

HER OWN VOICE: COMING OUT IN ACADEMIA  
WITH BIPOLAR DISORDER

by

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## **DEDICATION**

For James.

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## TABLE OF CONTENTS

|  | Page |
|--|------|
| ACKNOWLEDGEMENTS.....                                  | v    |
| ABSTRACT .....   | viii |
| CHAPTER  |      |
| I. INTRODUCTION .....                                  | 1    |
| Literature Review .....                                | 4    |
| Mental Illness and the Fragmented Narrative Self ..... | 5    |
| The Illness Narrative .....                            | 7    |
| Fighting Stigma through Narrative .....                | 9    |
| The Effects of Stigma on Rhetoricability .....         | 10   |
| “Coming out” .....                                     | 12   |
| Summary .....  | 15   |
| II. METHODOLOGY .....                                  | 18   |
| Autoethnography as a Method .....                      | 18   |
| Criticisms of Autoethnography .....                    | 19   |
| Data Collection, Analysis, and Interpretation .....    | 21   |
| S/CI Ideas Paper .....                                 | 22   |
| Critical Narrative .....                               | 24   |
| Secondary research synthesis .....                     | 27   |
| Primary research .....                                 | 30   |
| Autoethnography .....                                  | 34   |
| Evaluating Autoethnography .....                       | 35   |
| III. HER OWN VOICE: AN AUTOETHNOGRAPHY .....           | 38   |
| Stories of Bipolar Disorder .....                      | 38   |
| The Story According to the Chart .....                 | 40   |
| Another Story .....                                    | 41   |
| Coming Out .....                                       | 57   |
| Afterword .....  | 60   |
| IV. IMPLICATIONS .....                                 | 62   |
| Carving Out a Narrative Space .....                    | 62   |

|   |    |
|---|----|
| Bridging Trust and Understanding .....          | 64 |
| Embedding a “Deviant” Self-representation ..... | 65 |
| Coming Out to the Academy .....                 | 66 |
| APPENDIX SECTION.....                           | 68 |
| WORKS CITED .....                               | 76 |

## ABSTRACT

Autoethnography is a powerful tool for fleshing out one's sense of self in context with other selves, for creating empathetic bonds between writer and reader, for interrogating difference, and for challenging the dominant narrative. For example, through autoethnographic research, one has the authority to confront pervasive stigmas linked to mental illness in academia, where mental illness is discussed largely in third person. As evidenced by the pervasive themes of narrative identity/reclamation in mental health rhetoric, there is space in English studies for both the genre and topic. Margaret Price, in her book *Mad at School: Rhetorics of Mental Disability and Academic Life*, discusses ways that persons with mental illness make rhetorical gains through writing. Further, Linda J. Morrison argues that narrative is essential to empowering the Mad studies movement. This thesis attempts to get at the ways a student-scholar can challenge misrepresentations of individual and group identity in the dominant narrative. In it, I bear down on issues of agency in self-representation by asking, how does a person with bipolar disorder carve out a narrative space for herself in a culture that shames, devalues, distrusts, or otherwise ignores the mentally ill? Because of the connections between mental illness, counternarratives, and "rhetoricability," I am positioned to help shift the conversation from rumor and "the chart" to language that is more inclusive and humanizing.



## I. INTRODUCTION

This project began in a graduate course on autoethnography as a research method. To launch my own autoethnography, I proposed an idea for a critical narrative in which I would explore a self/culture intersection. Because I had recently experienced a psychotic break and was dealing with the social and professional fallout, I considered writing about my experiences with bipolar disorder. However, I had concerns. Before starting the first assignment, I proposed the idea to my professor. I wrote to her and asked, “Would it be professionally unwise to write from the perspective of a grad student and IA/TA with bipolar disorder?” (personal correspondence). She replied emphatically that it wouldn’t be. At that time, I had no plans of publishing my autoethnography; I would only be “coming out” to my professor and the students in my workshop group, many of whom I knew personally. In the beginning, I didn’t know how important this project would become to me. I didn’t know that it would change me.

