what you choose to do / You can't decide / And they're all screaming /
"Why won't you?" / I'll start the engine / But I can't take this ride for you /
I'll draw your bath / I'll load your gun / But I hope so bad /
That you'll bathe and hunt / And she's tired of forgetting about today /
And always planning for tomorrow / Yeah, tomorrow and she said /
"The saddest day that I came across /
Was when I learned that life goes on without me / Oh, without me" and she said /
"If everyone has someone else / I ain't got nobody's love to save me /
Yeah, to save me" and she said / "I think I'll pass away tonight /
It seems I'll never get it right if it's just me / Yeah, it's just me" and she said /
And when you wake up / Everything is gonna be fine /
I guarantee that you'll wake in a better place / In a better time /
So you're tired of living / You feel like you might give in / Well don't /
It's not your time / And she said she wouldn't mind /
If they never find a cure to all her problems / Her problems and she said /

As long as she had someone near /
To make it clear she doesn't need to solve them /
Yeah, to solve them and she said / “This loneliness / It’s killing me /
It’s filling me with anger and resentment / Yeah, resentment” and she said /
“I’m turning into someone that / I never thought I’d have to be again” /
And when you wake up / Everything is gonna be fine /
I guarantee that you’ll wake in a better place / In a better time /
So you’re tired of living / You feel like you might give in / Well don’t /
It’s not your time / And even if it was / I wouldn't let you go /
You could run, run, run, run / But I will follow close / Someday you’ll say /
“That’s it, that’s all” / But I’ll be waiting there /
With open arms to break your fall / I know / That you think /
That you’re on your own / Know that I’m here / And I’ll lead you home /
If you let me / She said “Forget me” / But I can’t (Kalnoky, 2011)

Tears stream down my face as I stare out the window, listening. I clutch my stuffed leopard even closer, burying my face in it, trying to hide the tears from the people sitting in my row.

Date: April 13th, 2016

I’m back from the conference, and I’m able to get an emergency appointment with my psychiatrist to discuss my new symptoms: the mania and psychosis.

Medical Records

Reason for Appointment

- 1. psy f/u for recent psychotic episode (see triage note) Pt last seen on 02.26.16. Still has 04/18/16 appt noted*

History of Present Illness

Psych f/u:

HPI This patient is a 31 year old Caucasian female for a unscheduled follow up regarding BPD NOS [Not Otherwise Specified], GAD, Agor + Panic D/O, PTSD. At last f/u increased cymbalta.

Histories reviewed – Past Medical Family Social Allergies Hospital/Surgical

Stressors include – Financial, Academic, Relationships, Medical

*Medications, effects, and side effects – **Cymbalta – increase did help with depression; may have made her manic and paranoid; no other known or physical side effects***

Mood changes since the last visit

sad/down/empty – worse

anger/irritability – worse

Denied: euphoria

stress/anxiety – worse

GRADES severe; is back to cycling [between mood states] within 1 week.

Sleep – Worse.

Energy – Worse (extremely variable).

Interest – Worse when down.

Concentration – Worse.

Appetite – Worse/decreased.

Manic symptoms – Increased: impulsivity, rapid speech/thoughts, or excess energy/GRADES severe.

Anxiety symptoms

Increased: worrying, panic attacks, /GRADES severe

Stable PTSD.

Perception symptoms

denies: hallucinations, illusions

Gets brief flashes of images of cutting her arm

Feeling more paranoid and that things are really scary.

Like everyone is watching her. Some possible IOR [Inhibition of return, a perceptual concept that has to do with how one perceives actions as taking place in time]

Maybe once object was distorted.

NO: TI, TB [what these are is unclear]

Thoughts of Harm/Death – (suicidal/homicidal/mutilation)

Wanting to die or not be alive - ? last yesterday am (“flash” of herself cutting her arm/ very brief, no act or intent) Scared her

Wants to harm self – denied except as above

Wants to kill self – maybe as above

(in the past has never cut deep enough to cause serious physical injury, just ot [to]

decrease emotional pain, not to kill herself and not more than superficially)

Denied: HI

Current Medications

Taking

- *Loratadine 10 MG Tablet 11 table Once a day*
- *Prenatal Multi + DHA*
- *Cymbalta 20 MG Capsule Delayed Release Particles – 1). 3 Q am and 2 Q noon X 10-14 days 2). 3 Q am and 3 Q noon thereafter, Notes: 3 Q am and 3 Q noontime*

Examination

Psych:

General VS and nurse intake reviewed above.

Appearance Appears well, stated age, normal rate of speech and psychomotor activity, Spontaneous speech. No observable muscle tightness, stiffness, tremor, or spasms.

*Mood/Affect Appropriate mood and affect, , **Affect range increased/** , **Affect intensity increased/**, **Anxious – moderate/severe.***

Orientation/Memory Alert and oriented X 3; Concentration good via conversation;

Recent and Remote memory intact.

Thought process/Cognition Coherent, logical, directed., Judgement/Insight/Abstraction adequate, No aud/vis halluc., paranoia, grand/persec. delusions.

Suicidal ideation No suicidal thoughts, ideation, plan, or attempts.

Homicidal ideation No homicidal thoughts, ideation, or plan.

Assessments

SAFETY ASSESSMENT (FOR SELF/OTHERS) Good insight into nature of perceptual distrubances and is able to ignore them. Decl[ined] voluntary psych admission, and is not currently committable. Husband is here to assist meanwhile/provide supervision and

has been notified of above thoughts already by pt. Has 2 apoints at CC [Counseling Center] next week (IT/Grp [Group]).

Treatment

1. Other bipolar disorder

Stop Cymbalta Capsule Delayed Release Particles, 20 MG, -, Orally, 1). 3 Q am and 2 Q noon X 10-14 days 2). 3 Q am and 3 Q noontime thereafter, Notes: 3 Q am and 3 Q noontime

Start Cymbalta Capsule Delayed Release Particles, 20 MG, -, Orally, 2 Q am and 2 Q noontime, 15 days, 60, Refills 1

Start Risperdal [an antipsychotic] Tablet, 1 MG, -, Orally, 1). 1 QHS X 3 pms [abbreviation unclear] 2). 1 & 1/2 QHS X 3-5 pms 3). 2 QHS X 3-5 pms \$. 2 & 1/2 QHS final dose, 15 days, 23, Refills 1

Notes: Pt with history of significant depression when on lower dose of cymbalta, and is aware of risks mania until stabilized on risperdal

Also with history of severe neurotransmitter withdrawal [sic] (SE and NE [abbreviations unclear]) on cymbalta

will do routine labs for atypical antipsychotics once stabilized that she tolerates this new class medic. [medication]

Clinical Notes: Discussed plan:

- 1. decrease cymbalta by 40 mg total (20 mg each dose) – pt to cont with taper by 20 mg Q 3 days if cont mania and increased depression – pt agreed*

2. *trial Risperdal – Informed Consent for Atypical Antipsychotics completed/Pt Educ[ation] Sheets given (declined restarting lamictal due to still planning on attempts to become pregnant this upcoming fall).*

2. GAD (generalized anxiety disorder)

Clinical Notes: cont IT [counselor] at CC.

3. Agoraphobia with panic disorder

Clinical Notes: avoid BZDs for now.

4. Chronic post-traumatic stress disorder (PTSD)

Clinical Notes: cont IT.

Follow Up

2 Weeks (Reason: medmgt)

What's noteworthy in the medical records are the shift in medications and my revelations of flashes of self-harm. Sometimes, out of nowhere, I would see, vividly in my mind's eye, my outstretched left arm, fist clenched, my right hand holding a knife, then slicing into my left arm, blood seeping out of the open wound. I could almost feel it piercing my flesh, and I would close my eyes as tightly as possible, as if to ward off the image. *No! Stop, stop, stop! I don't want to hurt myself!* These flashes would happen at random times—there was no predicting it, so there was no preventing it. Needless to say, it was terrifying. I resisted the impulses every time; I never gave in and carried out what the images urged me to do, but they were disturbing nonetheless. It was as if I had lost control over my mind. I no longer was master of my own cognition; rather, it controlled me. The images came without fail. The paranoia seeped in whenever I left the

apartment. I knew people could tell, with one glance, that I was crazy, and it was a new kind of crazy now: it was antipsychotic crazy.

Now, I had to reconceive of what it meant to be an individual with bipolar disorder. It wasn't just about mood swings anymore. It was about fear, a deep terror, really, and lack of control. Too much energy. Too vivid an imagination. Too much of everything. Too, too, too. The ordeal overwhelmed. I had been propelled into a terrifying place of mania and paranoia (psychosis) that I never thought I'd inhabit. I had to start reconstructing my identity as an individual with a mental illness. I also, to some degree, was perceiving stigma, or at least anticipating encountering it. What would people think if they knew I was taking an antipsychotic? Would they see me any differently? Would they think I was crazier now?

Date: unknown; sometime following the psychiatry visit.

"I just want to rip my skin off!" Sobbing uncontrollably. Tears. "I can't sit still. It hurts!" Rocking back and forth, I clutch my arms, digging my finger nails into my flesh until it stings. The pain is a slight relief.

"Do you want to go for a walk?" My husband is sitting next to me on the couch, looking at me with concern.

"No!" I'm lying. Of course I want to go for a walk. I want to do something, anything, that will divert all my energy. The only problem is the people I know we'll encounter. They'll look at me and know I'm crazy. People can just tell. "I don't know what I want to do!" The sobbing overcomes me, and I can no longer speak coherently. I'm curled in a fetal ball, rocking.

“Come on, let’s go for a walk. It’ll make you feel better,” my husband says gently.

“But where are we going?” I manage to croak out between sobs.

“Wherever you want. Do you want to go get some cookies? A ginger ale?”

I wipe my eyes with my sleeves and sit up. Meekly, “Can we go listen to the frogs?”

He puts his hand on my shoulders. “Yes, we can go listen to the frogs.”

“And then get me a ginger ale? I’m thirsty.”

“Okay.”

We get our shoes on and head out into the night. It’s dark and cool, and you can see the stars overhead. I stare up at them, mouth open, as we walk through the parking lot. My arms are wrapped tightly around my body, the hood of my hoodie pulled up over my head. *For safety.*

Everything’s going smoothly so far. We’ve made it to the ponds where the frogs live, and I’m happily listening to them sing their nightly tune. We’re about to walk to the last pond when trouble arises. *People.* I clutch onto myself again, instantly stiff, no longer relaxed. I hunch over as much as possible to keep myself from full view. *They know. They can see.* My breathing quickens. I grab for my husband’s hand, walking as quickly as possible to get past the small group. I feel as if my body is shaking as I walk. *I know they know. I need to get out of here.*

We successfully evade the small group, but I cannot manage the anxiety attack. I start crying, breathing loudly, hyperventilating, trying to speak in between breaths. It’s unintelligible. My husband holds my hand and tells me it’s okay. *Liar.*

We arrive back home, about half my ginger ale gone, sucked down on the walk home, during which we blessedly did not encounter any more groups of people. I kick my shoes onto the pile by the door and flop on the couch, relaxing a little. “I’m crazy, aren’t I?”

“No.”

“But I am! People can tell!” The tears start again.

I’m not sure how the conversation starts, but we turn to discussing our plans to have a baby.

“We have to think about your wellbeing first.”

“But I want to have a baby!”

“But you’re not well right now.”

“I don’t want to go back on my medications! Don’t you remember how hard they were to come off of? Did I seriously put myself through that for nothing?”

“I know it was hard, but how can you be a mom if you’re not well?”

The tears stream down uncontrollably. A whisper: “I knew I was too crazy to have a baby. You think I’m crazy, too. You’re going to have them lock me up. I know it!”

“I don’t want anyone to lock you up, but if you keep having episodes, I’m going to have to call 911.”

“No. . .” The shout dissipates into a whimpering plea. “Don’t let them take me away. They won’t let me out.” Sobbing makes it difficult to talk. “Don’t lock me up. Please?”

Date: April 18th, 2016

It's my first counseling appointment since the conference and my psychotic break. I know everyone is looking at me, judging. I avoid eye contact, staring at my phone, blankly, waiting for my name to be called. Everything is in a haze of Risperdal. The antipsychotic is starting to combat the mania, but it's leaving me drained and in a fog. It's not going to be a happy appointment—we have to talk about the decision my husband and I made not to have a baby. He was right: I needed to take care of myself first. I was a danger to myself when I had mixed episodes. I cannot recount all the times I ran away from home in a mixed state in the following month, threatening not to return home or to kill myself.

Counseling Records

Data: Client presented for one hour of psychotherapy to process concerns related to managing bipolar disorder. We discussed changes in functioning since our last session. She reported that she recently saw [psychiatrist] after having a mixed episode at a conference in DC. She described how cognitions changed during the next episode in that one night she started to believe that a lot of people were out to get her. She described mania and paranoia and had difficulty attending the conference. [Psychiatrist] prescribed Risperdal at her visit, and she is currently adjust to “what feels like a hangover.” Since beginning Risperdal, she reports significantly reduced paranoia. We processed fear around paranoia, and we explored unhelpful thinking about “being locked up and that something bad was going to happen.” She will meet with [psychiatrist] next Wednesday for a blood test and follow-up. She described a relational uplift in that both of

her parents are coming to visit this week. She described some ongoing academic stress related to finishing her semester on Wednesday and needing to write a paper by then. We discussed imagery and self-care, and we identified that a picture of her Milton [a cat] as helpful to remind her that, "she can love and do." We discussed continued self-care. She shared that she and her husband have decided to pause on getting pregnant, and she believes that this would be helpful to focus on self-care at present. She is not planning on taking classes this summer and will focus on writing for her thesis [this should be comprehensive exams]. We discussed ways to move forward on her paper due Wednesday.

Assessment: Ct. presented on-time, visibly tired in appearance, was motivated for therapy and displayed affect that included nervousness, jitteriness and discomfort. She denied SI/HI with intent or plan. She has developed insight into managing frustration and changes in mood but has recently experienced increased social anxiety after stopping Lamictal and Klonopin and most recently a mixed episode with mania and paranoia. She has been seeking medical support to cope with changes in medication, support related to academic challenges, interrupting self sabotage and increasing self-care. She may benefit from continued processing of academic, relational and mood related changes. She may benefit from continued compliance and a follow-up with her medical provider.

Plan: We will continue to process being strategic for self-care compared to emotional reasoning. We will follow-up on her use of self-compassion and exploring more satisfying alternatives to catastrophizing and isolation. We will process current mood including

depression, paranoia and mania. Client will contact the Counseling Center to schedule her next appointment.

I had one more academic hurdle: my final paper for my final class. It was a research proposal, and I had talked through a tentative timeline with my counselor for getting the paper done on time. He was helping me make good academic choices and supporting me in my attempts to be academically resilient. Despite giving up on the hope of having a baby; encountering psychosis, mania, and mixed episodes; and going on an antipsychotic that had severe side effects that interfered with my ability to focus and process information, I was trying to put a plan in place to help me succeed in completing my final assignment. What's more, I was beginning to view this as academic resilience. I was acutely aware of everything I was going through and how it compounded to make my situation difficult at every angle, but I was encouraged by my ability to forge a plan of action. At this point, however, I still only leave the apartment to attend my class, counseling appointments, and doctor's appointments.

Date: April 20th, 2016

I open my email on my phone to see what's come in. Butterflies flood my stomach. There's an email from my advisor with the program director carbon copied on it. *This can't be good.*

Email

Hi, Ren,

I'm following up on where you are in regard to GRA work. The last time we talked you were still recovering and finding it difficult to complete GRA tasks due to self-disclosed non-academic reasons. Is that still the case? If you're still recovering and unable to work, please let know so I can complete or reassign the [specified] tasks.

Take care,

[Supervisor]

I do not reply to the email. I don't know what to say. I'm barely leaving my apartment, still suffering from the fogginess and drowsiness brought on by the Risperdal and the lingering effects of the psychosis and mania. I'm not leveled out enough to function optimally. I can't bring myself to tell my supervisor what's going on. Not yet. It's too overwhelming, and I'm afraid of the repercussions. *What if I get fired? What if they won't assign me to an assistantship next year because I did such a terrible job this year? What if they think I'm too crazy to do my job?*

Date: April 22nd, 2016

My parents have arrived after their three-day drive from Michigan. My husband and father are out picking up dinner while my mother and I sit on the balcony, enjoying the evening breeze. We're discussing the trip down, when, all of a sudden, my mother blurts out "So when are you going to realize you just need to adopt?"

I want to cry. I can't let her see me cry. *The only reason they came to see me is because I'm crazy now. It took two and a half years to get them to visit, and it's only*

because I'm crazy. They never would have come if it weren't for that. And now she thinks I'm too crazy to have a baby.

Date: April 25th, 2016

My parents are still here, but they insist that I keep my counseling appointment, so I'm at the Counseling Center waiting to be called back. I feel jittery but happy. I'm excited to tell my counselor about how my visit with my parents has been going, even though it hasn't all been perfect or encouraging.

Counseling Records

Data: Client presented for one hour of psychotherapy to process concerns related to managing bipolar disorder. We discussed changes in functioning since our last session. She reported that her parents arrived Friday evening, and they went to [local tourist towns]; she reported having an enjoyable time. She described changes in mood and medication compliance as "hitting a therapeutic point" in which she feels "less drugged" and has been better able to maintain attention and mood. She described how she made it through an afternoon/evening class, wrote a paper, and starting writing her review for comprehensive exams. She is hopeful again to teach in the fall, and she expressed some worry about the possibility of not being able to do so. We discussed next steps in self-care and social support. We processed ways that she has continued to push out worry. We discussed next academic steps that include assistantship hours over the summer, going to her cousins wedding, working on her dissertation over the summer, completing manuscripts for publication and getting recharged/centered.

Assessment: Ct. presented on-time, visibly tired in appearance, was motivated for therapy and displayed affect that included nervousness, jitteriness and discomfort. She denied SI/HI with intent or plan. She has developed insight into managing frustration and changes in mood and in recovering from and mixed episode with mania and paranoia. She has been seeking medical support to cope with changes in medication, support related to academic challenges, interrupting self sabotage and increasing self-care. She may benefit from continued processing of academic, relational and mood related challenges. She may benefit from continued compliance and a follow-up with her medical provider.

Plan: We will continue to process being strategic for self-care compared to emotional reasoning. We will follow-up on her use of self-compassion and exploring more satisfying alternatives to catastrophizing and isolation. We will process current mood including depression, paranoia and mania.

As indicated in the counseling records, I was increasing my sense of academic resilience. I successfully made it through a three-hour class despite feeling hazy and drowsy from the Risperdal. I completed a paper. I worked on my comprehensive exams. I drafted a plan of everything I wanted to accomplish over the summer when I wouldn't be taking classes. I was motivated, starting to feel better, and determined to do better. Sure, I still saw myself as crazy—I was still experiencing periodic mixed episodes and paranoia—but I was propelling forward, albeit at what felt like an agonizingly slow pace.

Date: April 26th, 2016

I'm sitting on my couch in the middle of the day, not doing anything, as usual. Feeling somewhat empowered by my counseling appointment the previous day, I open up my email and start typing a reply to my supervisor. I read and reread the email, pouring over every word and weighing how it sounds. Every word has to be just right. I have to describe everything accurately without sounding "too crazy."

Email

Hi [Supervisor],

I had a bipolar relapse some weeks ago and again am trying to get on my feet. I'm finding that I'm having trouble feeling comfortable emailing/calling people; part of that process triggers anxiety and at times psychosis. Something I think I've learned about myself through this is that large-scale research, and perhaps full-time research, does not mesh well with my mental illness. I know I haven't done myself or you any justice as a GA this year. I guess I don't really know what it is that I feel capable of doing in this position because interaction with others has become so challenging for me.

Best,

Ren

Here lies an example of identity shift, not as a college student with mental illness, but as an individual aspiring to work in academia who has a mental illness. I was questioning if I had what it took to be successful at a research institution like the one I was attending school at. Could I be a researcher? Could I meet the demands of tenure? Would I be able to do it and maintain my mental health? I wasn't sure anymore. I couldn't complete simple tasks like sending emails—how was I supposed to teach and research and publish and do everything else expected of a tenure-track faculty member? I lost faith in myself.

Although I did not recognize it as such at the time, this was also an instance of academic resilience. I sought help, despite not knowing what kind of help I needed. I reached out and was honest about my illness and how it was interfering with my work. Instead of isolating, as my counselor had been coaching me not to do, I was reaching out, putting my mental illness center stage. I opened myself up to be judged, but I was not.

Email Response

Thank you for letting me know, Ren.

Take care,

[Supervisor]

That was the last communication I had with my supervisor that semester. I felt shame, but I did not feel stigmatized.

Date: April 27th, 2016

It's time for my follow-up appointment with the psychiatrist to assess how well the Risperdal is working. In short: it's not doing much. I'm not exactly pleased about that, but I understand the trial and error nature of finding the correct medication, so I'm hopeful that we can come up with a solution together. As I'm checking in, I noticed the reason for my follow up is listed as BPD-I [Bipolar Disorder Type I]. I'm no longer Not Otherwise Specified. *Interesting. All it takes to get reclassified is a psychotic break.*

This opened up an opportunity for self-stigmatization: I had been reclassified from the mildest form of bipolar to the most severe. I was extra crazy now that I'd had a psychotic break and full-blown mania. My feelings were conflicted—it was nice to feel validated that I wasn't Not Otherwise Specified, but at the same time, I wasn't sure I wanted to be Type I. Whether or not I stigmatized myself in this instance remains unclear.

Medical Records

Reason for Appointment

1. *Est Pt here today for spy f-up from 4/13/16 for BPD, GAD, PTSD.*

History of Present Illness

Psych f/u:

HPI This patient is a 31 Caucasian female for a scheduled follow up regarding Bipolar, GAD, Agoraphobia with Panic D/O, PTSD. At last f/u rec[ommended] decreasing cymbalta and trial risperdal..

Histories reviewed – Past Medical Family Social Allergies Hospital/Surgical.

Stressors include – Financial, Academic, Relationships, Medical

(spring 2016 cl[asses]; no summer cl; will be enrolling in Fall 2016; works as GA).

Medications, effects, and side effects

Cymbalta – Helps with symptoms depression/anx enough; No known side effects

Risperdal – Helps with symptoms mania/depression; some residual sleep interruption; no other known side effects.

Mood changes since the last visit

sad/down/empty – improved/GRADES mild

anger/irritability – improved/GRADES mild

euphoria/giddiness – improved/GRADES mild

stress/anxiety – improved/GRADES mild

Sleep – Improved (fall asleep ok; still interrupted 1 X in night for 5/7 nights at least);.

Energy – Improved.

Interest – Improved.

Concentration – Improved.

Appetite – Improved.

Manic symptoms – Significantly improved; impulsivity, grandiosity, increased sex drive, rapid speech/thoughts, or excess energy (had 1 episode of extra happiness and jitteriness lasting couple hrs yesterday).

Anxiety symptoms

Improved: worrying, panic attacks (only a couple of these in last 1 mo and only prior to reaching max dose risperdal), PTSD.

Perception symptoms – denies hallucinations, illusions, paranoia, or through disturbance (paranoia gone on this higher dose risperdal).

Thoughts of Harm/Death – (suicidal/homicidal/mutilation) Want to die or not be alive –denied

SIB: last 1 week ago (just as started final max dose risperdal); clarified as brief flashes or images of her doing self harm

Denied: wanted to kill herself or others.

Current Medications

Taking

- *Loratidine 10 MG table 1 tablet Once a day*
- *Prenatal Multi +DHA*
- *Cymbalta 20 MG Capsule Delayed Release Particles – 2 Q am and 2 Q noontime*
- *Risperdal 1 MG Tablet – 1). 1 QHS X 3 pms 2). 1 & 1/2 QHS X 3-5 pms 3). 2 QHS X 30=-5 pms 4). 2 & 1/2 QHS final dose, Notes: taking 2 & 1/2 QHS*

Examination

Psych:

General VS and nurse intake reviewed above.

Appearance Appears well, stated age, normal rate of speech and psychomotor activity, Spontaneous speech. No observable muscle tightness, stiffness, tremor, or spasms.

*Mood/Affect Appropriate mood and affect, affect normal range /, **Affect intensity increase sl[ightly]/, Anxious – mild***

Orientation/Memory Alert and oriented X 3; Concentration good via conversation; Recent and Remote memory intact.

Intellectual functioning Avg./adequate fund of knowledge, Vocab app for education level, App conversation.

*Thought process/Cognition Coherent, logical, directed.,
Judgement/Insight/Abstraction adequate, No aud/vis halluc., paranoia, grad/persec. delusions,*

Suicidal ideation No suicidal thoughts, ideation, plan, or attempts.

Homicidal ideation No homicidal thoughts, ideation, or plan.

Treatment

1. Other bipolar disorder

Refill Cymbalta Capsule Delayed Release Particles, 20 MG, -, Orally, 2 Q am and 2 Q noontime, 15 days, 60, Refills 2

Start Risperdal Tablet, 1 MG, -, Orally, 3 QHS, 30 day(s), 90, Refills 2

Clinical Notes: Discussed options for management of residual sleep disturbance with risperdal: written as total 3 mg QHS using same 1 mg strength

- 1. 2 & 1/2 QHS initially and then 1/2 prn [when necessary] if awakens and u/a [unable] rtn [return] to sleep within 40 mins*
- 2. or 3 QHS*

Pt may try each, notify provider of best methods at next f/u.

2. GAD (generalized anxiety disorder)

Clinical Notes: cont IT at CC

3. Chronic post-traumatic stress disorder (PTSD)

Clinical Notes: IT

BZDS contraindic [benzodiazepines contraindicated] – pt still planning on getting pregnant soon.

Follow Up

2 Months (Reasons: medmgt)

Although the medical records indicate I was getting better, I wasn't improving much. I still felt like clawing my skin off on a nightly basis. My husband still had to force me to take nightly walks to burn off some of my excess energy. I was still, from time to time, running away from him, trying to hide, get lost, or kill myself. It disheartens me that none of this is reflected in the medical records. From reading them alone, one would think I was getting better quickly, but I was not. I find the medical records from this time period particularly unsatisfying because they do not capture the full picture of what was going on in my life. They are too clinical, too detached from the reality of my everyday existence.

What shocks me most about reading these records is how my diagnoses are described, particularly for the bipolar. "Other bipolar disorder" does not match up with what I saw on the check-in screen (BPD-I). My psychiatrist never brought it up. I felt as though I was being lied to, and I started to distrust her. If she couldn't be honest with me about something as simple as a reclassification of my disorder, how could I trust that she would make the best decisions for my mental health? I left the appointment dissatisfied. The Risperdal wasn't working quickly enough for my liking, and the small increase we made (half a milligram) didn't seem like it would do much to quell the residual mania.

As I read through these records now, I'm surprised by how poorly they reflect what I was feeling. They indicate I had improved since my last visit, but I had only done so marginally. Why did the records not show that Risperdal wasn't helping me improve fully? I still felt crazy.

Date: April 28th, 2016

Email

Dear Ren,

I do hope that this note will find you well. Since I haven't heard from you since before the [name redacted] conference, I am concerned about your health. I am also sorry you were not able to provide a remote Skype connection to the Board meeting for yourself and other absent Board members. As you can see in the emails below, I tried to call you and Skype you, but never heard back from you.

It looks like you may need some time off the [SIG] service and focus more on your well-being and your immediate duties. Perhaps, you will be able to join the group at a later time. In the meanwhile, please let us know if you could recommend anyone who would qualify to take on the role of the [board position] and whether you would be able to give that person some initial training.

Please share your thoughts.

All the best,

[Name redacted]

I'm mortified. I'm still lying in bed, doing my morning routine of checking emails before I get up. *Crap. They don't want me anymore. I can't believe they're kicking me off the board!* I'm full of sadness and outrage. I forged my way onto that board, creating a position for myself to fill a distinct need they had. I made one mistake—one, that's it—and I was being told to step down. I lost my agency. It wasn't my choice anymore. I would no longer be involved in the board after about three years of service. I'm still isolating. I do not reply to the email.

Date: May 2nd, 2016

It's time for my favorite activity that gets me out of the apartment: counseling. I love my counselor, and I always leave our sessions feeling better than I did when I went in. I'm agitated, still not feeling stable. I'm not happy with how things went with the psychiatrist, and I intend to bring it up. I'm debating whether I should switch providers.

Counseling Records

Data: Client presented for one hour of psychotherapy to process concerns related to managing bipolar disorder. We discussed changes in functioning since our last session. She reported feeling hypomanic. Symptoms started Tuesday night when she began to feel

more agitated, “had too much energy,” and was more frustrated. She scaled her current mood. We explored the physical, behavioral and cognitive symptoms of hypomania. She described “physically feeling the energy, difficulty sitting still, and difficulty focusing.” She shared that Risperdal is helpful at night, and she is able to sleep for about 10 hours. We left a message for [nurse] at the SCH [Student Health Center] to contact her concerning the possibility of an earlier consult with [psychiatrist]. She also shared that walks, limiting caffeine, tending to her plants, housework, and cooking (and watching her diet-getting more proteins). We highlighted continued self-care, compliance with her provider, and mindfulness routines such as the marble exercise, heart focused color breathing and meditation on mantras as coping behaviors.

Assessment: Ct. presented on-time, somewhat tired in appearance, was motivated for therapy and displayed affect that included lessened nervousness, jitteriness and discomfort compared to our previous session. She denied SI/HI with intent or plan. She identified her current mood at a 7 (0=extremely depressed, 10=highly manic). She has developed insight into managing frustration and changes in mood and and in recovering from a mixed episode with mania and paranoia. She has been seeking medical support to cope with changes in medication, support related to academic challenges, interrupting self sabotage and increasing self-care. She may benefit from continued processing of academic, relational and mood related challenges. She may benefit from continued compliance and a follow-up with her medical provider.

Plan: We will continue to process being strategic for self-care compared to emotional reasoning. We will follow-up on her use of self-compassion and exploring more satisfying alternatives to catastrophizing and isolation. We will process current mood including depression, paranoia, and mania.

True to form, my counselor stepped in to assist me in my crisis by calling my psychiatrist's nurse to see about scheduling a follow-up earlier than my planned two-month one. Hypomania was creeping back in, and I needed to address it. It was becoming too much to handle—I had long ago stopped doing anything related to my assistantship, class was over, and all I had to work on was analyzing and writing up my comprehensive exams pilot study. It should have been easy, but my symptoms were getting in the way. I was still in a state of identity crisis: was I truly cut out for being in a doctoral program, or was I in over my head? Would I ever feel better? "Normal"? I started to doubt it. The implications for my sense of identity as a college student with a mental illness were devastating. If I wasn't cut out for being in a doctoral program due to my mental illness, what was I doing? What were my alternatives? I had put three years into my program. I had completed coursework. I had been making progress. What if I couldn't finish? What if it was all too much to bear? Could I truly be a college student and a person with bipolar disorder at the same time? Were the two identities compatible?

Date: May 6th, 2016

I started the day with a sense that I should tie up some loose ends: I emailed back the SIG member about stepping down from the board.

Email

Hi [name redacted],

I apologize for the massive delay in getting back to you. As you probably suspected, I've been struggling with my bipolar this semester pretty constantly. It's been an endless process of trying to find the right medication. I'm still plugging along at school, albeit slowly.

I'm afraid I don't have anyone I could suggest to take the position. It doesn't require much training, though. Mostly I would need to work with the individual to transfer things over from my account to a [SIG] general account, which I'd been planning to do soon anyway. The biggest task would be getting all the Skype contacts added for the new person.

Thank you for your support and concern.

Best,

Ren

Although I was heartbroken as I composed and sent the email because of what it meant for my professional career, I felt a sense of relief knowing some of my

responsibilities had been lifted. There was one less thing to worry about. Nonetheless, I was disappointed in myself.

I did not fear stigmatization from the board member I was communicating with—I had known her for five years, and I had a sense that she would be understanding. I did, however, stigmatize myself for not being able to fulfill my duties. I was mortified at being asked to step down. It was a failure on my part, and it indicated another way in which I was not cut out to be an academic. My sense of identity as a college student with bipolar disorder slowly became more and more negative, clouded over by my perceived failures.

Later that day, I make my way to campus for a follow-up with my psychiatrist as requested during my last counseling session. Interestingly, the check-in screen does not say BPD-I this time; it says BPD-NOS [Not Otherwise Specified]. *How can my diagnosis change that quickly? Does she even know what she's doing?*

I'm nervous that she won't be happy with me—I've decreased my dosage of Cymbalta without consulting her because I know antidepressants can exacerbate mania.

Medical Records

Reason for Appointment

1. *Est pt here today for f/up for episodes of hypomania.*

History of Present Illness

HPI This patient is a 31 year old Caucasian female for a scheduled follow up regarding BPD, GAD, Agoraphobia, PTSD. At last f/u increased risperdal..

Histories reviewed – Past Medical Family Social Allergies Hospital/Surgical.

Stressors include – Financial, Academic, Relationships, Medical

*(done with finals [this is not true—I did not have any finals]; not taking summer cl;
rtning [returning] to Fall 2016 here).*

Medications, effects, and side effects

*Cymbalta – decreased herself due to concerns reg[arding] mania; was helping
with depression; no side effects*

Risperdal – not helping enough for mania; sl[ightly] sleepy but manageable.

Mood changes since last visit

sad/down/empty – worse but only very sl (? due to decreasing cymbalta)

anger/irritability – worse/GRADES mod

euphoria/giddiness – worse/GRADES mod

stress/anxiety – same (ok/managed)

Sleep – Good.

Energy – Worse (agitated) – increased as below.

Interest – Good.

Concentration – Worse.

Appetite – Good.

Manic symptoms

*Increased: impulsivity (thoughts only/has not acted on these), grandiosity, rapid
speech/thoughts, or excess energy.*

Anxiety symptoms

denies: problematic worrying, panic attacks,

PTSD: increased a little.

Perception symptoms

denies hallucinations, illusions, or thought disturbance

Improved: paranoia (now only a little).

Thoughts of Harm/Death – denies wanting to harm or kill self or others.

Current Medications

Taking

- *Loratidine 10 MG Tablet 1 tablet Once a day*
- *Prenatal Multi + DHA*
- *Cymbalta 20 MG Capsule Delayed Release Particles - 2 Q am and 2 Q noontime,*

Notes: Pt now on 2 tabs in am

- *Risperdal 1 MG Tablet – 3 QHS*

Discontinued

- *Risperdal 1 MG Tablet – 1). 1 QHS X 3 pms 2). 1 & 1/2 QHS X 3-5 pms 3). 2*

QHS X 3-5 pms 4). 2 & 1/2 QHS final dose, Notes: now taking 3 tabs at HS

[bedtime]

Examination

Psych:

General VS and nurse intake reviewed above.

Appearance Appears well, stated age, normal rate of speech and psychomotor activity, Spontaneous speech. No observable muscle tightness, stiffness, tremor, or spasms.

*Mood/Affect Appropriate mood and affect, affect normal range /, **Affect intensity increase sl/, Anxious – mild.***

Orientation/Memory Alert and oriented X 3; Concentration good via conversation; Recent and Remote memory intact.

Intellectual functioning Avg./adequate fund of knowledge, Vocab app for education level, App conversation.

*Thought process/Cognition Coherent, logical, directed.,
Judgement/Insight/Abstraction adequate, No aud/vis halluc., paranoia, grad/persec. delusions,*

Suicidal ideation No suicidal thoughts, ideation, plan, or attempts.

Homicidal ideation No homicidal thoughts, ideation, or plan.

Treatment

1. Other bipolar disorder

Stop Cymbalta Capsule Delayed Release Particles, 20 MG, -, Orally, 2 Q am and 2 Q noontime, Notes: Pt now on 2 tab in am

Stop Risperdal Tablet, 1 MG, -, Orally, 3 QHS

Start Cymbalta Capsule Delayed Release Particles, 20 MG, -, 1 Q am and 1 Q noontime, 0 days, 0, Refills 0, Notes: Directions only; cont as above provided mania decreases

Start Risperdal Tablet, 1 MG, -, Orally, 1). 1/2/ Q noontime and 3 QHS X 3-5 days 2). 1 Q noontime and 3 QHS X 3-5 days 3). 1 Q noontime and 3 & 1/2 QHS, 15 days, 68, Refills 1

Clinical Notes: Discussed in detail following:

- 1. divide cymbalta Sat: 1 Q am and 1 Q noontime*
- if no more mania may cont*

-if mania cont for 3 days (and is manageable): decrease to 1 Q am X 3 days and then DC (to minimize withdrawal as had on Paxil)

2. increase risperdal: add noontime dose and if needed sl increase pm (pt tolerating night time dose well and needs daytime [sic] coverage).

2. GAD (generalized anxiety disorder)

Clinical Notes: going to Assessment and Counseling Center for IT for summer.

3. Agoraphobia with panic disorder

Clinical Notes: above.

4. Chronic post-traumatic stress disorder (PTSD)

Clinical Notes: above.

Follow Up

2 Weeks (Reasons: medmgt)

Luckily, the psychiatrist agreed that I did the right thing when I decreased my Cymbalta without consulting her. Clearly, I had developed a deep working knowledge of medications and their effects as well as how to manage them. We decided to continue tapering off Cymbalta as long as I didn't have any side effects from doing so and that I would increase Risperdal slightly (by 1 milligram) to try to combat the hypomania. I felt like I had some agency in my appointment. I was pleased with the outcome and felt positive that I would feel better.

Later that afternoon, I checked my email and found a response from the SIG member.

Email Response

Dear Ren,

Thank you for your reply. I certainly understand. [Name redacted], our new Chair, will be contacting you soon.

All the best to you.

[Name redacted]

This interaction demonstrates that I had nothing to fear in disclosing what was causing my difficulties. I had a safe space in which to disclose my mental illness; even though it may not appear this was a safe space, as I was asked to step down from my board position, I felt safe sharing this information with my colleague. I felt supported. I knew that I could disclose again without being shamed for it

Date: May 15th, 2016

It's nighttime, and I'm crawling out of my skin again. I'm sobbing, crying, frantic, sitting on the bed, clutching a pillow and rocking back and forth. "I don't know what to do!" I'm screaming, and I can't help it. The volume of my voice seems to be out of my control.

"Shh, it's okay."

"It's not okay! I don't feel good, even after seeing the doctor. I don't think she knows what she's doing. I can't feel like this anymore—I can't! I can't do it. I can't

live like this. It's agony just to exist." My words dissolve into tears and sobs. *Maybe this is it. My sign.* "Do you think I should go to the hospital?"

"I don't know. What would that do?"

"They would at least stabilize me, and maybe I wouldn't feel like this anymore."

We decide I should email my counselor. I'm not sure if I should be hospitalized or not, and I need some guidance.

Email

Hi [Counselor],

I have some questions about hospitalization. I'm pretty distressed again; the anxiety is getting out of control, and I think I might need to be hospitalized. I'm not sure what the best route is between seeing [psychiatrist] again and going in to a hospital. Would it be okay for me to call you and talk about it?

Thanks,

Ren

Within minutes, my phone starts ringing. It's a private number. I answer. It's my counselor. I cannot recall the conversation clearly enough to recount it here. All I remember is that he advised against hospitalization because my case wasn't that severe. I told him how much I distrusted my psychiatrist, and he suggested I go see her

immediately. Ultimately, I get in to see her the next day (the records for this appointment do not exist), and we decide to put me back on Lamictal and Klonopin. It was a defeat.

Brief Discussion

All of the above experiences demonstrate identity development, stigma, and academic resilience, perceived as such or not. My identity was in flux as a result of my diagnosis, my symptoms, and my drastic downslide into mania and psychosis. I constantly had to reassess who I was through this process, and it was never easy. Perhaps the same is true for other people with mental illness who encounter similar struggles.

I also encountered stigma, mostly self-imposed, as related to my identity crises. I feared being “too crazy” to be successful. I feared being perceived as crazy and incapable. In cases where I had to interact with others in my academic field, I was afraid of being stigmatized, so perhaps I did perceive it from time to time, but it’s clear that I more predominantly self-stigmatized.

Finally, in terms of academic resilience, I demonstrated a significant amount of it as I adjusted to doctoral studies, came off my medications in an attempt to get pregnant, and encountered full-blown mania and psychosis for the first time. At times, I isolated, retreating from the world and not engaging in academic pursuits. For example, I did not complete my assistantship duties in the spring of 2016. On the other hand, there were instances in which I sought out supports in the form of counseling, psychiatry appointments, and contacting my supervisor. I was a mix of resilience and self-sabotage (the isolating behaviors). Perhaps none of we college students with mental illness are one or the other, but rather an intermingling of the two, our strength surfacing when we most need it.

Limitations

As with autoethnography, it is difficult to reconstruct experiential data without the archival data as a corroborating force. As such, some of my experiences were recounted with difficulty. They may not be the most accurate depictions of what happened, which is why I consider them a limitation, although this is not necessarily considered a limitation of autoethnography.

A second limitation to this study is that my memory is patchy at best for several of these dates, particularly during the spring of 2016. It's lore that, when in the throes of mania or a mixed episode, the bipolar brain protects itself by glossing over the details of memory. It becomes a fog of general ideas, not of specifics. This rendered it difficult to recount some of the experiential data, so there are some holes in this account, such as when I would run away from home in an attempt to get lost or kill myself. Because I was experiencing mixed episodes at these times, all I know is that I tried to get away. I cannot remember what was said or the order in which events occurred. All I know is that I ran from my husband and eventually let him talk me into returning to our apartment.

Summation and Preview

This chapter explored the research questions, albeit in narrative form rather than structured by research question, through the lens of personal experience using a mix of archival and experiential data, focusing on two semesters and an intermediary period that set the stage for the final semester examined. In the following chapter, the three studies will be analyzed together for commonalities and differences in findings pertinent to each research question. Implications will be discussed and directions for future research will be given.

VII. CROSS-STUDY ANALYSIS, RECOMMENDATIONS, AND FUTURE DIRECTIONS

This chapter contains a cross-study analysis by research question, looking across the three studies to find commonalities and differences in the findings. It also provides a discussion of the results, implications for practice, and suggestions for future research studies in the realm of college students with mental illness.

Overview of Findings

This section is intended to give a brief refresher of the findings from each study. The findings from each study will be presented together, providing a cross-analysis, and then, in the following sections, they will be broken down by research question.

Identity Findings

In the survey with metaphorical data, the most predominant conceptual metaphors found for being a person with a mental illness were STRUGGLE, DIFFERENCE, INSTABILITY, and BEING STUCK. This is in contrast to the “being a college student with a mental illness is like. . .” metaphor for which the most predominant conceptual metaphors in the dataset were STRUGGLE and DIFFERENCE. Notably, a greater number of conceptual metaphors were present in the student metaphor dataset than the person metaphor dataset, which may indicate there could be a greater number of ways in which college students with mental illness identify as students versus as people with a diagnosed mental illness. Also of note is the near absence of the BROKENNESS conceptual metaphor from the student metaphor dataset—only one elicited metaphor fit with this conceptual metaphor as opposed to the 13 for the “being a person with a mental illness is like. . .” metaphor; considered alongside the unique conceptual metaphor of

INCLUSION in the student metaphor dataset, this may demonstrate that college students with mental illness may encounter peers with similar experiences, meaning college may be a place in which college students with mental illness can feel a sense of belonging instead of a sense of being flawed.

When asked if they perceive being a person or a college student with a mental illness as different, 94 respondents ($N = 219$) said “no,” 40 said “unsure,” and 85 said “yes.” This may point to the divergence that exists in identity as college students develop, per Abes, Jones, and McEwen’s (2007/2011) Multiple Dimensions of Identity framework, as approximately the same number of respondents reported they perceived the identities as the same or as different. It stands possible that the demographic data, had it been explored, would have given a clear picture of what factors influence this sense of singular or divergent identities, such as being younger or more newly diagnosed.

From the duoethnography, evidence demonstrates that Violet and I experienced identity in different ways, although it is not feasible to say whether we conceived of them in similar or different terms as much as it is clear that we experienced being a person with a mental illness differently than being a college student with a mental illness. In fact, Violet and I spoke more to our experiences of identity as a person, not as a student; there were only two exemplars in the dataset that spoke directly to college student identity. This alone indicates that we conceive of these identities differently in that only the person identity was found to be present in many cases. This supports identity development theory—our sociocultural cues caused us to foreground certain aspects of our identities (Abes, Jones, & McEwen, 2007/2011; Evans et al., 2009). It stands possible that, because we started by talking about diagnosis in general and then moved into the

academic realm in the interview conversation, our status as people with mental illnesses were foregrounded in front of our status as college students with mental illness.

Furthermore, in the duoethnography, it was found that interactions with others, including those with mental illnesses, related to identity shift or development in some manner, whether positive or negative, in alignment with some research (Arnett, 2000; Côté, 2000; Erikson, 1959, 1968). In some cases, such as when Violet self-disclosed to her supervisor, interaction with others related to having a more negative self-image and associated perceived stigma. This ties back to the findings from the survey with metaphorical data—her identity was tied to a sense of STRUGGLE (although it was not investigated as a conceptual metaphor) and DIFFERENCE, mirroring the most predominant conceptual metaphors for being a college student with a mental illness.

Identity was also found to be in flux in the autoethnography per my experiences over the semesters explored, further indicating that identity development may indeed be a recursive process, although this is not necessarily generalizable (Côté, 2006). There were distinct instances of identity as a person versus as a college student with a mental illness, for example, in my coming to terms with likely not being able to have a baby versus my experiences in struggling to keep up with the demands of my doctoral program while undergoing a period of mania, psychosis, and mixed episodes. These events occurred at the same time, yet I had two distinct senses of identity; the woman wanting a baby did not intermingle with the woman wanting to complete her coursework and assistantship duties. This study further supports identity development theory in this way.

Stigma Findings

In the survey with metaphorical data, respondents were asked whether they ever stigmatize themselves and if they perceive themselves as being stigmatized by others. The types of stigma were separated from each other in alignment with Tucker et al.'s (2013) findings that they are two separate constructs. Findings appear to support this notion as both were present in the survey results and the varying reasons respondents provided for self-stigmatizing or perceiving stigma. As demonstrated in the literature, both types of stigma existed in the population studied in this dissertation (Jennings et al., 2015; Martin, 2010; Megivern, Pellirito, & Mowbray, 2001; Quinn, Wilson, MacIntyre, & Tinklin, 2009; Tucker et al., 2013; Weiner, 1999; Weiner & Wiener, 1996).

In response to the self-stigma question, the majority of participants (117, $N = 219$) indicated that they stigmatize themselves for reasons such as feeling less than their neurotypical peers (note how this ties to the DIFFERENCE conceptual metaphor) and holding themselves to higher standards than they can meet. This last piece aligns with research on maladaptive perfectionism—recall how females identified as maladaptive perfectionists are more likely to experience depression than their peers (Castro & Rice, 2003; Elion et al., 2012; Gnilka et al., 2013; Schrick et al., 2012; Stoeber et al., 2014; Walker et al., 2008). Although this survey did not target females in particular and the findings were not analyzed by gender of respondents, it seems evident that those with mental illness are likely to hold themselves to what may be unattainable standards in light of managing their mental illness symptoms.

Part of these findings aligns with those from the duoethnography: both Violet and I discussed holding ourselves to high standards we could not always meet. Take, for

example, Violet's revelation that all the work she had done on her thesis was writing a few sentences and then deleting them; she stigmatized herself for not doing more, yet she was still taking action and working towards her goal (writing the thesis) despite the interference of her symptoms.

Self-stigma was also found in the autoethnography. I stigmatized myself for experiencing severe symptoms and not being able to keep up with the demands of school in light of them, again somewhat aligning with the research on maladaptive perfectionism. As a self-proclaimed maladaptive perfectionist, it was difficult for me to reconcile experiencing severe symptoms with not being able to meet the demands of my academic life.

In response to the perceived stigma question, the majority of respondents (107, $N = 219$) indicated perceiving stigma for reasons such as mental illness being seen as an excuse and the nature of mental illness not being fully understood by faculty or peers. This sentiment of mental illness being seen as an excuse was echoed by Violet in the duoethnography. She feared her supervisor and faculty would view her mental illness as an excuse for not performing well, not as something that made it difficult for her to function. Her interaction with her supervisor exemplifies how mental illness may be misunderstood, although Violet admitted she may have played a role in this because she called it a mood disorder instead of bipolar disorder, because of her supervisor's response that graduate school is not for everybody. Violet's experiences give concrete examples of what the survey respondents indicated perceiving in terms of stigma from peers or faculty.