In the years since I accepted my diagnosis, I have come out with bipolar disorder a handful of times. Responses have been mixed. My vulnerability has been met with silent skepticism, detachment, awkwardness, dismissal, confusion, and even contempt. I have come away from many of these experiences feeling more ashamed than I had at the start. Although people don’t usually say much in response, what I have seen in their nonverbal expressions tells me that I should be more diligent in masking my illness, that I should work harder to appear “normal.”

These attitudes toward disclosure of mental illness—manifestations of stigma—have taught me to cover up the true reasons for why I sometimes fail to do or say the

right things. When I said, “I need more time to finish,” I meant, “I’ve been reading the same paragraph over and over and over again because I can’t focus.” When I said, “I’m sorry, something came up, I can’t make it,” what I wanted to say was, “I’m overwhelmed with anxiety and paranoia and I can’t hide it today.” And that time I laughed and said, “I’m not making any sense—I must be tired,” what I didn’t say was, “I don’t know how to respond to what you said because I only heard the thing you didn’t say aloud *you think I’m an idiot I don’t belong here I should stop talking...*”

I often think of the times I have self-disclosed, sometimes wishing I could take it back, all the time hoping my memories will reveal a formula for helping others comprehend what happens to me in moments of bipolar crisis. What most of my disclosures had in common was this: they were spoken in a moment of crisis to someone who did not understand bipolar disorder. A major problem with coming out with mental illness is that when the need to disclose arises, a person in crisis isn’t likely able to express what is happening to them in a way that counters stigma, especially when disclosing to someone who doesn’t understand their illness. While bipolar disorder is tangible in the body, it is also observable in speech. During periods of mania or mixed mood states, and sometimes even when there are no other obvious symptoms, a person with bipolar disorder contends with thought disorder, a linguistic phenomenon that affects her ability to think and speak coherently. Simply put, persons with bipolar disorder are both physiologically and rhetorically challenged.

The one time I benefitted from disclosing, it did not matter that I was so anxious and tearful that I could barely speak; my confidant heard the words “I have bipolar disorder” and immediately made the connection between my recent erratic and disruptive

behavior and her understanding of the symptoms of my illness. She recognized that my inability to meet professional expectations was temporary, that my symptoms would subside, and that I would soon be back to my usual productive self. All this, because she had a prior understanding of my illness. This was (and still is) heartening, but it was serendipitous; I happened to confide in someone who happened to understand my struggle. It occurs to me that *prior understanding* of the realities of mental illness is critical to opening lines of communication between sufferers and non-sufferers so that mental illness isn't mistaken for bad character. We need more than serendipity.

While we can't always help others understand mental illness by talking about it, our chances improve when we write about it (and share that writing with others) preemptively. Through autoethnography, we can write about it authoritatively.

Although a handful of scholars have written autoethnographically about stigma and agency in self-disclosure of other disabilities, I did not find any autoethnographies specifically about mental illness in the field of writing and rhetoric. However, as evidenced by the pervasive themes of narrative identity and reclamation in mental health rhetoric, there is space in our field for both the genre and topic. Margaret Price, in her book *Mad at School: Rhetorics of Mental Disability and Academic Life*, discusses ways that persons with mental illness have made rhetorical gains “in various genres and spaces—through defiant writings, small victories, and our simple daily survival—thus pointing a way toward a more inclusive, and thereby enriched, academe” (8). Scholars in the social sciences also recognize the value of narratives of mental illness in academic writing: Linda J. Morrison argues that narrative “plays a crucial role in the [Mad Studies] movement, helping to build solidarity and empower resistant voices” (qtd. in Price 11).

By augmenting narrative through autoethnographic research, scholars in rhetoric and writing who have been touched by mental illness can weigh in on this conversation to the benefit of many. For my part, I prefer to speak *with* rather than only being spoken *about*.

To get at the ways rhetoric and writing can challenge misrepresentations of mental illness in the dominant narrative, I asked, how does a person with bipolar disorder carve out a narrative space for herself in a culture that shames, devalues, distrusts, or otherwise ignores the mentally ill? Other, related questions followed: What can be done to bridge trust and understanding between those within academic institutions who do not struggle with mental illness and those who do? How does she embed her counternarrative—a “deviant” self-representation—into the larger cultural narrative in order to confront and unravel stigmas associated with bipolar disorder? And finally, because sharing my autoethnographic research necessarily means disclosing my mental illness, I asked, what are the implications of “coming out” to the academy as having Bipolar disorder?