Perceived stigma was also present in the autoethnography. I sometimes felt stigmatized by my husband, the cornerstone of my support system, as he struggled to understand my diagnosis. I furthermore feared being stigmatized by my faculty and academic peers during the spring of 2016 when I first experienced severe mania, mixed episodes, and psychosis because I did not want to be seen as incapable or lose my assistantship. Although I did not fear that my symptoms would be seen as an excuse, *per se*, I felt that others would perceive me in a light I did not desire, one more negative in nature.

Academic Resilience Findings

In the survey with metaphorical data, the majority of respondents (65%, $N = 219$) reported that they perceived themselves as academically resilient for reasons such as still being enrolled, having no other choice, having goals that relate to college, and having dropped out and returned to college. As research demonstrates, these individuals are more likely to experience academic success than their peers who do not perceive themselves as academically resilient (Adams, Sanders, & Auth, 2004; Aroian & Norris, 2000; Kapikiran & Acun-Kapikirin, 2016; Roy, Sarchiapone, & Carli, 2007; Rydén et al., 2003; Vaishnavi, Connor, & Davidson, 2007).

Those who indicated they were unsure if they perceived themselves as academically resilient most predominantly reported they sometimes, but not always, perceive themselves as academically resilient. Finally, those who said “no” gave reasons such as giving up too easily (something that may align with perfectionism research [Castro & Rice, 2003; Elion et al., 2012; Gnilka et al., 2013; Schrick et al., 2012; Stoeber

et al., 2014; Walker et al., 2008]); letting their symptoms interfere with their work; and having dropped a class, project, or out of college in the past.

In the other two studies, there was little recognition of academic resilience even though it was demonstrated in instances such as Violet and I returning to college, my staying enrolled when I was experiencing the mania and psychosis, and Violet and I doing our best to complete our coursework. Violet did state that she tries to give herself credit for her work, however, indicating at least a desire to perceive herself as more academically resilient. Another key piece to our perceived lack of academic resilience was how Violet and I discussed holding ourselves to higher standards than we can meet, tying our experiences back into the research on perfectionism and mental health (Castro & Rice, 2003; Elion et al., 2012; Gnilka et al., 2013; Schrick et al., 2012; Stoeber et al., 2014; Walker et al., 2008).

Research Question One

This section is pertinent to the question “How do college students with mental illness conceive of their identities as people with mental illness?” Across the three studies, it was found that participants indicated overwhelmingly negative or troubling senses of identity, as evident in the predominant conceptual metaphors of STRUGGLE, DIFFERENCE, INSTABILITY, and BEING STUCK, and Violet and my difficulties conceiving of our identities as individuals diagnosed with bipolar disorder. In particular, it was evident in the duoethnography and autoethnography that sense of identity as a person with a mental illness may shift due to internal and external factors such as perceived or self-stigma and in response to identity crisis, as predicted by the theories of Erikson (1959, 1968). This could be seen in the duoethnography in Violet’s response to

being diagnosed with bipolar disorder after years of misdiagnosis. It was also evident in the autoethnography in my coming to terms with the emergence of symptoms typical of Bipolar Type I (the mania and psychosis).

Although this cannot be seen in the survey with metaphorical data findings because the questions did not get at potential identity crises, the other two studies demonstrate the link between identity crisis and identity development, supporting theory (Erikson, 1959, 1968). From all studies, however, it is evident that college students with mental illness perceive their identities as people with mental illness as tied to a sense of hardship, in cases because of a sense of being marked as different than their neurotypical peers (as was evident in the conceptual metaphor DIFFERENCE). This further demonstrates a connection between stigma, either self- or perceived, and sense of identity, something that has not been explored in the literature.

This may indicate, although the survey findings do not directly support this claim, that people with mental illness will not foreground that part of their identity unless socioculturally prompted to do so, such as when in safe settings like group counseling, as Violet and I spoke about in the duoethnography. This is in line with Abes, Jones, and McEwen's (2007/2011) Multiple Dimensions of Identity framework, which posits that individuals will only foreground the most socioculturally salient parts of their identities in a given setting.

Research Question Two

This section addresses the research question "How do college students with mental illness conceive of their identities as college students with mental illness?"

Again, the findings in the survey with metaphorical data indicated that college students with mental illness conceive of their identities as college students with mental illness in ways that represent hardship, struggle, and difference, although it is worth noting that the conceptual metaphor INCLUSION came up in the findings for this identity and not the identity as a person with a mental illness. This may indicate that being on a college campus gives some individuals a sense of belonging because they know they are not alone in their struggles, but, due to the low number of INCLUSION conceptual metaphors in the dataset, it is possible participants in this study have self-disclosed their mental illnesses, utilize counseling services on campus, or are part of a community of people with mental illness, leading them to feel that sense of belonging.

In the duoethnography and autoethnography, identity as a college student with a mental illness was tied to perceived academic resilience: both Violet and I predominantly conceived of our college student identities as problematic, meaning we did not see ourselves in a positive light, because of our perceived lack of academic resilience due to the manifestation of our mental illness symptoms. It was also tied into self-stigma, as with the identity as a person with a mental illness, because both Violet and I self-stigmatized for that perceived lack of academic resilience.

These findings may indicate that college students with mental illness, overall, have similar conceptions of identity as individuals and college students with mental illness and that these conceptions are tied to other issues like perceived academic resilience and the emergence of stigma, either perceived or self-imposed. How these identities may be constructed, then, involves a multitude of factors, much like the Multiple Dimensions of Identity framework posits (Abes, Jones, & McEwen, 2007/2011).

Furthermore, as these identities develop (as seen in the duoethnography and autoethnography), representational literacy (Cope & Kalantzis, 2009) may come into play through the interaction of identity and perceived academic resilience or perceived or self-stigma. When all these factors interacted, identity crisis occurred, which necessitated developing a new identity, using one's representational literacy skills to construct an identity for oneself and the world. One cannot extrapolate, however, that this is true for all college students with mental illness because the survey data did not probe into this interrelation or how identities are developed; rather, it focused on how identities are conceived of.

Research Question Three

This section addresses the research questions “Do college students with mental illness perceive themselves as stigmatized within academia?” and “If so, in what ways or for what reasons are they stigmatized within academia?”

Both perceived and self-stigma were found across studies. The majority of respondents in the survey indicated they perceive stigma on campus and stigmatize themselves. The reasons they provided for perceived stigma were that mental illness is not understood or is seen as an excuse, and the reasons they provided for self-stigmatization were that they feel different than their peers (often perceiving themselves as “less than”) and they cannot meet the standards they set for themselves due to the manifestation of their mental illness symptoms. These reasons were echoed in Violet and my experiences in the duoethnography and my experiences in the autoethnography.

Neither perceived or self-stigma appeared to be more predominant than the other in terms of presence in the experiences of college students with mental illness. The data

supports that these are two separate constructs, as found by Tucker et al. (2013), because of their distinctively different presence in the duoethnography and the autoethnography. In both studies, there were instances in which Violet and I either perceived stigma as coming from peers, faculty, or the popular media or self-stigma imposed because of the manifestation of symptoms and difficulty managing them alongside being a successful college student.

As stated previously, the notions of stigma present in these studies were found to be connected to identity development in the duoethnography and autoethnography, perhaps indicating that stigmatization from self or others may play a role in how identity is conceived of by college students with mental illness. This relates, too, to representational literacy, as mentioned previously: stigma may cause an identity crisis, which then may cause a reconceptualization of identity, therefore involving the process of representational literacy as a new identity is constructed for the world, perhaps one that does not merit or attract stigmatization, in this case.

Finally, it's worth noting how perceived stigma was present for Violet and I in the duoethnography in different ways. Violet perceived stigma from her supervisor in that he did not appear to understand the nature of her mental illness once she self-disclosed (perhaps best exemplified in his response that "grad school isn't for everybody"). On the other hand, I experienced a sense of perceived stigma from a well-meaning faculty member who, by appearances, simply wanted to make sure I was doing better in handling my symptoms alongside completing my coursework and assistantship duties (as explicated further in the autoethnography). Thus, perceived stigma may arise even when stigmatization is not intended.

Research Question Four

This section addresses the research questions “Do college students with mental illness perceive themselves as academically resilient?” and “If so, in what ways or for what reasons are they academically resilient?”

Academic resilience was perceived across all studies, although it was much more predominant in the survey with metaphorical data. The majority of respondents to the survey indicated that they perceive themselves as academically resilient for reasons such as still being enrolled and having no other choice but to be resilient. Although academic resilience was demonstrated by Violet and I in the duoethnography in that we both returned to college after a hiatus, we did not perceive it as such and sometimes stigmatized ourselves for having dropped out in the first place. We also demonstrated, but did not perceive, academic resilience in attending class despite a flare-up of symptoms related to our bipolar disorder and staying enrolled despite setbacks.

In the autoethnography, there were similar findings. Although I demonstrated academic resilience by staying enrolled in my program when I underwent mania and psychosis, reaching out for help when I needed it, and overcoming nonacademic issues such as the suicide attempt prior to my diagnosis with bipolar, I did not perceive my actions as exemplifying resilience. Rather, I perceived myself as weak and stigmatized myself for it. Additionally, in some instances, such as when I had to engage with my supervisor, I feared being stigmatized. This may indicate that there may be a connection between perceived academic resilience and the two types of stigma, although my experiences are not sufficient evidence for generalizability to the full population of college students with mental illness.

Summation

In short, the findings from these studies point towards college students with mental illness having negative senses of identity as people and college students with mental illness, most predominantly characterized by STRUGGLE or DIFFERENCE. These studies also support the literature that demonstrates stigma is experienced by people with mental illness (Jennings et al., 2015; Martin, 2010; Megivern, Pellirito, & Mowbray, 2001; Quinn, Wilson, MacIntyre, & Tinklin, 2009; Tucker et al., 2013; Weiner, 1999; Weiner & Wiener, 1996), particularly self- and perceived stigma, two separate constructs as identified by Tucker et al. (2013). Self-stigma existed for reasons such as not perceiving the self as academically resilient or equal with one's neurotypical peers. Perceived stigma came from faculty, peers, and the popular media for reasons such as mental illness not being understood or being seen as an excuse. Finally, academic resilience was perceived by the majority of survey respondents and demonstrated by Violet and I (although we did not always perceive it as such) for reasons such as still being enrolled, having returned to college, and having no choice but to persevere.

The overall findings from these studies indicate that college students with mental illness have identities as both people and students with mental illness that are largely marked by hardship or difference, yet the majority of respondents indicated that they perceive themselves as academically resilient for reasons such as still being in college or having no other choice. This speaks to a disconnect between conception of self and demonstrated strengths; the academic resilience, a strength, was not present in the majority of the conceptual metaphors identified in the survey results. Although

respondents in the survey perceived academic resilience, Violet and I did not, on the whole, although we demonstrated it in many instances. Across all studies, stigmatization was perceived and imposed by the self for reasons such as mental illness not being understood, individuals feeling different than their peers, or mental illness being seen as an excuse. All of this points towards one significant finding: college students with mental illness' conceptions of self do not necessarily reflect their strengths, even if they are perceived, as with academic resilience.

Recap

Findings from the first study indicate that participants in these studies have predominantly troubling or negative senses of identity both as individuals and as college students with mental illness, they encounter both perceived and self-stigmatization, and the majority perceive themselves as academically resilient. Findings from the second study may indicate that identity development may be tied to factors such as support systems and perceived stigma from others, including faculty, peers, and family members; perceived and self-stigma are encountered by individuals with bipolar disorder (recall the co-researchers were focusing on their diagnoses as individuals with bipolar, not mental illness in general); and academic resilience is often demonstrated even if not perceived as such by the student. Findings from the third study suggest identity development is a recursive process spurred by identity crises, that stigma is present from the self when one is a maladaptive perfectionist, and that academic resilience, again, although demonstrated, is not always perceived as such.

Significance to the Higher Education Community Writ Large

This dissertation investigated the lived experiences of college students from a range of levels, from the undergraduate to graduate, using three studies, a survey with metaphorical data, a duoethnography, and an autoethnography. This approach was selected to give as much breadth and depth to the dataset as possible, moving from the broadest, a university-wide survey, to narrowest, the autoethnographic explorations of my experiences as a doctoral student with mental illness.

The goal of this research was to provide knowledge about college students with mental illness, delving into their daily lived experiences as they relate to identity development and issues such as stigmatization, and academic resilience, in order to facilitate change across campuses nationwide. Having a better understanding of the challenges faced by this student population provides a roadmap for the academic and nonacademic supports that can be provided to them to help them succeed and grow as students and individuals, a goal of developmental education and of higher education writ large. The implications from this dissertation give a picture of what can be done to ameliorate the potentially negative effects that having a mental illness places on college students. This is something that may extend beyond the concerns of developmental educators into the rest of academia in terms of which campus entities should be involved in the process of helping college students with mental illness develop as individuals and students as well as what these entities can do to help support these students.

Investigating these experiences for common threads elucidates what the academic community can do to best support college students with mental illness to help them attain academic success and persist to degree completion. This has implications for educators,

learning assistance centers, and the administration of a university or community college. At all levels, supports can be implemented to ameliorate the effects of issues such as perceived stigmatization among this population of students. This may be as simple as changing the classroom environment to providing trainings to faculty or students who work with students with mental illness. Supports can be offered in a myriad of ways that emerged from the findings in this study.

Significance to the Developmental Education Community

The literature has little to say on the issues surrounding identity development in students with mental illness as well as how it may influence their academic achievement. The most literature has pointed towards this issue is in its exploration of types of perfectionism in female college students; findings indicated that maladaptive perfectionists, those who strove to present perfectionism to those around them who also could not adapt when not attaining perfection, had poor mental health and an associated struggle with academics due to reluctance to accept less than a perfect performance (Castro & Rice, 2003; Elion et al., 2012; Gnilka, Ashby, & Noble, 2013; Schrick, Sharp, Zvonkovic, & Reifman, 2012; Sironic & Reeve, 2012; Stoeber, Schneider, Hussain, & Matthews, 2014). Even this research, however, failed to examine the issue through a qualitative lens, so we still know little about how these self-perceptions affected students' academic achievement and what these identity claims meant to the participants. This dissertation helped fill this gap in the literature by expanding what we know about what it means to be a college student with mental illness in terms of stigma and resilience. This dissertation painted a rich picture of the lived experiences of college students with mental illness and how their self-perceptions may influence them and their identity development

specific to being a college student with a mental illness and more generally as an individual with a mental illness, a theme that was carried throughout the study to emphasize and explore identity development among college students with mental illness. This also lent itself to assessing how much students conceive of these as similar or disparate parts of their identities.

Practical Recommendations

The three studies come together to provide insights into what can be done to support the needs of college students with mental illness to help them succeed academically, something they have been shown to struggle with (Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Keyes et al., 2012; Thompson, 2013). The first implication from these studies—given the responses in the survey, the experiences of Violet and I, and my experiences—is that institutions of higher education need to help develop awareness of what mental illness is in faculty, staff, and students as demonstrated by the perception across studies that faculty, in particular, see mental illness as an excuse or do not understand its nature. A practical recommendation for this may take the form of workshops for faculty and staff or other such professional development activities to teach them about the nature of mental illness in order to decrease perceived stigma for college students with mental illness. Building an understanding of what college students with mental illness face may help reduce the sense that it is perceived as an excuse by faculty. Building awareness in students is a more difficult task, but one that should be undertaken given the finding that I perceived stigmatization as coming from peers. One way to accomplish this might be including a brief presentation on the prevalence and nature of mental illness at new student

orientations or in first year experience type courses. This may help reduce perceived stigma from peers and develop that sense of belonging among students with mental illness as they would be exposed to how prevalent mental illness is on college campuses, something which may further aid in positive identity development through a diminishing of self-stigma for having a mental illness, something that was found to interact in the duoethnography and autoethnography.

Along these lines, faculty and staff can also assist college students with mental illness in developing more positive senses of identity, particularly in response to the findings from the survey with metaphorical data in which the majority of participants' elicited metaphors were found to relate to negative sense of identity as indicated by the conceptual metaphors, perhaps by reducing self- and perceived stigma and increasing students' awareness of their positive attributes such as perceived academic resilience, something, for example, Violet and I did not often perceive in ourselves. This is not something that can be accomplished in a classroom setting due to the sensitive nature of asking a student to disclose their mental illness status, so perhaps this could best be accomplished through individual encounters.

For example, as demonstrated in the duoethnography, if a student were to self-disclose to a faculty or staff member, that individual could ask the student how the mental illness affects how they perceive themselves and whether they stigmatize themselves. The faculty or staff member could follow up with probing questions such as how well the student manages symptoms, how often the student seeks help, if the student has self-disclosed to anyone, if the student has a support system, and if the student feels academically resilient. This information can help the faculty or staff member better know

how to serve the student. All of these factors play a role in building a positive sense of identity as these can be perceived as strengths; if these strengths are foregrounded for the student, they may be more likely to integrate this sense of strength into their identity as either or both and individual and a college student with a mental illness.

Additionally, as was evident in the duoethnography and autoethnography, faculty, staff, and peers can play a role in how college students with mental illness perceive themselves and whether they perceive stigma or self-stigmatize. This calls for increased awareness regarding words and actions related to mental illness or mental health. Being supportive of the student's needs, if they self-disclose, can benefit how the student conceives of themselves in terms of their mental illness, helping them build more positive senses of self and reducing stigma. From my experiences, however, it's apparent that faculty, staff, and peers need to be aware of how often they are demonstrating their support to diminish the potential for giving the sense that the student is nothing more than a mental illness. There is a fine line for faculty, staff, and peers to walk, then, between demonstrating support and treating the student with a mental illness like they would treat a neurotypical student. This awareness can be built, much like awareness of the nature of mental illness, through professional development activities. The difficult part of this "intervention" is changing the actions of peers; perhaps this could be accomplished by having an open dialogue about mental illness on campuses through awareness events such as film screenings, discussions led by counseling staff, and guest speakers. It may also be possible to integrate mental illness awareness into the curriculum by reading about mental illness (although this approach may only be feasible in a literacy- or diversity-related setting) and discussing it as a class.

This leads back to the question of how developmental education fits into the picture of the needs of college students with mental illness. As demonstrated by Higbee (2009), students in developmental courses may encounter stigma, and compounded with the stigma faced by people with mental illness (Jennings et al., 2015; Martin, 2010; Megivern, Pellirito, & Mowbray, 2001; Quinn, Wilson, MacIntyre, & Tinklin, 2009; Tucker et al., 2013; Weiner, 1999; Weiner & Wiener, 1996), if a student enrolled in developmental education also has a diagnosed mental illness, it seems likely their experience of stigma would be amplified beyond what a student belonging to either population would face. This indicates a need for developmental educators to be aware that their students may have mental illness, particularly given the rising numbers of students reporting mental health concerns (ACHA, 2015; Novotney, 2014). All of the previously-mentioned support strategies extend to developmental educators.

Overall, the results of these studies indicate that developmental education professionals need to extend their awareness of the challenges facing college students with mental illness, which will enable them to identify the appropriate academic and nonacademic supports, so they can treat the student holistically, in line with developmental education's goals (Arendale, 2005, 2007; Boylan, 1995; Boylan & Saxon, 1998; Casazza & Silverman, 1996; Clowes, 1980; National Association for Developmental Education, n.d.). This may take the form of in-class supports, if possible to integrate them into the curriculum, such as discussing conceptions of identity, types of stigmatization and how to counter them, or simply bringing up what mental health is and how students may encounter issues with it during their academic careers. Furthermore, student support staff need to be aware of the challenges posed by mental illness because

of how it factors into student success (Breslau et al., 2008; Cranford et al., 2009; Elion et al., 2012; Keyes et al., 2012; Thompson, 2013). Because support staff have the ability to work one-on-one with students more so than instructors do, they have even more of an ability to treat the whole learner.

Additionally, because respondents indicated they perceive that faculty see mental illness as an excuse, instructors should be accommodating to students with mental illness by following the decree from disability services, if the student has one. Instructors should also strive to meet the needs of these students if they do not have allowances from disability services by extending deadlines or excusing absences when symptoms interfere with the student's ability to function. Doing such would demonstrate a level of understanding about mental illness, perhaps spurring the student to view it as less stigmatized by faculty.

All of the strategies for supporting college students with mental illness are pertinent to developmental educators as they are likely to encounter college students with mental illness, and, as was established earlier, they make up a part of the developmental education community. If, per the NADE motto (n.d.), developmental educators are purporting to support students across a continuum of their academic development, not merely when students are enrolled in developmental coursework, college students with mental illness merit inclusion in the developmental education population because of their needs in developing positive senses of identity, dealing with stigma, and becoming academically resilient as demonstrated across the three studies in this dissertation. The findings of this dissertation do not indicate that faculty, staff, and peers need to be experts in mental illness to help students with mental illness; rather, taking small steps like those

outlined above may begin the necessary work towards better serving this student population to help them succeed academically and develop more positive senses of self as tied to their mental illness.

Research Recommendations

A first area related to the experiences of college students with mental illness that merits further investigation is disciplinary differences in how mental illness is perceived given the conceptual metaphors identified in the survey with metaphorical data and the findings of the duoethnography. This is driven mostly by the findings of the duoethnography in which Violet and I had differing experiences of how our faculty perceived mental illness, something that may have been due to the fact that we belonged to different academic disciplines (the social and natural sciences, respectively). This kind of research may take the form of focus groups or individual interviews with individuals from a variety of academic disciplines to explore perceived disciplinary differences.

Another way to access this information may be to interview or survey faculty in different disciplines about their perceptions of mental illness. This research would give a sense of which disciplines, if any, have more negative attitudes towards mental illness, helping the higher education community to identify where the greatest need for developing awareness and diminishing stigma may lie.

A second research recommendation, based on the survey with metaphorical data conceptual metaphor findings, is to compare identity conception (such as found in the conceptual metaphors) to length and type of diagnosis to determine if the two interact. This would entail an analysis of the full dataset from the survey. Anecdotally speaking, length of diagnosis can have an effect on how much an individual with a mental illness

has come to terms with it and developed an awareness of how to manage the symptoms, so it stands possible that length of time since diagnosis may play a role in how people with mental illness conceive of their identities. If we can develop an understanding of how length of diagnosis affects identity development, we can form a plan of action for assisting students who have been more recently diagnosed develop more positive senses of identity as related to their mental illness, and, in turn, diminish self-stigma.

Again, in line with the conceptual metaphors identified in the first study, a fourthinal recommendation for research would be to examine demographic differences as related to college student mental illness. As research demonstrates, females report mental illness more than males (ACHA, 2014) and ethnic/racial minorities may be less likely to seek assistance for their mental illness due to cultural expectations (Hsu et al., 2008; Leung et al., 2012; Sheu & Sedlack, 2004; Walker et al., 2008; Wang, 2012; Zychinski & Polo, 2012). Identity development, academic resilience, and both perceived and self-stigma should be investigated in terms of demographics to better understand how mental illness affects different student populations. This would give higher education professionals access to information about how to best serve subpopulations in the community of students with mental illness.

Final Thoughts

As demonstrated in this dissertation, the needs of college students with mental illness are compounded as the factors of identity, stigma, and resilience interact with one another. As developmental educators, it is our job to support these students because they should be considered part of the developmental education community. This requires a great deal of professional development, but it does not require acting as a counselor;

rather, supporting college students with mental illness requires an understanding of mental illness in general, a desire to reduce stigma, and the goal of increasing students' perceived academic resilience to build a more positive sense of self and help reduce self-stigmatization.

What is clear from the three studies in this dissertation is that college students with mental illness face a number of challenges. It is our job as educators and peers to help support them on their journey to academic success. A substantial amount of research is still needed to better understand how we can best support this population in their identity development as this seems to relate to academic resilience and stigmatization. Although this dissertation has filled some knowledge gaps regarding the lived experiences of college students with mental illness, such as what we know about their experiences of stigma, academic resilience, and identity development, there is still much to be discovered as we, as a higher education community, seek to support them through to degree completion and on their identity development journey.

APPENDIX SECTION

APPENDIX A

The following survey has been designed to ascertain what your lived experiences are as a college student with a diagnosed mental illness. You are free to stop taking the survey at any point or skip any question without penalty.

1. Do you currently have a diagnosed mental illness? Y/N
Individuals who answer “no” will be directed to the end of the survey.
2. What is/are your diagnosis or diagnoses? (Please indicate all diagnoses if you have more than one.)

Part One: Metaphor Construction

In this section of the survey, you will be asked to construct metaphors related to your experiences as a college student with a diagnosed mental illness. Metaphors, in this study, are a relation of two unrelated ideas or concepts, not a literary device.

Example: An eyeball is like a camera. They have similar parts. For example, both have something to control the amount of light (the shutter and the iris), and they both have something that allows them to store images for processing (film and the retina).

1. Being a person with a mental illness is like. . . .
 - a. Why/how?
2. Being a college student with a mental illness is like. . . .
 - a. Why/how?
3. Are these different for you? Y/N/Unsure
 - a. Why/why not?

Part Two: Identity Claims

In this section of the survey, you will be asked to construct statements about your identity related to having a diagnosed mental illness. This means you will be making a sentence that explains, to some degree, the ways in which you conceive of yourself in relation to having a mental illness, similar to how you constructed metaphors in the previous section.

1. Despite my mental illness, I am the kind of person who. . . .
 - a. Why/how?
2. Because of my mental illness, I am the kind of person who. . . .
 - a. Why?/how?
3. Despite my mental illness, I am the kind of student who. . . .
 - a. Why?/how?
4. Because of my mental illness, I am the kind of student who. . . .
 - a. Why/how?

5. Do you see any differences for yourself as an individual and yourself as a student?
Y/N/Unsure
- Why/why not?
 -

Part Three: Self-Perceptions

The following questions are intended to assess your perception of yourself as an individual with a mental illness and related experiences you may have had as a student.

- Have you ever perceived yourself as being stigmatized by others for your mental illness? By stigmatized, I mean treated differently (in a negative light) because of your mental illness. Y/N/Unsure
 - Why/why not?
 - In what ways?
- Do you ever stigmatize yourself (view yourself in a negative light) for having a mental illness? Y/N/Unsure
 - Why/why not?
 - In what ways?
- Do you consider yourself academically resilient? By being resilient, I mean keeping going in the face of academic difficulties. Y/N/Unsure
 - Why/why not?
 - In what ways?
- Have you ever disclosed your mental illness to anyone at the university? Y/N
 - Why/why not?
- If you were falling behind in your coursework because of your mental illness, would you speak to a staff or faculty member about it? Y/N/Unsure
 - Why/why not?

Part Four: Demographic Data

This section is to collect demographic data that will assist in data analysis.

Gender:

Age:

Ethnicity/race:

Class rank:

Major:

Length of time since diagnosis:

APPENDIX B

This email message is an approved request for participation in research that has been approved or declared exempt by the Texas State Institutional Review Board (IRB).

I am a doctoral student working on a dissertation about the experiences of college students with mental illness. You have been selected for participation in this research study because you are currently enrolled as a student at Texas State University. The study is intended to better understand how college students with diagnosed mental illnesses develop a sense of identity, including their perceptions of stigmatization on campus. If you do not have a diagnosed mental illness, please disregard this email. By diagnosed mental illness, I mean that you have seen a medical provider and received an official diagnosis, not that you have self-diagnosed (ascertained that you may have a mental illness without receiving an official doctor-provided diagnosis). Some examples of mental illness are depression, anxiety disorders, bipolar disorder, and ADHD. For the purposes of this study, all you need is one mental health diagnosis, not limited to the examples provided.

Study Purpose

The purpose of this research study is to ascertain (a) how college students with diagnosed mental illnesses develop a sense of identity, (b) their perceptions of stigmatization on campus (being treated in a negative light because of your diagnosis), (c) their experiences with academic resilience (how well you are able to persist through your coursework given your diagnosis), and (d) their experiences with self-disclosure of the mental illness (sharing your status as having a mental illness with university staff or faculty), which is why this study is focused solely on college students who have a diagnosed mental illness. At the start of the survey, for validation purposes, you will be asked if you have a diagnosed mental illness; if you do not, you will be directed to the end of the survey.

Benefits and Risks of Participation

If you have a diagnosed mental illness and elect to take the survey, you may benefit from participating in this study by reflecting on your experiences of being a college student with a mental illness. There is a chance the questions might trigger difficult emotions; if this is the case, please contact the Counseling Center, located in LBJ 5-4.1, (512) 245-2208.

Confidentiality

You do not have to be in this study if you do not want to. You may also refuse to answer any questions you do not want to answer. If you volunteer to be in this study, you may withdraw from it at any time without consequences of any kind or loss of benefits to which you are otherwise entitled. By clicking the survey link, you are consenting to participate in this study.

Reasonable efforts will be made to keep the personal information in your research record private and confidential. Any identifiable information obtained in connection with this study will remain confidential and will be disclosed only with your permission or as required by law. The members of the research team, and the Texas State University Office of Research Compliance (ORC) may access the data. The ORC monitors research studies to protect the rights and welfare of research participants.

Data will be kept for three years (per federal regulations) after the study is completed and then destroyed. Data will be used for a doctoral dissertation, conference presentations, and publications. If you would like access to the findings of this study, you may contact the Primary Investigator (Ren VanderLind) at (512) 245-7661 or ren.vanderlind@txstate.edu.

To ask questions about this research please contact me, Ren VanderLind, at (512) 245-7661 or ren.vanderlind@txstate.edu.

Follow this link to the Survey:

[Take the Survey](#)

Or copy and paste the URL below into your internet browser:

https://txstate.co1.qualtrics.com/jfe/form/SV_cGd40UgpNi1yIYV?Q_DL=a5BD6XKvJXkJ4Tb_cGd40UgpNi1yIYV_MLRP_b402oVY84KgCeKV&Q_CHL=email

This project 2018318 was approved by the Texas State IRB on February 11, 2018. Pertinent questions or concerns about the research, research participants' rights, and/or research-related injuries to participants should be directed to the IRB chair, Dr. Denise Gobert 512-245-8351 – (dgobert@txstate.edu) or to Monica Gonzales, IRB administrator 512-245-2314

- (meg201@txstate.edu).

APPENDIX C

Following are the full set of elicited metaphors and metaphor extensions, arranged by conceptual metaphor, for “being a person with a mental illness is like. . .”. Data are presented verbatim as written by respondents, so there will be typos and grammatical errors as well as some issues with the flow of the responses.

STRUGGLE

being a product that someone purchased but can't read the instruction manual. When people find out that there's something slightly wrong with you, even if you can hide it really well, they automatically don't know how to react around you anymore. They judge what you do even though there isn't a reason to. They also know how they should treat you, but for some reason treat you like you're fragile and will break or explode at any minute.

Trying to fit a triangle block into a square shaped hole. You feel like the triangle could fit if you angle it correctly but no matter what you do it won't fit. Until someone explains to you why the triangle won't fit, and breaks it down into terms that you can understand, you won't get it.

darkness. it creeps up on you and soon you can't seem to find any kind of light being in the dark is scary. It's unpredictable. having a mental illness is very similar. sometimes it gets so dark in our minds that there is no sort of light. and no one can see you, and you're alone, and no one understands

a constant battle against two opponents at the same time. You're constantly fighting against your depressive thoughts and your irrational fears.

Running in a race where the finish line keeps moving further away You are exhausted and as soon as you see the end (being happiness) it moves further away

Being a person with a mental illness is like a car running out of gas. A car running out of gas will slowly slow down no matter how hard you push on the gas pedal. You can turn off the car and turn it back on and try to accelerate again but it's going to continue to go slow until it can't go anymore. Someone with a mental illness can do their best to move forward but sometimes no matter how hard they push they can't help themselves to move forward.

working on a real old computer. Sometimes it works fine, sometimes it shuts down for no reason. Sometimes it runs really slow and you can't get it to do the things you need it to do.

Being a person with mental illnesses is like using a tiny flashlight through thick fog. Fog, like mental illness, can overwhelm my senses, disorient, and hinder my ability to travel (accomplish my goals).

constantly feeling like you are drowning and trying to break the surface but just keep getting shoved back down by waves. Every day is another battle, whether my depression is overwhelming and I can't leave bed, or the panic attack's of social anxiety and the thoughts people could be having about me.

a fish trying to swim upstream. I try my best but sometimes I get swept up in the current and get taken further from where my goals are. Sometimes my disorders get the best of me even if the medication helps.

Having a mental illness is like being at the bottom of a deep well, treading water, while you see family and friends at the top of the well. It is like this in the sense that my mental illnesses make me feel like I am forced to be very distant from the people who care about me. I often feel as though I'm just 'treading water' by trying to make it through the week in hopes that the next week will be better. I can see my loved ones, but I can't call out to them for help because I'm afraid they won't understand how this happened and may perhaps blame me for falling into the 'well' that is my mental illness. I also hesitate to reach out because I worry that they won't know how to help me and that if I bring my illness to their attention they'll only be able to worry and then I'll have to constantly reassure them and make them feel better about my own suffering so they don't feel guilty for not being able to help.

being a firefighter on fire you have the ability to fix yourself but within all the chaos you cannot function or focus on getting the fire put out

Being stranded in the ocean without a life jacket I know how to swim, and I want to stay afloat but I get more and more fatigued and the shore never seems to get any closer

Being a person with a mental illness is like using a calculator with the wrong settings. When your calculator is on the wrong settings, you're putting in the correct inputs, but the answers that come out are always wrong and you don't know that they are, or if you do, you don't know why. The same thing happens with how we perceive and understand life. We get the same information as everyone else, but we don't process it the same way.

Trying to take care of a wild animal. If you don't take care of the pet, it will turn on you. Feed it, nurture it, and it will trust you and become manageable. Just like if you don't take care of yourself and recognize your triggers, your mental illness can really tear you down.

sitting on the shallow end of the beach but it feels like you're drowning. Anxiety makes you doubt yourself and depression paralyzes you, at least that is how they make me feel.

Being a person with a mental illness is like a baby. Because people do not understand or how they can help you. For example, Babies can not verbally express what they want and are very fragile. Therefore, it is hard to express emotion and people treat you very fragile.

Being a sailor with too many maps You know where your boat is supposed to end up, but often times the maps you are using are wrong. You can't navigate, you feel lost, you can't make an informed decision. But you may not realize until it's too late.

living in a world where the air is thicker than water, like jello. I seem to be moving slower than everyone else.

Being a dam Eventually it will break and you have to prepare for it. You can try to guess when but you'll never really know. There are things to try and do to make it last longer but you won't really know if it will work. We are all waiting for the time that the dam just breaks.

Trying to fit a square peg in a round hole. Im expected to conform to the norms of my peers. My brain just doesn't work like that.

Playing a card game without all the cards For someone like me, it's a disadvantage especially in everyday life. I can go times (months) functioning normally and then something stressful, for example 3-4 exams in one week, can trigger my anxiety which then fuels depression now creating a loop to the point to where there is no motivation or will power. This negative loop begins to step into other areas than just preparing for the exam but as well as my friendships, my out of choir obligations, my hobbies, and worst even getting the motivation to eat. Having anxiety trigger is like an almost self destruct button being triggered.

Constantly walking through water Your own brain drags you down and no one seems to understand why you can't get out of it. But the water is everywhere

Being a dog No one knows how you are feeling because you can't communicate it so everyone assumes you're happy

Driving a car threw a foggy road. Although they might help, the fog still blocks certain areas to see. You can use your lights and windshield wipers all you like. I take Adderall to address my disability, it only helps me so much. I still have parts that are foggy.

drowning in the middle of the ocean with passengers on boats passing you. You beg the other passengers to throw you a life vest or save you, but they either laugh, thinking you're joking, or tell you to swim or tread water. I have begged for help in the past when I was extremely suicidal and people have either thought I was blowing things out of proportion or told me that I should try to be happy. They acted like there was plenty of time and it wasn't anything to worry about.

running on a treadmill. You're trying to keep up / keep running, but sometimes it's incredibly hard. Because you want to keep up with all the normal activities and

expectations, but you want to lie in bed and do nothing... you have no energy and no motivation.

Being a duck on a pond. The perception that everyone has it that everything is ok, but the duck knows that under the water they are kicking and turning the water just to stay afloat and appear normal.

walking through rapidly setting concrete. While the general population is able to get from a to b with relatively little impediment, having a mental illness makes achieving goals harder. It takes so much more energy to handle typical daily living activities, work, & relationships.

Being underwater Because I can't breathe when I feel these things and the people above the surface can't see that I'm struggling for air.

Looking like Switzerland but feeling like Afghanistan. Switzerland is beautiful and calm, Afghanistan is one of the most war-torn countries.

drowning Sometimes it's hard to breathe and stay calm

Babysitting The job seems simple enough when you sign up, to just watch someone while they entertain them self (aka going through daily motions), but it can become really demanding when something goes wrong (symptoms flare up)

quick sand, the more you think about it the worse it gets

a little snowball starts to roll down the hill, and it keeps getting bigger and bigger until it crashes at the bottom; once it starts rolling there's no way to stop it. once I start having a thought that makes me anxious, I start having more anxious thoughts and then I start making up scenarios in my head of how that original thought could turn bad, and then I can't sleep and I start pacing around my room, and then I can't focus in my classes, and then I can't think of anything else except my anxious thoughts. It all starts with one small thought, and it's hard to snap out of it.

A hamster on a wheel It's never ending, constantly fighting to continue when you want to give up, but the momentum forces you to go through the motions. People see you living and moving forward, but don't see the struggle to not get thrown off the wheel (life).

Being a person with depression is like having a weight on your shoulders that some days is so heavy you can't move. You're spending all of your effort trying to support yourself that it's hard to do anything extra. Brain doesn't make enough serotonin to help motivate you to do things.

A dog covered in a crochet blanket, but has been that way their whole life It's covers you, it overwhelms you. But sometimes it keeps you warm even though it might be better to

get out. You get glimpses of light often because it's crocheted but the weight is always there and unbearable and you aren't in control. And even if you are, you're hindered constantly.

Being in a swimming competition with weights on your hands and feet It's still possible to be successful but you have to be stronger and overcome obstacles that other people may not have

Swimming against the pull of a water fall. You can try to make things better with good habits and perseverance but there is always a pull towards depression and isolation.

Walking through a fog and only having sunny days every once in a while. Sometimes it's hard to clear the fog to see the sun because it can get so thick and hard to breathe.

being in a room full of people who speak a different language and trying to get directions to somewhere unfamiliar because there is a constant desire for help and you are constantly asking but it feels like no one understands what you're trying to say and you can't understand what they're trying to say in response since most don't know how it feels and can't give adequate advice.

Swimming upwater in a stream that refuses to stop rushing around you It always feels like because of my disorder i am unable to meet the standards most professors hold and struggle to actually keep up with the work they assign. Most people think taking adderall is awesome but when you've been taking it your whole life it feels more like someone's prescribing you a drug addiction and if you stop taking it you'll fail anyways.

paddling a boat with holes in your oars. Everyone says this (rowing) is supposed to work, you have two paddles, but they don't see the holes in the oars. You aren't supposed to tell anyone about the holes either, because then there is more work or you are constantly being judged as less than a whole. Having a mental illness, I feel like I know where I should be but because of my genetic potential, I'm not where I could be. It takes more resources for me to function, and my functioning directly relates to my quality of sleep, but I need at least 10-12 hours to feel rested and not be in pain the next day. I feel the need to hide the extra effort I use though.

Being a puppy outside for the first time. Everything seems very surreal and distracting, simple tasks are hard to do because things seem more overwhelming.

being a fish out of water. In both situations they are out of the environment that allows them to thrive.

Being a professional fighter You spend every day fighting against yourself, to do basic functions.

Being a cat dressed as a dog. People expect you to act a certain way, but your mental illness makes it difficult for you to be what they want you to be.

Being “fake” news. People often don’t believe you have a mental illness and that you are just overreacting. They think it’s fake when in reality it’s not.

BROKENNESS

Being a book in which all the chapters are out of order. I never know what I’m going to have to deal with next. I think I’m getting better then “boom!” here I am in the midst of a depressive episode or on the verge of fainting from a panic attack.

Being an inanimate object Sometimes you feel like you’re not really there. You let your brain go blank and don’t want to think about anything.

Having depression and anxiety is like a clock where the second hand is stuck and all it can do is click in the same place. You feel like you can’t get anywhere, but you feel the pressure from being stuck in the same place for so long. Anxiety causes your mind to race, but depression tears down any motivation to get out of the rut that you’re in, so you just keep ticking in place.

If your brain was a computer, and it got infected with malware It’s an insidious virus, or disease, that you’ve somehow wound up with. It keeps your computer, or brain, from functioning the way it’s supposed to, and actively fights against you. You know that what it’s doing is bad, but at first glance, it seems like there’s nothing you can do to fix it. However, you can purchase anti-virus software to help clean it up and keep it at bay—”like medication”or you can even have someone teach you how to code, and go in and fight it yourself—”just like therapy.

having a defect. It’s hard to make life seem normal, when there’s something irreparable. Also, telling people about the defect generally seems to result in a loss of respect. It’s hard for people to look at someone the same when they see a defect/mental illness. Defects also aren’t always bad, and mental illness doesn’t always have to be.

a toy that is made faultily, so that it breaks when a child first uses it. I started off with faulty genetics, wired to fail.

riding on a ship with a broken sail Its hard to get going in any direction easily. You have to figure out how to make your broken sail catch the same “wind” everyone else gets but with a reduced ability to do it.

A leak in a house Nobody knows about it until it causes a huge puddle on the floor. When people realize it’s there, they patch it up. But, they are bothered when it leaks again. They patch it up again, but the water has to empty somewhere else. Then it does, and the people are unaware of it again.

being a defective toy Because you can't necessarily see the defect in the toy, but when you try to spend time playing with it, you can tell that something is wrong. And when if you open that toy up to inspect, you can see that it's probably trying to work right, but something is preventing it from doing so.

When you have a mental illness, it's not necessarily visible to anyone, but if someone spends enough time around you, they might be able to figure out that something is not quite right. If you get a person with a mental illness to open up, you'll see how hard they're trying to keep themselves together and act okay, but you'll also see how certain triggers prevent them from being "normal."

being a machine with broken parts. We were built very similarly like everyone else, however, no matter how much we try to function like others, we are held back by those broken parts. Some of us process information incorrectly, not being able to see things for what they are. Some of us over process things, to the point that we cannot do or think about anything other than things that hurt us.

A defective product. I don't function correctly like others typically do.

A computer that is missing pieces The computer still looks like a computer but the internal components don't function properly.

an apple with a worm in it. From the outside, an apple can look shiny and beautiful. It's tempting to take a bite out of it. A person with mental illness can also look fine on the outside. But once you bite into the apple, you see it has been eaten, beaten and destroyed, and you don't want it any more. A person with mental illness also hides those secrets that have destroyed whatever is inside. And you can't go back to being a good apple once the worm is there.

DIFFERENCE

Being in a room where everyone agrees on rules that make no sense, and who get incredibly defensive and sentimental about their existence. We have a culture of fear where anyone who could make a difference is terrified of rocking the boat and those who are powerless internalize the insanity rather than risk offending those with power.

being a person with uncomfortable clothing and often poop stained goggles. On the outside, it still looks like normal clothing, with maybe a bad fit. On the inside, it could be itchy or burning. The clothing could constantly poke at you to look at things. The goggles make everything look worse than it is. You can have something you used to take joy in and now it doesn't provide anything. You get neither joy nor revulsion; you are simply apathetic.

Being a rare unicorn in a field of horses People may admire you from afar but don't want to deal with you over how untamed you are

being marked as a permanent outcast by yourself and society Because when you see that you're different from the norm, it's really easy to outcast yourself in your head

being superman. Being a person with a mental illness is like being Superman. Everyone watches Superman, likes Superman, and overall thinks he's a good superhero. However, no one can relate to him. Why? Because Superman is only half a person. Clark Kent is the other half, he is far more flawed, struggles far more often, and people aren't always nice to Clark Kent like they are with Superman. In this scenario imagine the successful, attentive student that makes good grades as Superman. They are great at what they do and often get recognized for it. Clark Kent is the same student but now we know that they have a mental illness like Attention Deficit Disorder. Everyone admires Superman, everyone thinks that he has it easy with his ability to do well. However, Clark Kent is the reality. He's the one staying up till 3 am rereading articles over and over for comprehension because he can't read them in class like everyone else. He's the one who accidentally says too much, and actively embarrasses himself in front of bosses, friends, classes, etc. However, not many people like Clark Kent. They're so enamored with Superman but in order to truly understand him they must learn about Clark. Not everyone responds well to Clark. When people find out, some take it as offending that Superman took this long to tell them. Some put him on a pedestal and praise him for dealing with what he does every day. Others immediately are fearful because Superman is no longer this strong idolized person. Instead he comes with risks. That's exactly what it's like having a mental illness. No one can see it, but it's like living two separate lives simultaneously.

Riding on the spokes of a wheel when everyone else is riding on the hub. Everything is more extreme (ups and downs) and you are constantly afraid of getting crushed or falling off (not being able to accomplish tasks or ending up committing suicide or something).

Being the black sheep Because a normal person doesn't have the thoughts I have

A hairbrush in a room full of bald men Out of place

Being an alien on another planet. daily life seems like being stuck in another dimension from your surroundings.

being born excluded from the world. Because you grow up thinking that the nothingness you live in is normal, the best there is, until you're shown/told about the industrialized world and you realize you are exactly the opposite of normal.

having a crazy birthmark that looks like a very tasteless tattoo. People appreciate your efforts to hide it so as not to offend them, but those unfamiliar with your situation often think that your personality was what drove you to get that "tattoo" i.e. your diagnosis.

Having a pebble stuck in your shoe. You are the only one that can know that the pebble is there and sometimes you might forget, but as soon as you step forward you feel it again. And you could be in lots of pain but nobody's would be the wiser if they never asked what was wrong.

Being a dull, grey color amongst the rainbow. You see everyone happy... either it being a facade or true happiness, no one knows.. you just long to be on that side. Where the colors are.. bright and beaming.

A plant with a strange mutation Both I and the plant have a genetic flaw, but we still grow in our own ways - It is still a plant and I am still a human.

Being a dark cloud in a world of clear skies. Everything seems to get you down when you have depression. Everyone seems so happy and you're just barely functioning.

Seeing other people walking on clouds when I'm stuck in quicksand Because on Facebook everyone is all smiles and I see no reason to sugar coat my awful feelings. It seems like everyone else has their life figured out.

Being a black sheep in a group of white ones. Mental illness makes you feel like you're different and don't belong.

being on trial. Like the defendant, the person with the mental illness always feels like people are judging them. Everyone has to go through struggles in life, but when someone has a mental illness those struggles become intensified.

A doe in a pack of deer I'm vulnerable but I have protection by my loved ones and can keep myself in safe situations.

Being a bad avocado Both bad and good avocados look the same on the outside. The bad ones are just browning and rotting away on the inside while looking fine on the outside.

"...Drowning, except you can see everyone else around you breathing." It's like you're drowning and even though you know how to swim, you can't get yourself to swim to the surface.

Meaning you're failing at everything and you know the solution because it's right in front of you and because everyone else is doing it and breathing, but you don't swim to the surface because you don't care. You don't care meaning you feel nothing towards fighting to live, or even care about drowning itself. Or you don't care that you don't care and you feel nothing at all.

being a fraud with honest intentions, walking into a room and feeling like everyone can see right through you purposefully. Being a person with a mental illness is feeling like you have super powers that can do nothing but alienate you, yet you have an ability to discuss deeper emotions with others that they can easily set aside. Feelings of confusion,

unreasonable guilt for being who you are and not understanding life like other people. Feeling consistently down, but being different gives a deeper insight into life itself

Playing a poker game with a bad hand Feels like everyone has better hands and you just have to deal with what you have.

If you were in a weightlifting competition, except my bar has more weight than everybody else and this extra weight cannot be seen by others and it does not affect the score given to you
an Olympic athlete being held to a higher standard than those he's competing with. Every task given is possible, but it requires significantly more strength than someone without a mental illness. This extra effort is never seen and never taken into account by others. It is also impossible to explain something you feel that others cannot without being perceived as one who makes excuses

see college student metaphor [running a race against professional athletes] Everyone looks somewhat similar to you (as in you can't see mental health issues), but they are much faster once the race actually starts (other people seemingly have no trouble "running the race" that I'm struggling in)

Like a round ball in a room full of squares Some of the squares know you are the odd ball, and some are oblivious. The ones that know recognize that you understand react and encounter things differently. For example, the way I choose my seat in a room, or how I react to triggers. Others may feel the brunt of my triggers like a verbal altercation.

having to jump an extra hurdle at a relay race. I am on the same track as other students, but I need to do more work in order to reach the finish line. I need to attend doctor appointments and counseling that take up time that I could spend on my studies.