### **Literature Review**

This project began with memories of my experiences with Bipolar disorder, but it grew through literature. Like Sarah Wall says in her article “Easier Said than Done: Writing an Autoethnography,” I “reacted to the ways in which my experience was or was not captured by the literature. I wanted to...demonstrate that I was open minded and willing to learn something new about my experience” (41). Before searching the archives for scholarly views on mental illness, all I knew of bipolar disorder outside my own

experience of it I had found in memoirs, support group websites, and clinical manuals. When I began my research, I knew that I was not alone. I knew that I was not to blame for my mental illness, that it is a medical condition. I've identified with some, but not many of the stories I've come across in support groups. (For instance, I have never sprinted down a street in the dead of night believing that I am flying, and God has never spoken to me directly.)

I organize the following sources into categories that move from general to specific—how cycles of mania and deep depression create fragmentation and distrust in one's understanding of self, the issues that a person with bipolar disorder should consider in developing a narrative self, "rhetoricability" for expressing the narrative self, and the implications of "coming out" through narrative as having bipolar disorder to the communities to which one belongs. Within each section, I identify the argument and main claims in each source and discuss how sources relate to one other.

### *Mental Illness and the Fragmented Narrative Self*

In her essay "The Language of Madness," Debra Bielke asks, "If one is deeply depressed, is this mood an expression of the 'true' self or is the self distorted beyond recognition? Does the manic mood, which frequently results in brilliant insights, reveal an aspect of the authentic self that might otherwise remain muted? Or does it alter the 'real me' beyond recognition?" (29). She searches for answers to these questions through the analysis of memoirs by Kay Redfield Jamison and Kate Millett on their experiences with bipolar disorder. Based on her understanding of these two authors' struggles with writing about their narrative selves, she believes that the challenges a person with a mood disorder faces when attempting to write a personal narrative can be monumental, and

while anyone who writes a personal narrative must “wrestle with competing forces of signification to construct the narrative ‘I,’ people afflicted with mood disorders must confront an additional set of challenges” (30). Bipolar disorder, Bielke says, “makes the sense of fragmented, multiple, defective selfhood all the more dramatic” (30). She emphasizes that how we think, talk, and write about mental illness “profoundly colors how [those with bipolar disorder] experience their emotional turbulence” (38).

My interest in Bielke’s work prompted an examination of one of her primary sources: In *An Unquiet Mind: A Memoir of Moods and Madness*, John Hopkins University senior psychiatrist Kay Redfield Jamison asks, “Which of my feelings are real? Which of the me’s is me? The wild, impulsive, chaotic, energetic, and crazy one? Or the shy, withdrawn, desperate, suicidal, doomed, and tired one?” (68). These questions epitomize the narrative crisis one with bipolar disorder faces. In her memoir, she recounts the “madness” that accompanies manic depressive illness (her preferred term for bipolar disorder) from the perspective of both wounded storyteller and wounded healer. She writes, “...by the time I began my professional life, I became, both by necessity and intellectual inclination, a student of moods. It has been the only way I know to understand, indeed to accept, the illness I have; it has also been the only way I know to try and make a difference in the lives of others who also suffer from mood disorders” (5). *An Unquiet Mind* offers a troubling glimpse into the deeply fragmented bipolar selves of people with the disease. Writing a memoir was difficult for Jamison—she began writing toward the end of a long, successful career in psychiatry; one can imagine how much more difficult it is for the rest of the bipolar population, for those who hardly know where to begin.

### *The Illness Narrative*

In “Psychopathology and the Narrative Self,” James Phillips argues that we can better understand psychopathology, or the study of mental illnesses, through the philosophical concept of narrative identity. In philosophical terms, narrative identity is more than a story of self; it is the way humans experience and conceptualize time—our past, present, and future selves. He applies this theory to four case studies previously presented by psychiatrist Lloyd Wells. In order to explore our narrative identities, we must accept that “a self is constructed of not one but multiple narratives, some short, some long, some subdivisions of others, many contradicting one another, some coherent and some less coherent” (315).