Being a chipped piece of china in a stack of pristine china i feel flawed amongst the flawless

starting a race a half mile behind. You are expected to perform just the same as everyone else, but given a huge disadvantage.

Having to climb over a brick wall while other people pass right through it. With ADHD and anxiety, I can still usually perform a task, but it takes more effort, more time, and more resolve to accomplish anything. The brick wall is mental illness. I can get to the other side of the wall, but it's a challenge that normal people don't face. And simply encountering the wall can decimate my will to try and cross it because sometimes it's taller. And when other people walk right through, I feel like I'm falling farther and farther behind.

Being unable to move Everyone around you is moving, walking up stairs and running, and you just can't get your legs to work even though everyone says it's easy and anyone can do it

Walking around in a black room with a bunch of dark black holes that are very close together compared to everyone else whose black holes are more spaced and farther apart. All people have black hole moments that they are capable of falling into, however my black holes are closer and easier to fall into.

Being a lightbulb in a room full of lights that flickers and strains itself to stay lit like the rest. It is like this because it feels like you're constantly struggling just to get where everyone else gets and to do what everyone else does everyday.

The color grey Everyone else has vibrant colors. Nobody notices grey, unless they are feeling grey as well. Grey is tired, sad, stuck inside like a rainy day. In painting, if you mix color (like red) into grey, the color looks muted and muddy. Not vibrant, but dirty.

Swimming underwater and trying to communicate with those around you that you are drowning in your brain's own toxicity Sometimes people don't understand how you are feeling or what you are saying, they themselves would have to drown or go underwater to understand where we are coming from.

Watching life around you happen on a movie screen. When I'm doing something fun with friends, I feel like I'm only observing. I see them being carefree and having a good time and I'm there but somehow separate. I'm stuck thinking about things I'm anxious about or that I'm not feeling the same happiness as them. I feel separate from people who don't have nagging obsessive or suicidal thoughts.

Being the only person without an instruction manual. Because you have to find a different way to do things. What works for "normal" people, and the skills that are taught to succeed often don't work. You have to find your own way.

a sheep among wolves. A disabled person may have a difficult time fitting in with other people. It may seem that you are and quite possibly never will be in step with everyone else.

Being a background/extra character to someone else's play. Sometime you will stay quiet and observe while others move on with their lives. You will try to jump in and be a part of life, but either no one pays attention to you or they move on quickly.

Making an ice cream sundae with frozen yogurt because while an ingredient is not missing it is being substituted with something else, and the taste just isn't quite the same.

INSTABILITY

A bobber in an ocean I'm all alone, I don't like it, but I can't go anywhere.

Riding a roller coaster, when you're up high you are okay but when you are down low you are very down and there is no determination of how you will be down. As a student with mental illness, I have learned to identify my triggers and when I'm becoming over

stressed. Learning to deal with them is a task of its own and sometimes you don't always win.

For the most part it's feels like I'm on stable ground. But if I stop being diligent, I sink lower and lower into the sand below me. If I stop using the coping techniques that I've learned, I can get overwhelmed in depression or anxiety.

Depression is like the seasons of the year. Sometimes things are wonderful; other times they are dark and cold.

Texas weather Life is unpredictable and so is how your brain will handle life's challenges.

Exploring a cave. You don't know how far it runs, how deep it goes, how wide or how narrow the path is and you don't know where it leads. Having the mental issues, I never know how my day is going to be. I never know how my issues can effect just one day. I don't know how long a depression session (time where I am or am not for the moment) can last. I never know when I am hit a wall of anxiety.

Having your shoes untied. Some days are good and you only trip a little. Some days you fall to the ground. You are unsure of your steps. When you walk you have to be extra careful and it takes you longer to get to places.

Well, it's kind of like being a balloon. There are days where we're inflated (this can be happiness or anxiety respectively), days where we're deflated or deflating (often depression or days of extreme self-depreciation), and days where we unexpectedly pop (examples include hysteria). It's like being a balloon that's always in motion. Because when you live with a mental illness, you're never sitting still. You are constantly going through different ranges of emotional, psychological, and physical movements. Like a balloon, these activities can stretch on for days and days. But, like a balloon, this means your mind is fragile. Sometimes the simplest things can send you popping.

being on a roller coaster. You have your good days then something happens and your day is ruined.

Being on a rollercoaster Some times it is calm, some times it is thrilling (when times are easier/higher up), and some times it can get really low.

Having someone point a revolver at you with one bullet it in and not knowing which bullet is going to kill you The constant anxiety builds up and since people are ao afraid to talk about mental illness, it's hard finding help or finding someone who can relate to how you're feeling.

the ocean. The ocean can be warm and calm depending on the external forces around it, or it can be cold, violent, and dark depending on those same forces. It changes temperament with enough force, and it very rarely exists in the same way for too long.

Walking on eggshells. You never know when you are gonna have a flare up and how severe it will be. Also, the disorder is invisible.

the spinning teacup ride at Disneyland. The harder I work or study the faster I head towards an emotional breakdown, just like the dizziness you feel when you're spinning too fast. trying to accomplish daily tasks can be difficult when my mania makes me want to go out and be social, or spend money I don't have. Then if I act out in my manic phase then I get upset because I feel guilty the next day or week later, which makes me go into negative thought cycles and then I get depressed and start having anxiety.

Automatic lights. I never know when something will distract me and cause engagement. If that thing comes in and moves around,I can't turn off - even if I want to or need to.

Being the passenger in your own car, and mental illness is the driver. You don't always have control over where it will take you, but you're along for the ride whether you like it or not.

Having a dark shadow follow you even on the brightest of days The feelings of depression, anxiety or PTSD can hit without warning sometimes. The same is with a dark cloud covering the sunlight.

driving a car Sometimes you feel completely in control and everything is going smooth. But, sometimes you are completely out of control. Sometimes your tire blows out when you're driving 90 down the highway. Sometimes there's a thunderstorm out and your brakes don't work. Sometimes you're driving along and everything seems fine, but then someone blows a red light and slams into you.

Being a ship at sea without reliable weather forecasts. What a given day or hour will be like is unpredictable, but you're hoping for smooth waters. There are a lot of storms and rough waters that you might drown as a result of, and you can often feel helpless against them. Sometimes you can go weeks or months on end without a cloud in the sky or a swell to be concerned over, other times you're in a hurricane without knowing how much worse it will get.

Being a bike without handlebars Most people have control over their daily lives. With depression, I have learned that I simply have to deal with the loss of control and cope, but it's always there

A sensory target...and every single trigger is coming out you at once. With balancing school, kids and fulltime work I have a lot on my plate. All of these items are cause stress. This stress is expected, but I have to remind myself of my triggers, which include " looking too much into texts, forum posts, replies " and such.

Is like being a wild fox Because I am constantly adapting and changing myself to blend in and survive the various seasons/environment

A glass cup with cracks running throughout We both have purpose but can fall apart easily and be reduced to nothing.

A person walking on the slippery bank of a river I never know if or when I'll slip and fall back in

being on a rollercoaster Because I feel extreme highs, and devastating lows.

Being on a roller coaster There's all of these ups and downs and when you're up, you just have this feeling of impending doom because you know it can't stay good forever no matter how hard you try and then when you do go down it just sucks that much more because it's like "I was doing so well, what happened?"

a cup filled to the brim with water. The water fits in the cup, but the smallest twitch can make it go over and spill everywhere, like emotions, fear, etc.

my depression being a dark cloud that follows me around, you know like the rainclouds in the cartoons. Sometimes they are a little bit lighter, and I can temporarily forget about them, but sometimes they are dark and heavy, reminding me that they are always there. Depression to me is so dark and heavy, like a mental barbell on my mind. Sometimes I have my good days where I'm upbeat and light, but sometimes i have my bad days, and really bad days.

Being a wobbly tire on a car. Because emotionally I go back and forth between extreme emotions quickly without any trigger or warning

having a tornado in your mind continuously. It constantly makes your mind go in a million different directions, some of which are not even practical or things that will even happen.

A ball of yarn A ball of yarn is wound up into a form. It may become unraveled on its own for no reason and become a huge knotty mess, or it may become unraveled as it is turning into a beautiful afghan.

surfing, snorkeling, or swimming in the ocean... because sometimes the water is calm, you are floating and everything is clear but then when the oceans are rough, visibility is zero, and you worried you are going to drown...

Being an actor and playing a part depending on the situation. At times it's being an audience member, looking at events unfold from the outside and not being able to change the script. Sometimes you can't control how your body acts to certain stimuli, people and situations. It can be like watching a scary movie and hoping the lead character makes it out alive. Sometimes you have to avoid certain situations entirely which can be difficult and hope things don't fall apart so completely that you can't put them back together.

a piñata You look nice and fun on the outside, but on the inside there's a lot of messiness going on which sometimes shows itself to the outside world (breaking the piñata). Sometimes people don't always understand it either which makes it harder (the piñata being hit).

BEING STUCK

Drowning Both are a suffocating sensation

being trapped in a dark cave. Sometimes, you feel okay with the unknown, knowing that this is just part of who you are. Many times, though, you cannot see the light from the mouth of the cave and feel like you are all alone in the cave.

Having sunglasses on permanently Those who don't have them on see the world differently, and some might say "just take them off," but it's a lot more complicated than that if they're glued to your face.

Being trapped inside an invisible box You feel confined and afraid but no one can see the struggle you are facing

Being trapped inside your own mind By the terror that put you there. Seeing out your own eyes but feeling trapped behind then, living in fear like a caged animal I feel like I am somewhere, the me before all of this but like I am held back from doing the things I want because of my anxiety.

Being stuck in a bubble. It seems like there is no way out.

Being stuck inside water tank Heavy, difficult to breath and see but overtly aware anybody can see me

Being trapped in someone else's body. You can feel everything yet control nothing. I know what is going on inside my head, I can feel the physical and emotional effects of my depression and anxiety, yet I feel as though nothing I do can control/retard it from happening.

It's like being trapped on a snowy mountain. On the good days, you're able to climb it even if it takes considerable effort. You've got to be careful not to cause an "avalanche" though; you avoid triggers and anything that could stop your progress in its tracks. On bad days, you're stuck under pounds of snow and ice, unable to avoid the avalanche. You're numb from the cold, have no energy to crawl your way out- no way of getting out at all. And you're scared or unable to call for help. You can only pray that the snow melts around you, or that by some miracle, someone finds you and helps pull you out. Otherwise you risk succumbing to the scarily comforting thought of letting the cold take your life this time: wouldn't that be easier, anyway?

going through life hanging on to the side of a hole and praying you won't fall in
Sometimes my anxiety is so bad, I have to go to the restroom and cry because I feel so overwhelmed. But that determination, that hanging on, is still there.

1. It's like being trapped in a box or a cage. 2. It's like wearing a mask all the time. 1. The world is functioning normally all around me but I feel stuck, I feel trapped. 2. I smile and try to act exactly the opposite of how I really feel.

Living in a room that has no door. Depression can be dark and limit you in places of your life. I feel like it can relate through the room in the sense that you know you're in the room and may not know how you got to it but you can't really find a way out.

Drowning Because you can see the surface of the water where everyone is happy and fine. But you are stuck under the water where it hurts to breathe.

Being stuck in a box with no escape A box is dark and compact. It leaves you claustrophobic. Depression and anxiety is the same. You are so uncomfortable in your position but you can't stop it and you can't escape the feeling.

Being a person with depression is like being stuck in a deep dark pit. You look up and you can see everyone around you enjoying themselves but you can't figure out a way to climb up out of the pit to join them. There is a constant weight on your chest and a feeling of being overwhelmed and a lack of motivation that makes it seem impossible that you will ever get better.

Being isolated in a prison cell. You feel trapped and you feel as if there is no way out. Personally, depression affects me in way where I feel disconnected. That means I feel like a zombie or robot because at times I cant feel a thing.

Being stuck in a dark forest with fog everywhere. There's no escape you are trapped and the branches of the trees are grabbing at you like negative thoughts that won't stop. But you can't get too bright because you'll burn down the Forest around you.

A fish in a bowl Some times you are surrounded by empty space that can make you scared or stressed. Then some times you have people that look at you and tap on the glass just to see what you will do. But you learn to live life to the fullest without the distractions that can get you down

living in a glass cage. You can see and hear the world around you, but everything is muffled. Interacting with the world takes a large amount of pantomime and patience from both sides of the glass.

Having a ball and chain. You can take things to placate it, but at the end of the day can never actually shake it off. With anxiety, it's like having a voice in your head that never turns off fully. Not a conscience, but a nuisance. Even when you're by yourself and and

have checked whatever you're worried about several times. You also tend to worry what others think, silly as that may be.

being water-boarded You're constantly exhausted and not finding a will to live. You're In a constant state of panic and it never goes away. You have zero control and it takes over you're whole life. You feel like there's no way out. You're inside of your head and there's these voices constantly telling you how you're a worthless piece of shit that doesn't deserve to live.

A thick, dark blanket (mental illness) blocking out the light (happiness, good things in life, etc...) There's no light under the blanket. I can pretend there is, but there isn't. I can laugh and smile, but in reality I am quite miserable. This blanket is heavy and makes me tired. Along with that, I can't lift it up by myself. I need help from family, friends and God.

Steering a ship with a broken rudder The decision-making process gets warped. You can see yourself making these horrible decisions, but you're powerless to stop it.

a bird in a cage. No matter how hard you try to escape your thoughts, you cannot escape/avoid them.

being in the middle of the maze and you can't find the way out. And when you think you're out, you just end up being back in the same situation. I feel lost sometimes and I feel like I can't find a way out. I'm given options by people around me but I still feel lost and when I try it I end up going to a dead end. There are times when I think I got it figured out but I just end up realizing I'm still in the same maze.

Being in prison, unable to do basic things but the prison is your own mind stopping you. You want to do things and go places but your mind convinces you it's not a good idea or you are simply not allowed to go.

Being trapped in a open cage. You can see the escape but just cant leave Many times i understand the root of my sadness and anxiety. Although, it seems that this doesn't help and only makes me feel more guilt for not getting better.

taking step after step yet never getting to your destination. You learn coping mechanisms and tips and tricks to keep yourself from getting worse, but it feels like you'll never truly be free from this disease.

Being a person with mental illness is like being in stuck in an elevator. You know where you are trying to go, but if the doors won't open you can't get out of your own head. It feels like you are constantly on this ride that you can't get off of. When the doors finally open, and you're able to express the emotion you're feeling, outwardly, (for me this would be a panic attack), you feel better, but you also feel exposed to the people standing outside of the elevator waiting to get on. you retreat back to the elevator you've been stuck on for so long, because for some reason that feels safer than getting out.

Window You can see out of what you are in (situation/building). You are viewing your life happening rather than participating

Being encased within a bubble. You feel disconnected or distanced from the world around you. In a bubble, you are able to experience the world around you (via sight and sound), but your perception of the world is obscured by that bubble. You feel as though you're living, but you're not truly experiencing reality to its fullest. Just as sound is muffled within a bubble, so too is sound muffled when you have depression or anxiety. Your senses are jaded and your encounters with reality feel inauthentic. What once made you happy, doesn't anymore once it's filtered through your "bubble."

a moving hamster wheel. My thoughts go round and round in the same pattern just a hamster wheel turns and never goes anywhere

having a little fog cloud that surrounds you. The fog is all the internal thoughts and worries that are ever surrounding.

walking through puddles on a rainy day. Sometimes it is fun and you don't get wet or step in a puddle but some days you step in a puddle and it's hard not feel like you're drowning in it. Because some days are good days and happy days and others you feel so helpless and for me I think what is the point.

EMPTINESS

The emotional equivalent of watching paint dry. It feels like I'm drifting through life - I don't care much about anything and rarely feel emotions on either end of the spectrum. I don't feel sad and I don't feel happy. I don't get frustrated about the things I should, like where my life is headed. I don't feel any sense of goals or accomplishment.

being a balloon filled with air and the balloon also has a small hole, with time the balloon begins to empty. Having anxiety, at times I feel empty especially if I'm by myself

Being in a room full of people, but everything is kind of silent. You know you're not alone, but for some reason, everything feels absolutely silent. You feel like you're completely alone. No one really cares if you're there or not.

EXCLUSION

being outside a walled garden you can see all the normal plants and animals going about their business but you're not part of it.

Staring at a black canvas. There's never any room for gray areas.

NO CONTROL

Being a shopping cart. It feels like you are getting pushed around. People sometimes reject you just for having a “janky wheel”. Doctors want to load you full of things (meds) to “help” you cope during the therapeutic process.

Holding a donut in your hand while staring at a bagel. Each have centered holes but extremely different flavors. Craving sweetness inches away while being distracted by savory. Sometimes I feel like I'm not in control of my own mind, I can write myself a to do list, but be unable to check anything off of it. Wanting to focus on something important but becoming consumed by something meaningless to me. For no other reason than procrastination, lack of discipline, and bad habits burned into my skull. Making me never achieve what I want, helpless.

a raging river that never seems to end it's a constant flood of emotions

Racing with an old bicycle against professional cyclists. Having less control and more obstacles in my life.

Being in a fight that you know you have trained for but, in the moment you constantly question yourself If you have trained for a fight you know what you should do but, with a mental illness all you can do is constantly question yourself

Drowning and not knowing which way is up. Watching a car wreck and not being able to do anything about it even though you're the one behind the wheel. I never trust my own feelings, myself, the world, or the people around me. I almost never feel in control of my own emotions or my decisions.

Feeling like someone threw you into the ocean with bricks tied to your ankles Everyone seems to be happy and going forward around me and you keep going backwards and you feel like you can't control how You feel or yourself really

Being in a straight jacket Feeling of being trapped in your body with no control over your mind or your body or your life

Waiting for a jack in the box to POP My mood switches rapidly. The turning of the crank signifies the anxiety and uncertainty leading up to either a manic or depressive episode.

OCD is like being in a dark alley, far away you see a light that represents true safety, but right here you see a trap door. You feel as if this trap door can give you what that safe light can. You know deep down this is the wrong decision but your anxiety kicks in and you do it anyways. Only to find you are in the same place you were before. Your compulsion is that trap door. Knowing it's wrong or not truly what you need, you have every urge to take it. On top of that, your anxiety plays with your mind telling you you have to get out of here and that's the quickest way go go go

Limbo. I never know what's going to happen and I'm in a constant state of apathy, which gets confused for being relaxed.

It feels like every day, every minute and every second of my life is a dream and I have absolutely no control over what happens. Because life isn't what you expected it to be and all those hopes and dreams you had growing up were just shattered once you enter the real world.

Being forced to walk through the clothes section of a department store that's either all the wrong size or intended for the other gender. There are plenty of people and they're perfectly fine. I'm just not interested in talking to them/'taking them off the rack'.

A microwave. No matter how much i want to enjoy my life and be happy, its like my moods have a cap and once i hit that cap, whether its happy or sad or mad (etc), I immediately shut down. Its like a timer goes off and I'm done feeling things, or warming things up. Everything gets as hot as the cap allows it and then after that, im left feeling empty.

Depression and Anxiety is like having a filter over the world. ADD is more like a radio station in my head that I cannot turn off. . When I am depressed everything has a blue-grey tint. Everything seems dull and uninteresting. When I have anxiety everything has a yellow hue. I feel like there is a spot of pee on me somewhere but I cannot see it because of the yellow hue, but everyone else can see it and they are all talking about it. When my thoughts are like a radio because of ADD, I do not have much control over what is broadcast, I can change the station, but I do not know how to turn the radio off. Sometimes I can ignore the white noise, but if something exciting is happening in my head it is hard to tune out.

HIDING

carrying an invisible rambunctious monster on your back Nobody else can see either. They're constantly tormenting you, and you have to pretend like everything is okay

being an actor Because in order to be perceived as "normal" I have to act contrary to how I feel at times.

Being a fox in sheep's clothing. Because I feel as though if others know about it then they will treat me differently than they would if they didn't know. I don't like sympathy.

Being a spy You yourself know that you aren't like everyone else around you, and you know that your identity, if revealed, could get you in trouble if given to the wrong person. You look ordinary, but you have to pretend and hide.

Halloween everyday. Having to wear a smile and pretend you are okay around others.

Being a superhero You go around being a normal person with a secret, but rather than having the secret of powers your secret is that you are at war with yourself.

Being a secret agent You can't disclose the confidential information that you have a mental illness or they treat you differently. You have to be a different person on the outside than you are on the inside.

Having to wear a mask whenever I go anywhere I have to try extra hard to keep a good composure when small things happen. I may be worrying about something I said ten minutes ago or wanting to break down, but to everyone that is interacting with me, I am perfectly fine. Just like a mask, you cannot see what the persons actual face looks like when they are wearing it.

Being a fugitive. You feel like you have to hide things from other people because most of them will treat you like you've done something wrong.

being a still-shiny apple with a rotting core. I continued to smile and try to carry on like normal when internally I felt like I was wilting.

wearing a mask everyday. I try to ignore the fact that I have ADHD, yet I can't run away from it. No matter what i tell myself to convince myself otherwise, the habits I have identify me.

Having the flu You want to isolate yourself so that you don't bring others down

Being haunted by ghosts. People, no matter how well intentioned, often say 'Oh, you don't look haunted', or 'I thought I was haunted for a while but then it went away', 'are you sure you're actually haunted and it's not just a phase'. But you are haunted, and despite explaining you're haunted until it basically becomes your introduction, some people still don't believe because they don't 'believe ghosts are a real thing'. When the ghosts start controlling, those same people ask what's going on, and you just respond 'nothing', because it's better to let them judge you than have the conversation again for the umpteenth time.

Being a stage performer. Sometimes you know what the audience wants, sometimes you don't. You're given scripts but sometimes they feel like they're not working. You're supposed to wear a mask to cover what you really look like. Either way, what's on the inside, and what's on the outside are often disconnected for the benefit of the people on the other side of the curtain. Mental illness is a difficult in and of itself, and a lot of other people aren't equipped to handle that burden. I myself struggle with the appropriate responses in conversation with others that have mental illness, and I like to think I at least have some idea of what they're talking about.

Having a bad friend you hang out with but don't want anyone else to know. I have never opened up about my illnesses to more people than I can count on one hand.

Being a person with a mental illness is like being a room with a lock. We have similarities. For example, both are particular about who can enter. The locked room and I require a "key" to be opened. You do not know whats inside...and you may never know

unless you can get in. Though you may have a general idea of what's inside. What's inside might scare or surprise you, or it may be entirely insignificant...but it doesn't matter what you think. There is a lock for a reason.

being an actor or theater performer I spend a lot of time playing a "persona" - pretending to be someone who's more cheerful and confident than I really am to please the crowd. The only time I get to be me (a nervous wreck, easily upset, lacks motivation) is when I'm alone, when I know I won't bother or worry anyone with my thoughts/behavior.

the scratch off paper with different colors underneath. Each person I meet and interact with sees a different color of my personality. The closer I am to them personally, the more my anxiety affects our relationship.

INVISIBILITY

An iceberg You wouldn't see the entirety of it by looking at someone. A lot of the things I deal with, I keep underwater. I don't like people to see me as sad and I don't like people to know how I have to function sometimes because of the ocd and anxiety. It's not to say that I don't get the help I need; I see a doctor once a month, but I don't talk about it to friends or family very often. I've realized that some people can't handle knowing those things about you and it's not their fault, it weighs very heavy on the ones that do love you.

NEGATIVITY

being a person with mental illness a vacuum cleaner Because it sucks all the energy out of you, focusing only on the negative stuff - dirt, mud, etc.

CONFUSION

going on a trip and knowing you forgot something important, but you can't figure out what it is you left. something just always feels a little off. it feels like you're missing something that other people have.

FEAR

Being a fugitive If you make contact with anyone and tell them about your mental illness, there is a very good chance you are going to be reported or even hospitalized, just how if a fugitive is recognized, they'll be reported.

COMPLIANCE

Hating what's for dinner and eating it anyway You know you will not like what is going to happen, but for whatever reason you do it anyway

OVERWHELMING

A baby given a can of soda for the first time. When given a baby a can of soda, their little bodies are not used to that amount of sugar in one sitting before, and they can't control their excitement or being hyper (sugar rush).

EXPOSURE

Walking around without a case on your phone. You feel sort of naked or like really in your thoughts about what you do and the worries that would come with no case would be a lot.

AWE

an entry way into the Garden of the Gods. It's captivating-all your senses are engaged simultaneously and your focus seems razor sharp.

SECRECY

Knowing an unfortunate secret that others don't Not many can notice those who have mental illnesses and when they're struggling, so it's like a secret only you know that you wish you didn't

Following are the full set of elicited metaphors and metaphor extensions, arranged by conceptual metaphor, for "being a college student with a mental illness is like. . .".

Data are presented verbatim as written by respondents, so there will be typos and grammatical errors as well as some issues with the flow of the responses.

STRUGGLE

a robot trying to function with a missing cog. It is difficult, yet possible. Sometimes you run out of steam and break down, but most times you work with what you have and push on. People often can't see from the outside that there is a piece of you missing, that it is hard to do small daily tasks at times.

Having to do all your work with your wrong hand. It's frustrating as it takes you longer to complete assignments as you're having to complete them with a disadvantage; yes it's possible, but not the most ideal situation.

Being haunted with ghosts while juggling eggs on a unicycle. On top of dealing with the hauntings already, trying to balance course work, relationships with roommates, friends, eating/sleeping, it gets overwhelming quickly. There are days where eggs (grades) smash all over the floor, or the pedals don't work on the unicycle (motivation), and we have to

stop and reorganize. Professors are a hit-or-miss in terms of understanding absences when it comes to mental health. Unless you provide a doctor's note, they won't excuse it. Some will even refuse the psychologist's note because "that's not the doctors note referred to in the syllabus".

drowning. You don't have time to keep your head above water. with school work, keeping up with relationships and financial responsibilities, oftentimes our mental health gets pushed to the back burner.

a constant battle against three or more opponents at the same time. You're constantly fighting against learning the course material, understanding the teacher's expectations and being social, on top of your depressive thoughts and your irrational fears.

A heavy weight in my back dragging me down Difficult to do anything and never motivates to move

Being an old sponge You absorb what you think you need but can't hold everything in

learning a language to by a certain date to travel. Getting into a groove is hard. Fear of failure is a huge issue, because failure means not being able to thrive. It can become so stressful you just stop trying.

Climbing a mountain No one understands what it's like to walk into a room of 200 people with social anxiety, it is the hardest parts of my day, talking to others is hard, teachers don't exactly allow "sorry my panic attack kept me from class" as an acceptable answer

Trying to to run a race with your legs half chopped off You are trying to juggle many different things such as school and work and all the while little things like leaving the house are terrifying, you're trying to walk but your leg has fallen off like you should probably stop and go to the hospital to take care of yourself but you feel like you can't stop in a race just as it's difficult to stop when studying for your degree. It's painful and you should stop to help yourself because if you don't you could die.

Treading water I look fine on the surface but I'm Struggling to stay afloat

running out of gas 2 miles from a gas station with a broken leg you see the finish line but the effort to fix the situation seems impossible.

Walking on a tightrope Balance is everything

Eating a cow for dinner. (Yes, an entire cow) I feel as though I am trying to absorb information rapidly and it is not even pausing in my brain. In one ear and out the other.

Getting beat until you can't feel anything. The stress becomes too much and you'd rather not think. It's an everyday struggle to get out of bed to go to class.

Swimming in a river upstream. Because daily life as a student is a constant struggle

Being in a race with a ton of other students and letting them have a headstart. With all of the stresses that accompany being in college, having a mental illness just sets you back that much more.

Going to work out class even though you're sore. You're already sore, and you know you should take a break. However, it's very easy to think that nothing will happen if you ignore you're soreness and push through anyway. Sometimes, if you stick to light exercises, your soreness can end up being about the same the next day. But sometimes, it can give you even bigger injuries. At the same time, you are expected to continue at the same pace as those who are not sore. You can tell people that you are sore, but they cannot see it nor feel it. They push you to be at the same level as everyone else because they don't understand. Then you get mad at yourself, you beat yourself up for not being able to lift as much or run as fast as everyone else. You start to question, "Should I have given myself time to rest? Or is that me being weak? Why don't I have the same energy as everyone else?"

Having a lead backpack There's this added weight that is always there but usually it's manageable, until you get over tired, or the backpack gets too full. Then it seems like an impossible weight to carry.

Drowning. Most people can summon the mental energy needed to get their work done, a lot of the time I can't. I think to myself, "I really need to start this / work on that / finish this" but my brain tells me it's impossible and I'll never figure the work out, and that I'll probably get a bad grade no matter what (I know its all in my head because when I put the work in I get good grades, that is if I can gather the energy I need).

Trying to compete in a 100-yard sprint with a broken ankle Everyone has expectations of you, because they don't see that you're impeded for the task laid out in front of you. Trying to brave it without treatment and special accommodations will only harm it more.

Running a race with your hands tied behind your back. Finishing(graduating) isn't impossible, but it's much more difficult and you need to adapt to keep running.

It's like sleeping on one of the beds in a dorm without a mattress topper. It makes it harder to handle at some points, most people don't notice if you don't tell them, but when you wake up you feel sore much like thoughts that I don't think most people have to deal with.

Folding a fitted sheet. You have tried to understand different ways to do it, you have even watched videos, but you still cannot grasp the concept of folding it. If there is a subject that I cannot understand I try to ask others to explain it. I also watch videos on it. In the end if I do not understand the subject nothing helps me.

Trying to swim but not knowing how You know you need to do something or try harder but just don't know how to

Drowning... each individual class isn't hard, however you pile on a full-time course load, depression, and working. It becomes incredibly overwhelming... some other students have the same amount of work and handling it so well, so then I think "I have to too" ... Because family and friends have expectations... I wanted to meet those expectations, so I'd overwhelm myself to an awful point...

Coming into a movie late and the movie is in a language you don't understand. You are always trying to catch up, the language makes the catching up process difficult, but you don't want to ask anyone for help because it's assumed that you should know and you don't want to bother anyone with your shortcomings.

running an uphill marathon after pulling an all-nighter. I feel like I am constantly exhausted--whether I sleep or not. I have to work hard to keep the negative self-talk at bay when I don't perform in the manner I wanted, to maintain the energy to deal with the constant hypervigilance, to get myself to not "have to recheck" everything, etc. I know that the marathon will eventually end, but it is still difficult while it is happening.

Carrying more weight than you are physically able to. College in itself is very difficult, so going through college with a mental illness is 100x more difficult.

Trying to spin 100 plates on rods at the same time. Having to attend to homework, pay attention in class, worrying about getting accommodations, at the same time, trying to get enough time for self-care.

Babysitting at a second job The same explanation for babysitting, but 50% of your attention is required to be spent on something besides the child you're watching

Trying to sail a boat with a few holes. Well if the boat had only a few holes, it wouldn't sink right away. But the water would still be coming in. So you'd constantly have to keep shoveling out the water to keep from drowning.

Being a college student with depression is like leaping hurdles to get to every class, complete every project. You have to get past all of the insecurities that are keeping you from doing things.

wearing a prisoner's ball and chain. I don't hate being mentally ill but I can't deny how much it holds me back. The pressure of needing to perform well in school makes my mental health plummet like nothing else. I get so bogged down with self hatred and self sabotaging behavior that it makes college a bigger struggle than it needs to be.

A rock and a hard place. The more I try to stay on top of studying or my classes the more my mental illness acts up, and it makes me want to sleep for days, or give up because of

my negative self talk saying it's not enough. The less I'm focused on classes the more anxiety I feel that there's so much I need to be doing and it becomes overwhelming

Struggling to keep your head above water while trying to replay your entire life with a motivational lens for the future Feelings of stress about grades mixed with your past hardships to cling to a hope

trying to stay afloat in an ocean with heavy clothes College exhausts people and having a mental illness holds people down from staying "afloat"

wearing a heavy wool cloak, invisible to everyone else, in the middle of the summer. In my graduate field, which is highly competitive, no one should know you are struggling. Being seen as "flaky" means you are probably going to be passed over for a job or letters of recommendation. Conversely, if someone does know, you must take every effort to prove that the condition does not actually affect your work life. I have a professor who bragged to me that he missed his grandmother's funeral in order to come to a graduate class once, and he expects that of his students. Class, research, writing, and attendance all trump any mental health issues or other personal problems, and so they must remain invisible or be seen as negligible.

Steering the same broken ship in a storm Stress compounds on an already poor state.

Being a calendar with days missing My goal as a student is to show up to lectures and absorb them. However sometimes my illness takes days away that are simply give forever: missed opportunities that are always impactful.

being trapped in a box with no way out while those on the outside are impatiently waiting for you to go somewhere because there is so much to do and so much to keep up with. So much time is wasted trying to figure out how to finish things and almost no time is spent actually being able to finish those things. Those who have no issue with it get frustrated that you don't move as fast as they do. They are waiting for you to get your stuff together but you don't know how.

Knowing what is being taught but, unable to let people know You learn everything just like other students but, as soon as you have to articulate what you have learned you shut down

Being a child in college. Children have trouble managing/understanding their emotions, may be afraid of child like things (like the dark, monsters under the bed) and can get overwhelmed. I feel like that in College a lot. Overwhelmed, afraid of everything.

swimming up stream With ADHD it can take an extreme amount of effort to focus on a subject.

A dog in a field of butterfly's and squirrels. Who do I chase, who gets my attention. Well they both do because I'm here and there and everywhere I believe with school, the thing

that most effects me is my adhd. It's hard to keep focused in class, every little noise takes my brain to a completely different place. Then when I'm home I'm just off the walls and it's hard to sit there and focus on studying and homework

Being a college student with a mental illness is like preparing for the cold You think you'll be warm enough and you can handle it but once you finally go outside you realize you were not prepared for it. I was excited for college because I was finally getting back in school and moving forward with my life. I thought I was prepared for the stresses of college but I realized it was more difficult than I thought.

seeing two people at the same time, eventually you have to choose one over the other. its like an affair, my mental illness wants all my attention and so does school. they are constantly fighting for it and making me feel guilty for having both.

Being late for a lecture You always feel like you missed the first ten minutes of everything.

FEMA I'm supposed to be prepared and organized, but even when I am, I don't do a great job.

BROKENNESS

A leak in a school The people who take care of the leaks in a school aren't the faculty or students. They are the maintainance.

DIFFERENCE

running a 100 meter sprint while wearing flip flops a mental illness is debilitating like wearing flip flops. having a mental illness while being a college student is more difficult because you normally don't have time to cope with it like a normal person can. College doesn't care if you're struggling on the inside, you have to finish the race no matter what.

being a skittle mixed in with M&M's Everyone looks the same because everyone labels themselves with some bullshit disorders and says they need a pet to help them get through the day, but half the people don't even have what they claim they do. Meanwhile YOU actually have that disorder and problem

A race car driving a constant loop, trying to keep up with the other cars but never quite drifting right. During school everything goes so fast it's very hard to keep up. Especially the students around you, they seem to be picking everything up at a faster rate.

Being a blind person at an art museum. Sometimes you feel like all the odds are against you and everyone else deserves this more than you and you start to question why you're even here in the first place if your brain has trouble doing the one thing it came to do.

Being a college student with a mental illness is like trying to drive on a toll road through that thick fog mentioned earlier. College, like the toll road, has an incredibly fast speed

expectation. I have to pay close attention to my driving (lifestyle, self care, pace I set for myself) and overcome my fear of crashing in order to continue driving (working towards my degree). Meanwhile, most of the other drivers (students and sometimes even instructors) can't see the fog (mental illness) that I do, so they don't understand why I have such a difficult time driving (participating in class and doing homework).

The emotional equivalent of watching paint dry while being surrounded by toddlers. The mental illness is the same, but now you have a bunch of people who "understand," but don't really understand. People who come from well-to-do backgrounds that tell you to just stop being sad. People who haven't experienced the days of not being able to get out of bed, or the thoughts of worthlessness. Depression is not just being sad - in fact I hardly ever feel sad because I don't feel much of anything. And these people look down on you, even if they don't outwardly display as much.

The same as being any other person with mental illness. The only real difference is that the training wheels are off the bike. You go to college with the directive to "get out there and be somebody". You start to feel like you're the only one who is considered an adult that still feels like a child on the inside.

It's like trying to race in a pool, but everyone else can swim and you're only allowed to try to run along the bottom of the pool. Many times I feel very overwhelmed and I struggle to find the energy to force myself to keep up with classwork. I know I need to do it, and I very much want to do it, but I literally can't stop myself from waiting to the last minute to do things. I see everyone else being organized and prepared and doing things at a good pace, but I feel sluggish and stuck in comparison.

Trying to run a marathon with a hurt ankle. In a race you are expected to run and keep up with the other competitors and in school students with disabilities are expected to compete with others who do not have the same struggles as they do. In both situations one has a greater advantage than the other.

Being a college student with a mental illness is like trying to run a marathon with a freshly broken arm. The broken arm doesn't exactly make you incapable of running, but it's incredibly distracting and puts you at a big disadvantage, because you can't take care of the broken arm without taking away from your performance in the race. Having mental illness is like that, you have this thing, I consider it a pain, that is constantly trying to make you quit the race that is college and jobs and generally being a productive member of society. It doesn't make you physically incapable of learning or working or anything, but it still is a detriment.

It's like swimming upstream with 800 pounds of extra weight strapped to your body. For the most part, everyone around you has the same or similar goal: graduate in approximately four years. You see others, on land and not in water. They are walking unincumbered by the stream or added weights. They finish classes with relative ease and manage to show up every day. Meanwhile you're stuck, fighting just to stay above water to breathe. The weights pull you down beneath the water's surface, the violently

unforgiving current pushes you back. You desperately want to go to class, to finish this semester even with straight Cs. But you can't, no matter how hard you fight. And you see others moving forward without you. Graduating. Earning credits. You feel pathetic since you're unable to show up to class. Classes you love to take. Classes for your major/minor. But there you are, drowning. Four semesters into college, just barely avoiding academic probation, and having nothing but scars and your beating heart to show for it.

being in a different time zone, slightly out of sync with others around me. It takes much more effort mentally, physically, emotionally to do what I remember doing at a faster rate.

Being a black sheep You try to blend in and hide everything that is wrong with yourself to make yourself seem normal so you can just be like everyone else. But no matter how hard you try to hide there will be a day where you suddenly break and everyone is there to see it

Having only 75% vision I don't always have the same experiences as my friends do or don't see a situation the same as majority in the group may. I feel like I have blurry vision and glasses haven't been invented yet but my friends all have perfect eye sight. They get the true experience and I get to only experience what I've missed through them. This is specifically part aiming to the social aspect where in the situation I'm experiencing a bit of anxiety and depression, I have to monitor more of how I act and come across putting much energy into that than just enjoying the experience and being ok with myself at that time.

Living in a room with no door and a window that can't be opened by everyone. I think that being a college student can open you up as a person and increase how social you are. The room is still the same for depression but the window shows you where other people are and can lead to comparing your life to theirs and making you feel worse. People can also try to help you through the window but it cannot be opened unless it's by someone special.

Being a puzzle piece with no puzzle to fit into Lots of kids self diagnose and it makes me feel like it's a competition of sorts, but they still fit in with the crowd and I stand out because mine is more more apparent

Being on trial Everyone questions your motives and character. Taking care of yourself can be controversial - do you lie to your professors or tell them something easier? What is the jury's verdict? Excused or unexcused?

a dramatic film You hear phrases all the time like "omg I'm so OCD i like to colorcode my planner" or "I'm like having a panic attack about that test," but people don't really understand what that means. A lot of people have never really experienced those things and use a mental illness as a hyperbole for how they are feeling. It's used as drama and a method of storytelling to get the message across.

Having ankle weights and chains during a race where everyone is free to run without them. We are all seeking an education, but those of us with mental illnesses have obstacles and different ways we have to approach situations.

Drowning while others watch It always seems like everyone has everything together and then there's me.

being a lost puppy everyone else is happy and knows what they're doing but you're in a constant state of panic and feel incredibly lost

Like I am an alien trying to understand foreign cultures. I feel that how to act comes very easy to others, almost instinctively. I, being an alien, find it hard to understand why most people think one thing is funny. It is easy to see the differences between them and me making me feel isolated, and homesick for a planet that doesn't exist. A planet where everyone takes the time to understand me and don't think I am weird or too cold and quiet.

a cup of coffee with too much sugar in it. If the cup of coffee had less sugar, like the rest of the Jo's walking around, he/she could be considered "normal." Life would be seen without the extra stress, or over-dose of sugar in this case.

Being at a pool party where everyone is having a good time, but I am drowning. Everyone is able to go to school every day and walk around campus without a second thought. As for me, sometimes I do not have the willpower to leave my bed all day, or I walk around campus with my mind going 100 mph thinking about who is looking at me, who looks better than me, if someone saw me trip, if I see someone I know but don't look good enough. It is as if I am always drowning in my thoughts and emotions, while everyone else is going to school as normal.

running a marathon where half of the water stations are empty. Even though you can go at your own pace, going too slowly means you won't place well, and the breaks that are supposed to be there for everyone may or may not work for you.

being a windup car versus a mercedes. It takes a lot more effort to go the same distance, and the effort required is harder.

Being one stalk of corn in a field of maize. Everyone says that they're the corn, and they might be, but there isn't any way to tell until you see what's really inside.

A person screaming underwater to a group of mermaids People (mermaids) act like they get it they understand.... they have seasonal depression or w/e so they "know" what it's like to be chronically depressed. But it's not like that. And these are the people who enjoy it almost, use it to say "see I'm not privileged I'm sad sometimes!" nor they use their mental illness to justify themselves. But I am screaming that I suffer too tho I'm not nearly as public about it.

playing sports Sometimes you feel great and are running along with the rest of the group. You feel like you can keep up and, sometimes, get a spur of energy to move faster. But, sometimes, you feel so drained and exhausted even walking is a task, don't even think about running. Curling up in a ball seems like a much better idea and you might do so and watch everyone else run, feeling awful.

Same ship, but with inflexible port deadlines and other ships around you that don't understand why you took a route with big storms ahead. It'd be safe to assume that all college students get stressed out at times. The stress of deadlines and assignments doesn't negate the stress and mental/emotional strain of mental illness. It usually compounds or exacerbates it.

being physically handicapped while competing in a triathlon. Both are endurance challenges which may be more difficult to complete than for other people.

running a race against professional athletes Everyone looks somewhat similar to you (as in you can't see mental health issues), but they are much faster once the race actually starts (other people seemingly have no trouble "running the race" that I'm struggling in)

A penguin trying to fly within a flock of oversized intellectual crows. Even though not everyone is perfect, I am easily discouraged when compared to other people and unable to match up. Feeling slow and under accomplished than my peers who understand the material faster and are exceptional at anything they put their minds to.

Trying to write with a broken wrist Because writing is simple and easy to most people, most can do the task without thinking about what they're doing, they don't mind doing it, and it comes naturally (at this age anyways). But writing with a broken wrist is quite the task; it can hurt, your handwriting is probably much uglier, and it can discourage you. A college student without a mental illness perceives certain tasks- like going to class, talking to people, smiling, acting interested, etc.- as easy, and they don't mind doing it and may actually enjoy doing it. While for someone with a mental illness, these 'simple' tasks are painful and hard; they don't want to do them and have to put all their energy into doing the bare minimum.

Not being able to call in sick to work because your sickness isn't the right kind of sickness. Some days you lose the fight with your mental illness and its not acceptable to call in sick to school, because its not the right kind of sick. Getting yourself to do basic things like get up and shower and eat in the morning are the most formidable challenges some day. Something that you should be proud of yourself for doing but the rest of society will always chastise you.

Walking up a mountain only to realize you had more weight to carry than others, and no one else believed you. I have the same requirements as other students, but I have panic attacks and depressive episodes that take a lot out of me, and yet I still have to get out of bed and work as hard as the other people who don't have the same inhibitions as I do. So when you're proud of the 88 you got, your peers don't understand why you were worried.

Learning to scuba dive with flotation devices. You try hard to do what you're supposed to, but you have to work twice as hard to complete a task that someone without a mental illness completes

running a race with a broken ankle. Despite being at the same starting point, you are given a disadvantage that sets you behind.

Swimming in syrup Everything is slower and harder and you get worn out so easily because when everyone else is swimming in water, you expend twice as much energy to go half the distance

A wounded animal in a herd. Although a wounded animal is visible, it can feel like you're weak compared to everyone else invisibly.

Having to run a race with weights on your ankles, but you don't know if other people have weights too It slows you down and it's a struggle to lift up one foot after the other, and because you don't know if other people have weights too, you don't know if you're just overreacting to how hard it seems to be or if they have an unfair advantage. Having a mental illness is the same way, it's hard to make yourself study and not procrastinate or skip class. It's an illness; it's tiring and you want to give up, and you tell yourself that you're just being dumb and everyone else can do it, so why can't you?

Same as above, but more prominent and negative [note: previous metaphor was 'window'] Everyone around you seem to be alright while you are crumbling and falling apart.

INSTABILITY

Walking around with a time bomb Sometimes everything is fine, but other times you really need to write a paper and boom. Your brain can't focus on anything without freaking out. You go through repetitive actions to try and calm your brain back to a state of working, at least enough to meet the deadline. Often deadlines are the only impetus to override the brain's freakout patterns.

Taking a test and blanking every time you want to write down the answer. At one point you have total control and the next moment, you can't seem to control how you feel or when you feel, it happens randomly. Similar to blanking on a test.

Being a wobbly tire that is falling off. The stress from school and home life with a mental disorder constantly has me on edge feeling like I'm going to break at a moments notice.

Stacking blocks too high until they topple over You think you can keep adding on things but things get too much and everything can come crashing down

Walking into a tornado and having your world spun up
Setting yourself up for triggers of stress and depression

Riding a roller coaster and trying to keep a straight face. Everything is at such a fast pace in college and through the entire experience you're trying to juggle the highs and lows of your mental state all while maintaining good grades. Sometimes it's easy from routine, and others you have to allow yourself to breakdown.

going to a cliff diving. You're taking a leap and hoping the rope doesn't break because then it's all downhill from there. Well college is already a stressful place. The thing that bothers me is that people do not take the time to separate true anxiety and depression versus college anxiety and depression. College is hard. You get criticism from professors, tests stress you out and being on top of things to get a job when you get out is stressing. There are ways to handle all those. The thing is handling your own social anxiety, paralyzing depression, generalized anxiety from creeping into your college life and crippling you. That's what I mean by hoping the rope doesn't break.

Is like going on a first date with someone. With both you hope to go in one direction. You hope your date is going to be good and you can click and date and that your both going in the same direction (you both like each other). With my issues... I hope to have a good day, I hope that I don't have issues, I want a good day, and I never know what is going to trigger a bad day.

A freezer with a broken door. I feel unregulated. I am either warm or cold, but never both and always melting. I have bouts where my anxiety races twenty years into my future, and other times where my depression keeps me from getting out of bed because it's not worth the work.

Being a college student with a mental illness is like a rollercoaster. Because life can be going great and the next thing you know you're falling fast downhill. additionally, you did not see the "Drop" coming.

having a lease on a really great apartment, where you can make a lot of progress in life so long as you live there, but terms of the lease agreement are not at all forgiving and you are completely unsure if you can abide by those terms for the next few years even if you want to. I can't really predict or prevent getting sick again. If I do, I feel like so much of the stuff I've achieved since the last time I was very sick could easily go out the window. Of course, I don't want that to happen, but I feel like if I get "evicted" from my current circumstances, I will have to start over entirely.

Being a tight rope walker, trying to maintain the delicate balance of school and personal life, hoping you don't take a misstep and fall completely from your path. I have had to make great sacrifices to make sure I do well in school. I don't really have friends right now because of limited time. I have to maintain a sense of regularity and keep to a strict schedule to help me maintain a stable mood and get enough sleep. Because I am

vulnerable to stress as a catalyst for mood swings, I must take medication and cannot work more than one day a week to prevent mental exhaustion and breakdowns.

Trying to keep your head above water but your body is so very tired. Your body is your mind trying to keep positive thoughts above the darkness below. But you can't push too hard or you'll float too high and lose sight of the ground.

Tectonic plates meeting Because it's hard to balance school and life. On both sides stress and triggers continue to build. Yes people can feel the warning signs of the tectonic plates as they come closer and closer together, but it only takes one slip for a mountain to emerge- or an earth quake.

an ocean that's being polluted. On top of an ocean being consistently unstable in its temperament, pollution can put the ocean in a worse condition as it seeps into the water and causes instability as an internal factor. Pollution could include normal school stress, negative peers, possibly a bad experience at school, financial stress, etc.

Being a college student with a mental illness is like being a surgeon with narcolepsy. The two both have to stay on task in order to be successful, but both have a disability that makes it challenging to stay on task. If either of the two fall victim to their disability, The consequences are highly severe given their positions. Imagine a surgeon who's performing neuro-surgery, falls asleep during; in this case, the patient more than like sustains damage or even death, the surgeon could then lose his license...there may even be lawsuits. Imagine a college student with a mental illness cannot perform well due to their condition (every day is different, even with medication), the student is likely to not do well on an assignment or even in the class...the student could fail, the student could then be put on academic probation and the student can lose their scholarship. this happened to me.

A rollercoaster. College students have a lot of pressure and having anxiety makes it worse. It is not always easy to talk about.

A few bumps in the road In the middle of a panic attack or a period of major depression, I can recognize it's just my brain playing games. I know it's not the end of the world and it sucks, but it won't be forever.

climbing a ladder and having the bottom rung fall off as soon as you pass it. I have mostly been a straight-A, ambitious student my whole life. I have never been challenged in school to the point where my mental health has been affected until the 2017-2018 school year. I over-extended myself and there is no going back so I have pushed through it and sought help. But every time I get to a stable point with my mental health and control over my life, I screw myself over and spiral into a panic again.

running through a dark tunnel that is on the verge of collapse I am constantly worried I will have a panic attack during class

Driving a car that's rusted and old You know the car can get you to your destination, but it falls apart all the time. It takes so much time and effort to fix things, and you have to worry about the constant stress of will my car break down today and how will I explain my absence

A person walking on the slippery bank of a river while carrying \$20,000 This time if I fall back in I'll waste all my tuition money

being in the ocean. I feel like there are so many things I have to cover and I feel like drowning. There are so many waves and I go up and down. So many challenging waves come to me. I survive each wave somehow.

BEING STUCK

Being in a never ending maze. Some days are good but most are bad. It's like sometimes you think you have it under control then all of a sudden everything is back the same and looks the same.

Being chained to the sidewalk outside of a house party You are close enough to hear and see the party and you were on your way, but something is holding you down that you can not break away from without a key

being on a never-ending roller-coaster that everyone both doesn't want to get off (but also does). College challenges you in every way possible. I stand by the notion that these are some of the most intense moments in an academics life. Finals, meeting new people, working to pay student loans, and sleep deprivation are examples of stress in every student's life, but especially in those with a mental illness. There are days where I've given up. Where I've been so discouraged by the impacts of my mental illness that I just lay down and cry. But I never leave, because I've come so far.

Trying to stay afloat in a pool with piles of rock chained to your feet Every single moment feels like you're just drowning no matter what

being constantly poked with a very long and sharp needle. The anxiety is always focusing my attention on something that happened years ago, and telling myself don't do that again. Don't do that again. A person similar to this person hurt you years ago, avoid, run away.

Being a souped up race car with it's motor running full speed, but forever stuck in park in a closed garage. Again, I was born with some gifts as most of us are, but some of us are emotionally wired to screw up. Oh yes, I have officially been diagnosed as an anorexic.

Drowning Because I'm stuck in my negative thoughts from the depression and it goes around in circles because of the anxiety. I'm drowning because my depression impedes my ability to focus and remember and then more things to remember are shoved down

my throat. All to get a degree so my non-existent future children hopefully have a better existence than me.

Perpetually drowning in an infinite sea of quicksand. Being a college student with mental illness is like perpetually drowning in an infinite sea of quicksand because it feels like you're drowning over and over again. And in between drowning again it feels like you're drowning forever, like time is going by you and you're just stuck watching it go by. And then you sink in the quick sand and it starts all over again with a new month or a new year or a new deadline or after you got one breath of fresh air and false hope.

Someone holding a gun to your head. You're going through the motions just hoping or praying that the trigger isn't pulled. You're trying to please the gunman (the voices), and you're overwhelmed with panic and anxiety and anticipation for the bullet.

A big bird in a tiny cage. Similar to my first response, it is harder to function with the illness. On top of the illness, tasks that have due dates and schedules make it difficult to keep up with.

running and running and running and never getting anywhere. It sucks when you are trying your hardest, but freak out during an exam causing you to make a bad grade. Or having to miss class because you're panicking even though you wish you could be there, and having to take an unexcused absence because you can't get a doctors note excusing you just because you were feeling a little anxious one day. There are some things that have helped, like having accommodations for testing.

Being stuck in concrete and being told to move forward. No one really cares if you can't move because you just need to get up and do it

Staring at a blank wall. You are expected to have your life planned out and if you don't, it's hard to know where to even begin. Starting ANYTHING feels like failure is always ready to jump on, so it's better to not start anything because you'll never fail.

EXCLUSION

Being an onion Classmates will be able to deal with you, but may see you differently once they find out what you have. Like peeling an onion layer. Once you fully cut an onion (for me that would be an instant of me having an episode) no one wants to be near you.

being an empty bottle at a party. You are present but no one really notices you are there any more.

Being a leper. As soon as someone finds out about your mental illness on campus, you become an outcast, just like someone in a leper colony. They all want you to seek help, but none of them want to actually help you.

A piece of corn in between your teeth Not supposed to be there

a bottle of fresh water floating in an ocean. At the core the 2 elements are both water (humans) but the presence of salt makes one very different than the other and isolated from the rest. Ultimately the bottle (mental illness) keeps them separate and apart when they want to mix together and interact.

Separation because no matter what you do you do mix in with everyone....

Being the ugly red headed step child. Everyone looks at you differently when you tell them you have a mental illness.

A sock missing its match. I dont know anyone else who has the same anxiety/depression problems that i have, even though i know theres another person on campus that feels the same way i do.

Batman As a student, I focus and work hard, but always feel like I have this big secret. The secret isn't necessarily good, but once I tell someone or show them my "bad side" I feel like they look at me differently. People in Gotham City often saw Batman as bad and that he hurt those around him, but Bruce Wayne was the good guy who did a lot with charities. Sometimes I feel like I hurt people because of the bipolar and depression. That I don't act the same as others around me.

Being invisible I don't typically disclose my illnesses to people unless I'm really struggling. So, I'm typically struggling alone.

If you were going to hitchhike in 2018. People don't pick up hitchhikers on the highway. People are wary of them and worried about their own safety. A college student with a mental illness is like the hitchhiker because students are worried about their own fun and are wary the person with mental illness will threaten that care free attitude.

Being a square peg in a round hole Tests and quizzes give me anxiety, none of this matters to professors. Job aspects for my life gives me anxiety, college doesn't care about this. I've worked 40 hours and gone to school, college doesn't care about this. Ill be in debt for the rest of my life, college doesn't not care about this. The campus is also pretty toxic with nazis and such. I wonder if its worth it and i wonder whats the point of it all at all times.

A hamster on a wheel You are exhausted and alone on this wheel. You feel like you can't get off and things are moving to fast. You can't do anything else but die on the wheel. Everyone else is running the wheel with a smile on their face, but you only have tears

someone suspicious following you at all times. My anxiety is like this. Someone suspicious is following me and I'm hyper aware of everything all the time, worrying what will happen if this person jumps out at me. For me, anxiety happens all the time, everywhere. Even if its just talking to my professor. I feel like it has limited me in so

many social events in college and then that feeling just adds on the feeling of being left out, and even more anxiety that I am "failing" as a college student.

NO CONTROL

Watching a movie with your favorite characters. You want the best for them, but they obviously can't hear you. When I can't get out of bed to go to class I'm watching myself fail and I can't do anything about it.

Driving a race where you are the only one without breaks, and the gas pedal operates itself. Everyone else seems to be zooming along safely, slowing down and speeding up as needed, getting their tasks done and progressing. I can't slow down so I keep crashing into walls (manics, panic attacks, etc), and then when I try to get back up to speed after righting myself, the car (my mind) won't speed up when I want it to (depression)

Not being able to find the right outfit in you're closet so you go out wearing something you're uncomfortable in or staying home. A lot of the time I don't feel like I'm in control of myself.. A lot of the time I feel like I can't study because of my ADD so I take my vyvanse. Then the vyvanse causes me to have a panic attack which causes me to leave class and go home.

baptism by fire you are thrown into a situation you have no control over. It's demanding and unrelenting.

trying to ride a bicycle after only riding on a tricycle for your whole life. You feel off balance and out of control at times.

Being thrown into the wolves. Because college is already hard as is. Having a mental illness along with it can feel impossible to be successful in college because there is no drive and no looking forward to the future.

Standing in a room of people, screaming, but no one hears you. No one can see you. No one knows you're hurting. And then the room gets more crowded and you scream louder, and still no one hears you. And then you start to feel like you can't breathe, and the room starts to cave in, and everyone else starts running but you can't move. You're stuck in the room as it caves in, and all you can do is brace yourself for what's about to happen, because you can't stop it. When you're depressed, you feel like you're dying on the inside yet as you're walking about no one thinks anything is wrong with you. No matter how hard you try to snap out of it, the sadness won't stop caving in on you, and eventually you give up because neither you or anyone else seems to be able to help.

Is like being thrown center stage nude Because you're completely aware that you're naked, you didn't have a choice to be naked, and now everyone is watching you.

a coin flip that will determine the height of the hurdle. Sometimes, peers and professors are incredibly understanding and offer support. They will listen to me when I speak about

my experience and will offer help. Other times, peers and professors will not be understanding and can act as an extra hurdle. They may even claim that I am being dramatic and/or making it up. People that are understanding of mental illness make the extra hurdle that I need to jump shorter. People that are not understanding of mental illness make the hurdle taller.

Having a constant weight pressing on your chest and trying to smile when all you want to do is disappear into the abyss and never come back. No matter how hard you try the weight is always there. It will lift and give you peace but then comes back with a force and you have to work even harder to pretend that there is nothing wrong. It's a companion that is always by your side and never gives you complete peace.

having a boulder chained to your ankles. You try your best to make others and yourself proud, the intentions are wholeheartedly there. Yet, even one simple step forward is a grueling and exhausting task when you have the weight of the world with you. Things that normal people take for granted, like waking up and getting out of bed, eating meals, maintaining hygiene, etc. are also increasingly difficult for broken, shackled people like us. Whether its depression, anxiety, or any other mental illness, it is always with us. It really does make even the simplest of tasks so hard for us to do. We can't fully get away from it no matter how hard we try.

being just one car on a train that's going to wreck and knowing none of you can stop it but trying to survive anyway. i feel like anxiety is going to kill me one day and it sucks because I don't know how to find the motivation to do school when i know i'm gonna fucking die, why bother??

Being in a straight jacket, tied to a cinder block, tossed into a lake Same as before, but with so much more to worry about. Grades, work, money, laundry, dishes, physical health, pets, personal relationships, etc

Performing on a stage. Anxiety controls my school performance so i do well. I'm too afraid not to. But it's a massive battle. So while anxiety is controlling my performance my depression is there underneath the act telling me I don't deserve the grades I got, I'm not actually smart, I don't deserve the praise I get from friends and family. It's all just for show.

Being trapped on a leaking boat As all students know, college is a never ending continuum of assignments, exams, and homework. However, to a person with anxiety and panic disorder, college is a never ending continuum of stress, disillusionment, and worry. Just when you think you're finished with one assignment, another one opens up for submission. These constant back to back due dates make people with anxiety feel like they can never stay afloat. As soon as one hole is fixed, another is created. This tenuous state can rip at the seams of a anxious student's peace and leave them feeling helpless.

Being a college student with depression is like spending every moment of your time on someone else's life. The classes you're taking and the degree you're following doesn't

feel important anymore. Nothing does. It feels like you're wasting your time on something you're only doing for your parents.

INCLUSION

being slightly less of an outcast surprisingly! I've met so many people who also have mental illness and makes me feel less like an outcast. People are just more open in college! We all see we're adults and if we need help we are more open to it and it's more accessible

Still being in sinking sand but other people are with me. I know several people who also suffer from the same mental illnesses as me in college.

A ball of yarn A ball of yarn wants to be what it is. A ball of yarn, but through experiences and support of peers and educators it is weaved into the beautiful afghan. Sometimes it's a struggle to accept the beautiful thing it is becoming, but so worth it!

A pack of sardines. People I have met or have heard from during discussions of class... experienced it or have it. It might not be the same experiences but everyone is somewhat the same. We're all packed into the university trying to get through it. Hence, a pack of sardines..

Being a superhero in a world of superheroes We all know we aren't the only one but we still hide that part of ourselves

Having a bad hand in poker except everyone including you is on fire We are all on fire

Being a member of a secret club that doesn't know who the other members are. Being a person with mental illness is not a unique problem, there are so many of us. But often the people who suffer are not likely to tell anyone due to stigma, so you don't know how to find each other.

Drowning, but others are with you. Everything can become really overwhelming. But you know you aren't alone.

ENDLESSNESS

Being one of those automated vacuum cleaners Because you're always on and there's a dirt - stress, anxiety

HIDING

Playing with drama masks It's like a drama mask because while you're in class or with friends, you put on your happy mask so no one questions you or asks if you're ok. You're hiding yourself to seem normal

Being a spy needing to blend in in plain sight. I parade around campus with my earphones in, trying to appear normal while hoping nobody confronts me.

Living a fake life On the outside everything seems fine and all of your friends think you're fine but in reality you're struggling

Constantly trying to play out Halloween and not take off your mask and make others know who you really are. I don't want others to judge me by assuming the types of thoughts I have everyday.

Being a comedian You joke about it so your friends know somethings wrong but won't feel sorry for you. If you couch it in a joke you still get that layer of separation from it.

Drowning in a sea of your thoughts, but no one sees or hears your pleas Whenever I'm going through a rough time, I don't like to burden others with my thoughts or problems. I often act or say that I am fine when, in reality, I'm not.

carrying an invisible rambunctious monster on your back Nobody else can see either. They're constantly tormenting you, and you have to pretend like everything is okay

hiding from others. I act like other people do in order for others to accept me as their own.

Being in a room full of squares and I am the ball, but the squares are blind, and I pretend to be a square as well as much as possible. No one knows anything about me, and are so consumed in their Facebook and Iphones they are oblivious to my odd behaviors. I also adapt my behaviors in school so as not to have negative impacts on my fellow students. For example, I yield to the crowds and instead of snapping at the student that may trigger my ptsd, I whisper as polite as possible that what they are doing is negative and not "the bobcat way"

wearing a mask Because I want to conform and fit in

being a flightless bird surrounded by beautiful doves, parrots, and other flying birds. Everyone around you is going out and making friends and "spreading their wings." But for me, going out is terrifying. I was sexually assaulted 3 years ago and tend to panic a lot when I go to parties now. I feel like if I show people that I'm fun and friendly, then that makes me more vulnerable. Instead, I tend to stay home and do things on my own.

Wearing a mask I'm not generally very open about my mental illness with my class mates

Having a mask on Many times I pretend I am okay, when really I am yearning to be some place else, close to family or in bed.

being a rabbit hiding in the bushes If I let anyone know I have a mental illness, I will be treated differently. If I have a typical problem that most everyone has, I feel like people are suspicious about whether my problem has to do with my bipolar disorder.

being a clown in a circus. You have to act and be "happy" to get through but deep down you don't want to do anything.

DOUBT

having someone in your mind telling you can't do this or you'll never succeed. I am constantly feeling as if I am not good enough because of how overwhelmed I am.

STRATEGY

playing chess. I have to plan strategically to ensure I am making the correct moves that support my well-being while also achieving goals.

OVERWHELMING

Dinner being extra big. There's school on top of just trying to eat and pay rent.

Adding too many toppings to the aforementioned sundae because on top of the substitution of fro yo you decide to overwhelm the tastebuds with too many flavors

FRAGILITY

Dropping an egg It breaks immediately

THREAT

Playing catch, only stepping out of the way at the last minute instead of catching the ball Im expected to catch the ball, but I dont see it as a game, just as a ball being thrown at me.

DISTRACTION

Having someone pressing on the top of their pen. When someone keeps clicking their pen, it's a distraction for everyone in the classroom because of a distinct sound it makes caused by plastic and a springer.

A TV show with too many commercial breaks. I'm constantly being interrupted by distracting messages that prevent me from enjoying what I'm trying to do.

FEAR

Cutting an onion I want to share how it makes me feel, but when the effects make me teary eyed or others nervous I stop.

A doe in headlights Challenges frighten my and I don't have the safety net of my loved ones and comfort of my home.

UNCERTAINTY

Carrying a weight that's already too heavy and having extra weight added as you're walking down a dark, never ending corridor. You already feel so much weight from dealing with your illness and as the weight is added, you're not sure you can keep carrying it or if you want to continue. What's in front of you is uncertain and so it makes you not want to continue walking or carrying any of the weight anymore.

NEWNESS

A baby deer You are just learning how to get up on your own, learn the world around you by yourself. You grow up a little bit each day because you learn something new about the world or yourself.

PERSEVERANCE

Being a turtle on speed. You want to accomplish all of the tasks set in front of you, but you feel like you constantly fall short (even if you are succeeding). You wish you could hide, but instead you push through because you want to be a respectable student.

volunteering for something you know will probably cause some problems, but you do it any ways because anyone can quit, but not everyone finishes. Even though school has run me down, added stress to my life, and possibly given me less healthy habits since I am a student, I have seen so many of my friends drop out of college due to mental illness and I want to push myself. School is the one area I feel like I can stand out because of my intelligence, but getting stuck with uncommitted partners in group work is a common result because I try to do more than I should.

NAVIGATION

Is having the tools to climb out of the hole by learning coping strategies etc, but still the problem is the fact that the holes are still so close together and easy to fall into. As I learn how to work with children and families with coping techniques I myself have learned what it takes to overcome negative feelings, however the tools might still be there but they do not space out the holes, they only allow me the ability to climb out of them depending on their depth and width.

APPENDIX D

Interview Protocol

Campus:
Interviewee (Name/Title):
Interviewer: Ren VanderLind
Date:
Start Time:
End Time:
Location:
Notes:

Interview Sections Utilized; Degree of Fidelity to Protocol (Check if Used/Applicable):

_____ Pre-Interview
Degree of Conformity to Protocol ____ %
_____ Topic Domain I: Diagnosis
Degree of Conformity to Protocol ____ %
_____ Topic Domain II: Academic Life
Degree of Conformity to Protocol ____ %
_____ Topic Domain III: Perceptions of Mental Illness
Degree of Conformity to Protocol ____ %
_____ Conclusions:
Degree of Conformity to Protocol ____ %
_____ Follow Up/Thank You Email
Degree of Conformity to Protocol ____ %
_____ Other Topics Discussed:
_____ Post Interview Comments/Concerns/Irregularities:
_____ Length of Interview:

Pre-Interview

A. Introductory Narrative:

I'm going to ask you questions about your experiences as an individual diagnosed with a mental illness; I will also share my experiences during the interview. Please feel free to ask questions if you would like me to clarify anything during our interview.

B. Interview Overview: The interview should take 60-90 minutes, depending on the length of your responses.

C. Informed Consent: If there are questions you do not wish to answer, you are free to do so. You will be assigned a pseudonym, and, with your consent, general demographic information will be included in my write-up. Do I have your consent to include this information?

D. Other Permissions: To facilitate documentation and analysis, I would like to record this interview. I will be video recording myself, but only your voice will be captured in the recording. Is it okay with you if I record this? If you're feeling uncomfortable at any point and would like me to stop recording, you can let me know, and I will stop the recording, okay?

-

Topic Domain I: Diagnosis

1. Please describe any mental health diagnoses you have at present or have had in the past.
 2. When did you first notice you might have a mental illness?
 - a. Could you tell me a little about how you knew?
 3. Could you tell me about when you were diagnosed?
 - a. How old were you?
 - b. Describe your life at that point (e.g., work, family).
 4. Describe what you felt when you were diagnosed.
 - a. Describe how you feel about the diagnosis now.
 5. Could you tell me about any challenges you've encountered because of your diagnosis?
 - a. How did/do you cope with these kinds of situations?
 6. Could you tell me about any successes you've had related to your diagnosis?
 7. If someone who knew nothing about your diagnosis asked what it was like, how would you describe it?
-

Topic Domain II: Academic Life

1. Could you tell me what it's like—now and/or in the past—to be in college while
2. What advice would you give to a college student with mental illness?
 - a. Could you describe any ways you'd advise a student recently diagnosed differently than a student who's had a diagnosis for a period of time?
3. Could you tell me a little about how you feel about self-disclosure in academic settings?
 - a. Describe any differences between yourself as a student, a teacher, and a researcher.
 - b. Why (don't) these differences exist?
4. Describe any campus resources you know about for students with mental illness.
 - a. Could you tell me about any you've used (e.g., what they are, whether they were/are effective)?
5. Please describe your journey from being an undergraduate student to being a graduate student.
6. What role has your diagnosis played in this?

Topic Domain III: Perceptions of Mental Illness

1. Describe how you think people with mental illness are thought of by the general public.
 - a. Why do you think this is public perception?
 - b. What do you think of this perception?
2. Describe how you think people with mental illness are perceived on college campuses.
 - a. Why do you think this is the perception?
 - b. What do you think about it?
3. Tell me about how you see yourself as an individual with a mental illness.
 - a. Could you compare how you see yourself to how you think others see you?
 - b. Why do you think there might be differences or similarities?
4. If you could make any changes you wanted, what would you like to see available for college students concerned with mental health?
 - a. Why?
5. Could you tell me about why you decided to participate in this study?

Conclusions:

Before we finish, is there anything else you would like to share that we didn't talk about?

Post Interview Comments and/or Observations:

REFERENCES

- Abes, E. S., & Jones, S. R. (2004) Meaning-making capacity and the dynamics of lesbian college students' multiple dimensions of identity. *Journal of College Student Development, 45*, 612-632.
- Abes, E. S., Jones, S. R., & McEwen, M. K. (2011). Reconceptualizing the model of multiple dimensions of identity: The role of meaning-making capacity in the construction of multiple identities. In M. E. Wilson (Ed.), *College student development theory* (2nd ed.) (pp. 85-103). Boston, MA: Pearson. (Reprinted from *Journal of College Student Development, 48*, 1-42).
- Adams, K. B., Sanders, S., & Auth, E. A. (2004). Loneliness and depression in independent living retirement communities: Risk and resilience factors. *Aging & Mental Health, 8*(6), 475-485.
- Allan, J. F., McKenna, J., & Dominey, S. (2014). Degrees of resilience: Profiling psychological resilience and prospective academic achievement in university inductees. *British Journal of Guidance & Counselling, 42*(1), 9-25. doi: 10.1080/03069885.2013.793784
- Alexander, P. A. (2005). The path to competence: A lifespan developmental perspective on reading. *Journal of Literacy Research, 37*(4), 413-436.
- American College Health Association. (2014). *American College Health Association National College Health Assessment II spring 2014 reference group executive summary*. Retrieved from http://www.acha-ncha.org/docs/ACHA-NCHA-II_ReferenceGroup_ExecutiveSummary_Spring2014.pdf

- American Psychological Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) American Psychological Association.
- Arendale, D. (2002). Then and now: The early history of developmental education: Past events and future trends. *Research and Teaching in Developmental Education*, 18(2), 3-26.
- Arendale, D. (2005). Terms of endearment: Words that define and guide developmental education. *Journal of College Reading and Learning*, 35(2), 66-82.
- Arendale, D. (2007). A glossary of developmental education and learning assistance terms. *Journal of College Reading and Learning*, 38(1), 10-34.
- Armstrong, S. L. (2015). Retrospective metaphor interviews as an additional layer in elicited metaphor investigations: Bridging conceptualizations and practice. In W. Wan & G. Low (Eds.), *Elicited metaphor analysis in educational discourse* (pp. 119-138). Amsterdam, Netherlands: John Benjamins Publishing Company.
- Armstrong, S. L., Davis, H. S., & Paulson, E. J. (2011). The subjectivity problem: Improving triangulation approaches in metaphor analysis studies. *International Journal of Qualitative Methods*, 10(2), 151-163.
- Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, 55(5), 469-480. doi: 10.1037/0003-066X.55.5.469
- Arioan, K. J., & Norris, A. E. (2000). Resilience, stress, and depression among Russian immigrants to Israel. *Western Journal of Nursing Research*, 22(1), 54-67. doi: 10.1177/01939450022044269

- Baxter Magolda, M. B. (2001). *Making their own way: Narratives for transforming higher education to promote self-development*. Sterling, VA: Stylus.
- Belch, H. A. (2011). Understanding the experiences of students with psychiatric disabilities: A foundation for creating conditions of support and success. *New Directions for Student Services*, 134, 73-94.
- Bettinger, E., Boatman, A., & Long, B.T. (2013). Student supports: Developmental education and other academic programs. *The Future of Children*, 23(1), 93-115.
- Boylan, H. R. (1987). The characteristics of developmental education students. *Research in Developmental Education*, 2(1), 1-6.
- Boylan, H. R. (1988a). The historical roots of developmental education. *Research in Developmental Education*, 5(3), 1-4.
- Boylan, H. R. (1988b). Models and foundations of developmental education. *Research in Developmental Education*, 3, 3-5.
- Boylan, H. R. (1990). The cycle of new majorities in higher education. In A. M. Frager (Ed.), *College reading and the new majority: Improving instruction in multicultural classrooms* (pp. 3-12). Oxford, OH: College Reading Association.
- Boylan, H. R. (1995). Making the case for developmental education. *Research in Developmental Education*, 8(1), 2-5.
- Boylan, H. R., & Bonham, B. S. (2007). 30 years of developmental education: A retrospective. *Journal of Developmental Education*, 30(3), 2-4.
- Boylan, H. R., & Bonham, B. S. (2011). Seven myths about developmental education. *Research and Teaching in Developmental Education*, 27(2), 29-36.

- Boylan, H. R., & Bonham, B. S.. (2014). Introduction to Developmental Education and the Present. In H. R. Boylan & B. S. Bonham (Eds.), *Developmental education: Readings on its past, present, and future* (pp. 59-62). Boston, MA: Bedford/St. Martin's.
- Boylan, H. R., & Saxon, D. P. (1998). The origin, scope, and outcomes of developmental education in the 20th century. In J. L. Higbee and P. L. Dwinell (Eds.), *Developmental education: Preparing successful college students*. Columbia: National Resource Center for the First Year Experience and Students in Transition.
- Boylan, H. R., & White, W. G. (1987). Educating all the nation's people: The historical roots of developmental education. *Research in Developmental Education*, 4(4), 1-4.
- Boylan, H. R., & White, W. G. (1994). Educating all the nation's people: The historical roots of developmental education—condensed version. In M. Maxwell (Ed.), *From access to success* (pp. 3-7). Clearwater, FL: H & H Publishing.
- Breslau, N., Lane, M., Sampson, N., & Kessler, R. C. (2008). Mental health disorders and subsequent educational attainment in a US national sample. *Journal of Psychiatric Research*, 42, 708-716.
- Byram, M. (1997). *Teaching and Assessing Intercultural Communicative Competence*. Clevedon, UK: Multilingual Matters.
- Cameron, L., & Low, G. (1999). Metaphor. *Language Teaching*, 32(2), 77-96.
- Casazza, M. E., & Silverman, S. L. (1996). *Learning assistance and developmental education: A guide for effective practice*. San Francisco: Jossey-Bass.

- Castro, J. R., & Rice, K. G. (2003). Perfectionism and ethnicity: Implications for depressive symptoms and self-reported academic achievement. *Cultural Diversity and Ethnic Minority Psychology*, 9(1), 64-78. doi: 10.1037/1099-9809.9.1.64
- Center for Collegiate Mental Health. (2013). *Center for Collegiate Mental Health 2013 annual report*. Retrieved from http://sites.psu.edu/ccmh/wp-content/uploads/sites/3058/2014/05/2013_CCMH_Report1.pdf
- Chang, H. (2008). *Autoethnography as method*. New York: Routledge.
- Charmaz, K. (1983). *The grounded theory method: An explication and interpretation*. In Robert M. Emerson (Ed.), *Contemporary field research: A collection of readings* (pp.109-125). Prospect Heights, IL: Waveland.
- Clowes, D. A. (1980). More than a definitional problem: Remedial, compensatory, and developmental education. *Journal of Developmental and Remedial Education*, 4(1), 8-10.
- Cohn, M. A., Frederickson, B. L., Brown, S. L., Mikels, J. A., & Conway, A. M. (2009). Happiness unpacked: Positive emotions increase life satisfaction by building resilience. *Emotion*, 9(3), 361-368., doi: 10.1037/a0015952
- Côté, J. E. (2000) Identity transformed. *Arrested Adulthood: The Changing Nature of Maturity and Identity* (pp. 119-154). New York: NYU Press.
- Côté, J. E. (2006). Emerging adulthood as an institutionalized moratorium: Risks and benefits to identity formation. In J. J. Arnett & J. L. Tanner (eds.), *Emerging adults in America: Coming of age in the 21st century* (pp. 85-116), Washington, D.C.: American Psychological Association.

- Cope, B., & Kalantzis, M. (2009). "Multiliteracies": New literacies, new learning. *Pedagogies*, 4(3), 164-195. doi: 10.1080/15544800903076044
- Cranford, J. A., Eisenberg, D., & Serras, A. M. (2009). Substance use behaviors, mental health problems, and use of mental health services in a probability sample of college students. *Addictive Behaviors*, 34, 134-145. doi: 10.1016/j.addbeh.2008.09.004
- Crocker, J., Olivier, M-A., & Nuer, N. (2009). Self-image goals and compassionate goals: Costs and benefits. *Self and Identity*, 8(2-3), 251-269.
- Denzin, N. (2014). *Interpretive Autoethnography* (2nd ed.). Los Angeles: Sage.
- Dumond, M., & Provost, M. A. (1999). Resilience in adolescents: Protective role of social support, coping strategies, self-esteem, and social activities on experience of stress and depression. *Journal of Youth and Adolescence*, 28(3), 343-363. Doi: 10.1023/A:1021637011732
- Edwards, T., Catling, J. C., & Parry, E. (2016). Identifying predictors of resilience in students. *Psychology Teaching Review*, 22(1), 26-34.
- Elion, A. A., Wang, K. T., Slaney, R. B., & French, B. H. (2012). Perfectionism in African American students: Relationship to racial identity, GPA, self-esteem, and depression. *Cultural Diversity and Ethnic Minority Psychology*, 18(2), 118-127. doi: 10.1037/a0026491
- Ellis, C. (1991). Sociological introspection and emotional experience. *Symbolic Interaction*, 14(1), 23-50.

- [Ellis, C., & Bochner, A. P. (2000). Autoethnography, personal narrative, reflexivity: Researcher as subject. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 733-768). Thousand Oaks, CA: Sage.
- Ellis, C. S. & Bochner, A. P. (2006). Analyzing analytic autoethnography: An autopsy. *Journal of Contemporary Ethnography*, 35(4), 429-449. doi: 10.1177/0891241606286979
- Erikson, E. H. (1959). Late adolescence. In D. H. Funkenstein (ed.), *The student and mental health: An international view* (pp. 66-106). Cambridge, MA: The Riverside Press.
- Erikson, E. H. (1968). *Identity: Youth and Crisis*. New York: Norton.
- Evans, N. J., Forney, D. S., Guido, F. M., Patten, L. D., & Renn, K. A. (2010). Social identity (pp. 232-251). *Student Development in College: Theory, research, and practice*. San Fransisco: Jossey-Bass.
- Fowler, P. R., & Boylan, H. R. (2010). Increasing student success and retention: A multidimensional approach. *Journal of Developmental Education*, 34(2), 2-10.
- Gee, J. P. (2005). Meaning making, communities of practice, and analytical toolkits. *Journal of Sociolinguistics*, 9(4), 590-594. doi: 10.1111/j.1360-6441.2005.00308.x
- Gee, J. P. (2009). Reflections on reading Cope and Kalantzis' "'Multiliteracies: New literacies, new learning'". *Pedagogies*, 4(3), 196-204. doi: 10.1080/15544800903076077

- Gee, J. P. (2013). Reading as situated language: A sociocognitive perspective. In Alvermann, D. E., Unrau, N. J., & Ruddell, R. B. (Eds.). *Theoretical models and processes of reading* (Vol. 978, No. 0-87712). International Reading Assoc., 136-151.
- Gibbs, G. R., (2007). Thematic coding and categorizing. In *Analyzing Qualitative Data*. London: SAGE.
- Gonzalez, L. M., Stein, G. L., Shannonhouse, L. R., & Prinstein, M. J. (2012). Heuristic understanding as a component of collaborative, interdisciplinary, social justice advocacy research. *Journal for Social Action in Counseling and Psychology*, 59(4), 59-84.
- Gnilka, P. B., Ashby, J. S., & Noble, C. M. (2013). Adaptive and maladaptive perfectionism as mediators of adult attachment styles and depression, hopelessness, and life satisfaction. *Journal of Counseling & Development*, 91(1), 78-86. doi: 10.1002/j.1556-6676.2013.00074.x
- Hartley, M. T. (2011). Examining the relationships between resilience, mental health, and academic persistence in undergraduate students. *Journal of American College Health*, 59(7), 596-604. doi: 10.1080/07448481.2010.515632
- Hess, T. R., & Tracey, T. J. G. (2013). Psychological help-seeking intention among college students across three problem areas. *Journal of Counseling & Development*, 91, 321-330. doi: 10.1002/j.1556-6676.2013.00100.x

- Higbee, J. L. (2009). Student diversity. In R. F. Flipppo & D. C. Caverly (Eds.), *Handbook of college reading and study strategy research* (2nd ed.) (pp. 67-94). New York, NY: Routledge.
- Higbee, J. L., Arendale, D. R., & Lundell, D. B. (2005). Using theory and research to improve access and retention in developmental education. *New Directions for Community Colleges*, 2005(129), 5-15.
- Hoppes, S. (2014). Autoethnography: Inquiry into identity. *New Directions For Higher Education*, 2014(116), 63-71.
- Houghton, S. A. (2013). Making intercultural communicative competence and identity-development visible for assessment purposes in foreign language education. *The Language Learning Journal*, 41(3), 311-325. doi: 10.1080/09571736.2013.836348
- Hsu, L. K. G., Wan, Y. M., Chang, H., Summergrad, P., Tsang, B. Y. P., & Chen, H. (2008). Stigma of depression is more severe in Chinese Americans than Caucasian Americans. *Psychiatry: Interpersonal & Biological Processes*, 71(3), 210-218.
- Jennings, K. S., Cheung, J. H., Britt, T. W., Goguen, K. N., Jeffirs, S. M., Peasley, A. L., & Lee, A. C. (2015). How are perceived stigma, self-stigma, and self-reliance related to treatment seeking? *Psychiatric Rehabilitation Journal*, 38(2), 109-116. doi: 10.1037/prj0000138
- Jones, S. R., & McEwen, M. K. (2000). A conceptual model of multiple dimensions of identity. *Journal of College Student Development*, 41, 405-414.

- Kalnoky, Tomas. (2011). A better place, a better time. [Recorded by Toh Kay]. On *Streetlight Lullabies* [CD]. Los Angeles, CA: Pentimento Music Company.
- Kapikiran, S. S., & Acun-Kapikirin, N. N. (2016). Optimism and psychological resilience in relation to depressive symptoms in university students: Examining the mediating role of self-esteem. *Educational Sciences: Theory & Practice*, 21(6), 2087-2110. doi: 10.12738/estp.2016.6.0107
- Kegan, R. (1994). *In over our heads: The mental demands of modern life*. Cambridge, MA: Harvard University Press.
- Keyes, C. L. M., Eisenberg, D., Perry, G. S., Dube, S. R., Kroenke, K., & Dhingra, S. S. (2012). The relationship of level of positive mental health with current mental disorders in predicting suicidal behavior and academic impairment in college students. *Journal of American College Health*, 60(2), 126-133. doi: 10.1080/07448481.2011.608393
- Koch, B., Slate, J. R., & Moore, G. (2012). Perceptions of students in developmental classes. *Community College Enterprise*, 18(2), 62-82.
- Koch, L. C., Mamiseishvili, K., & Higgins, K. (2014). Persistence to degree completion: A profile of students with psychiatric disabilities in higher education. *Journal of Vocational Rehabilitation*, 40(1), 73-82. doi: 10.3233/JVR-130633
- Kövesces, Z. (2002). *Metaphor: A practical introduction*. New York: Oxford University Press.
- Kövesces, Z. (2010). What is metaphor? In *Metaphor: A practical introduction* (2nd ed.) (pp. 3-16). New York: Oxford University Press.

- Kucer, S. (2014). *Dimensions of literacy: A conceptual base for teaching reading and writing in school settings* (4th Edition). New York: Routledge.
- Lakoff, G., & Johnson, M. (1980). *Metaphors we live by*. Chicago: University of Chicago Press.
- Lea, M. R., & Street, B. V. (2006). The “academic literacies” model: Theory and applications. *Theory Into Practice*, 45(4), 368-377. doi: 10.1207/s15430421tip4504_11
- Leung, P., Cheung, M., & Tsui, V. (2012). Help-seeking behaviors among Chinese Americans with depressive symptoms. *Social Work*, 57, 61-71. doi:10.1093/sw/swr009
- Low, G. (2015). A practical validation model. In W. Wan & G. Low (Eds.), *Elicited metaphor analysis in educational discourse* (pp. 15-38). Amsterdam, Netherlands: John Benjamins Publishing Company.
- Luborsky, M. R., & Rubinstein, R. L. (1995). Sampling in qualitative research: Rationale, issues, and methods. *Res Aging*, 17(1), 89-113. doi: 10.1177/0164027595171005
- Markham, A. N. (2005). Go ugly early: Fragmented narrative and bricolage as interpretive method. *Qualitative Inquiry* 11(6), 813-839.
- Markoulakis, R., & Kirsh, B. (2013). Difficulties for university students with mental health problems: A critical interpretive synthesis. *The Review of Higher Education*, 37, 77-100. doi: 10.1353/rhe.2013.0073
- Martin, J. M. (2010). Stigma and student mental health in higher education. *Higher Education Research and Development*, 29(3), 259-274.

- Mashiach-Eizenberg, M., Hasson-Ohayon, I., Yanos, P. T., & Lysaker, P. H. (2013). Internalized stigma and quality of life among persons with severe mental illnesses: The mediating roles of self-esteem and hope. *Psychiatry Research*, 208(1), 15-20. doi: 10.1016/j.psychres.2013.03.013
- Maslun, R., & Cameron, L. (2010). *Metaphor analysis: Research practice in applied linguistics, social sciences, and the humanities*. London: Equinox Publishing.
- Megivern, D., Pellerito, S., & Mowbray, C. (2003). Barriers to higher education for individuals with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 26(3), 217-231. doi: 10.2975/26.2003.217.231
- Meuus, W. (1996). Studies on identity development in adolescence: An overview of research and some new data. *Journal of Youth and Adolescence*, 25, 569-598.
- National Alliance on Mental Illness. (n.d.). Bipolar disorder. Retrieved from <https://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder>.
- National Association for Developmental Education. (n.d.). About NADE. Retrieved from <http://nade.net/aboutnade.html>.
- National Association for Developmental Education. (2015). NADE 2015-2016 facts. Retrieved from http://www.nade.net/site/documents/fact_sheet/2015_NADE_FactSheet_06-2015.pdf
- National Institute on Mental Illness. (2015). Bipolar disorder in children and teens. Retrieved from <https://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-teens/index.shtml#pub1>.

- Norris, J., & Sawyer, R. D. (2012). Toward a dialogic methodology. In J. Norris, R. D. Sawyer, & D. Lund (Eds.), *Duoethnography: Dialogic methods for social, health, and educational research* (pp. 9-40). Walnut Creek, CA: Left Coast Press.
- Norris, J., Sawyer, R. D., & Lund, D. (Eds.). (2012). *Duoethnography: Dialogic methods for social, health, and educational research*. Walnut Creek, CA: Left Coast Press.
- Novotney, A. (2014). Students under pressure. *Monitor on Psychology*, 45, 37-41.
- Ong, A. D., Bergeman, C. S., Bisconti, T. L., & Wallace, K. A. (2006). Psychological resilience, positive emotions, and successful adaptation to stress in later life. *Journal of Personality and Social Psychology*, 91(4), 730-749.
- Park, C. L., Edmondson, D., & Lee, J. (2012). Development of self-regulation abilities as predictors of psychological adjustment across the first year of college. *Journal of Adult Development*, 19, 40-49. doi: 10.1007/s10804-011-9133-z
- Paulson, E. J. & Armstrong, S. L. (2011). Mountains and pit bulls: Students' metaphors for college transitional reading and writing. *Journal of Adolescent & Adult Literacy*, 54(7), 494-503. doi: 10.1598/JAAL.54.7.3
- Piper, J. (1998). An interview with Martha Maxwell. *The Learning Assistance Review*, 3(1), 32-39.
- Quinn, N. N., Wilson, A., MacIntyre, G., & Tinklin, T. (2009). 'People look at you differently': Students' experience of mental health support within Higher Education. *British Journal of Guidance & Counselling*, 37(4), 405-418. doi: 10.1080/03069880903

- Reetz, D.R., Bar, V., & Krylowicz, B. (2014). The association for university and college counseling center directors annual survey. Retrieved from http://files.cmcglobal.com/AUCCCD_Monograph_Public_2013.pdf
- Rose, H., & Montakantiwong, A. (2018). A tale of two teachers: A duoethnography of the realistic and idealistic successes and failures of teaching English as an international language. *RELC Journal*, 49(1), 88-101. doi: 10.1177/003388217746206
- Roy, A., Sarchiapone, M., & Carli, V. (2007). Low resilience in suicide attempters. *Archives of Suicide Research*, 11(3), 265-269. doi: 10.1080/13811110701403916
- Rubin, M. (1991). A glossary of developmental education terms compiled by the CRLA Task Force of Professional Language for College Reading and Learning. *Journal of College Reading and Learning*, 23(2), 1-14.
- Rydén, A., Karlsson, J., Sullivan, M., Torgerson, J. S., & Taft, C. (2003). Coping and distress: What happens after intervention? A 2-year follow-up from the Swedish Obese Subjects (SOS) Study. *Psychosomatic Medicine*, 65(3), 435-442.
- Sanguras, L. Y. (2017). *Grit in the classroom: Building perseverance for excellence in today's students*. Waco, TX: Prufrock Press.
- Schrick, B. H., Sharp, E. A., Zvonkovic, A., & Reifman, A. (2012). Never let them see you sweat: Silencing and striving to appear perfect among U.S. college women. *Sex Roles*, 67(11-12), 591-604. doi: 10.1007/s11199-012-0223-6

- Seung, E., Park, S., & Jung, J. (2015) Methodological approaches and strategies for elicited metaphor-based research: A critical review. In W. Wan & G. Low (Eds.), *Elicited metaphor analysis in educational discourse* (pp. 39-64). Amsterdam, Netherlands: John Benjamins Publishing Company.
- Sironic, A., & Reeve, R. A. (2012). More evidence for four perfectionism subgroups. *Personality and Individual Differences*, 53(4), 437-442.
- Smagorinsky, P. (2001). If meaning is constructed, what is it made from? Toward a cultural theory of reading. *Review of educational research*, 71(1), 133-169.
- Spencer, C. C. (2014). *"Wow, that bitch is crazy!": Exploring gendered performances in leisure spaces surrounding reality television* (Doctoral dissertation). Retrieved from proquest.com
- Spry, T. (2011). *Body, paper, stage: Writing and performing autoethnography*. Walnut Creek, CA: Left Coast Press.
- Stoeber, J., Schneider, N., Hussain, R., & Matthews, K. (2014). Perfectionism and negative affect after repeated failure: Anxiety, depression, and anger. *Journal of Individual Differences*, 35(2), 87-94. doi: 10.1027/1614-0001/a000130
- The Center for Universal Design. (2008). About UD: Universal Design history. Retrieved from https://projects.ncsu.edu/ncsu/design/cud/about_ud/udhistory.htm
- Thompson, E. A., Connelly, C. D., Thomas-Jones, D., & Eggert, L. L. (2013). School difficulties and co-occurring health risk factors: Substance use, aggression, depression, and suicidal behaviors. *Journal of Child and Adolescent Psychiatric Nursing*, 26, 74-84. doi: 10.1111/jcap.12026

- Tucker, J. J., Hammer, J. H., Vogel, D. L., Bitman, R. L., Wade, N. G., & Maier, E. J. (2013). Disentangling self-stigma: Are mental illness and help-seeking self-stigmas different? *Journal of Counseling Psychology*, 60(4), 520-531. doi: 10.1037/a0033555
- Vaishnavi, S., Connor, K., & Davidson, J. R. (2007). An abbreviated version of the Connor-Davidson Resilience Scale (CD-RISC), the CD-RISC2: Psychometric properties and applications in psychopharmacological trials. *Psychiatry Research*, 152(2), 293-297. doi: 10.1016/j.psychres.2007.01.006
- VanderLind, R. (October, 2017). *Providing supports to college students with mental illness*. Paper presented at the meeting of College Academic Support Programs, Galveston, TX.
- VanderLind, R. (May, 2017). *Stigma and self-disclosure in college students with bipolar disorder*. Paper presented at the meeting of the International Congress of Qualitative Inquiry, Urbana-Champaign, IL.
- VanderLind, R. (March, 2017). *Stigma, self-disclosure, and resilience: Two women's experiences with bipolar disorder in college*. Paper presented at the meeting of the Women and Gender Research Collaborative Symposium, San Marcos, TX.
- VanderLind, R. (March, 2017). *Mental illness, stigma, and self-disclosure in college students*. Paper presented at the meeting of Teaching Academic Survival and Success, Fort Lauderdale, FL.
- VanderLind, R. (March, 2017). *Stigma and mental health in college students: Changing perceptions for student success*. Paper presented at the meeting of the National Association for Developmental Education, Oklahoma City, OK.

- Van Nguyen, H., Laohasiriwong, W., Saengsuwan, J., Thinkhamrop, B., & Wright, P. (2015). The relationships between the use of self-regulated learning strategies and depression among medical students: An accelerated prospective cohort study. *Psychology, Health, & Medicine*, 20(1), 59-70.
- Vasconcelos, E. F. d. S. (2011). "I can see you": An autoethnography of my teacher-student self. *Qualitative Report*, 16(2), 415-440.
- Walker, R. L., Wingate, L. R., Obasi, E. M., & Joiner, T. E. Jr. (2008). An empirical investigation of acculturative stress and ethnic identity as moderators for depression and suicidal ideation in college students. *Cultural Diversity and Ethnic Minority Psychology*, 14(1), 75-82. doi: 10.1037/1099-9808.14.1.75
- Wan, W., Low, G.D., & Li, M. (2011). From students' and teachers' perspectives. Metaphor analysis of beliefs about EFL teachers' roles. *System*, 39(3), 403-415. doi: 10.1016/j.system.2011.07.012
- Wang, K. T. (2012). Personal and family perfectionism of Taiwanese college students: Relationships with depression, self-esteem, achievement motivation, and academic grades. *International Journal of Psychology*, 47, 305-314. doi:10.1080/00207594.2011.626050
- Weiner, E. (1999). The meaning of education for university students with a psychiatric disability: A grounded theory analysis. *Psychiatric Rehabilitation Journal*, 22(4), 403-409. doi: 10.1037/h0095209
- Weiner, E., & Wiener, J. (1996). University students with psychiatric illnesses: Factors involved in the decision to withdraw from their studies. *Psychiatric Rehabilitation Journal*, 20(4), 88-91.

- Williams, J. L. (2015). Metaphorical conceptualizations and classroom practices of instructors teaching an accelerated postsecondary developmental literacy course. In W. Wan & G. Low (Eds.), *Elicited metaphor analysis in educational discourse* (pp. 239-264). Amsterdam, Netherlands: John Benjamins Publishing Company.
- Zychinski, K. E., & Polo, A. J. (2012). Academic achievement and depressive symptoms in low-income Latino youth. *Journal of Child and Family Studies*, 21, 565-577.
doi:10.1007/s10826-011-9509-5