While Phillips urges us to explore our multiple narrative identities, Grant Gillett, in his book *The Mind and Its Discontents*, advocates for mental illness narratives as a way of closing the gap between those who are ill and those who aren’t. Speaking directly to the mentally ill and those who are affected by mental illness, he argues that because humans are “intensely social animals,” we should seek to understand the causes of mental illness through language, social interactions, and the power structures at work within society. He frames his argument around emotion, morality, thoughts and actions, agency, rationality, and perceptions of mental illness and analyzes each as they emerge differently in a variety of mental illnesses, including mood disorders. Further, he argues that clinicians should help patients develop other-involving narrative skills so that they may see themselves as others see them in order to remedy damaging “mismatches between where one puts oneself and where one finds oneself” (137). Further, he writes, “the more

other-involving narrative skills we have developed the more we will be able to see the position from a different view or from somewhere else” (137).

Moving into more specific narrative terrain, Arthur Frank presents a type of narrative that might be of value to people with mental illness. In *The Wounded Storyteller*, he presents a collection of “illness narratives” from those who have suffered an assortment of physical “wounds,” including his own. He explains that there are three types of stories: the restitution plot, the chaos narrative, and the quest. The restitution plot, he says, is not ideal because it is “told *by* a self but not *about* that self” (92). The chaos narrative is not a narrative at all because it has no linear or coherent structure but has its own value because it is a testament to the ill person’s suffering. Rather than these types of narratives, Frank urges readers to take on the quest, a narrative journey in which one may find healing and renewal (115).

Adopting Frank’s “illness narrative,” Nancy Nyquist Potter lays the foundation for helping persons with bipolar disorder “to construct a narrative that *accounts* for effects of bipolar illness but is not *driven* by it” (57-8) in her article “Narrative Selves, Relations of Trust, and bipolar disorder.” Many bipolar patients, Potter writes, “feel stuck with the chaos narrative—in which they narrate their lives as hopelessly out of control, senseless, and fragmented, with little hope of improvement” but they are unable to claim agency, or “to piece together a picture of their lives that is not paradoxically both chaotic and deterministic” (60). As an alternative to Frank’s chaos narrative, Potter offers the “hinge narrative,” one that “capture[s] the sense of being at a swinging door that can be opened or closed to varying degrees and that does not move by itself by rather is moved upon” (61). The hinge narrative allows persons with bipolar disorder to “move within the



zone of creativity, narrativity, and self-trust while staying (somewhat) connected to others” (62) and gives them space to explore multiple paths for themselves in ways that won’t worsen their condition or lead to “debilitating self-doubt” (64). The ultimate goal for Potter’s Hinge Narrative is for the person with bipolar disorder to “develop a sense of self that will help them both to account for their illness while allowing them to see themselves as something more than just their illness” (64). Finally, persons with bipolar disorder must practice a self-oriented therapy that focuses on goal-setting and reality testing to evaluate constructions of self with reflexivity (63).

### *Fighting Stigma through Narrative*

Adrienne Chung et al., in their article “Reducing Stigma and Out-Group Distinctions Through Perspective-Taking in Narratives,” argue that homogenizing sufferers of stigmatized illnesses can be harmful because it has the effect of “depersonalizing out-group members, which encourages negative stereotyping, prejudice, and antisocial behaviors” (895). In their study, they examine the value of entertainment narratives by or about persons with illness as a way to engender empathic bonds between viewers (or readers) and stigmatized characters. They found that participants vicariously experienced the humanity of stigmatized characters through identification, or “empathetically experiencing the emotions, thoughts, and responses of the other” (897), thereby reducing stigma. Chung et al. call on Social Identity Theory (SIT), which suggests that “we strive to achieve and maintain a positive social identity by feeling good about the social groups that we belong to, and consequently about ourselves” (895), to demonstrate the importance of perspective-taking. *Sherrybaby*, the entertainment

narrative Chung et al. showed participants, was based on a true story; it follows that creative non-fiction narrative has the same stigma-fighting power.

Similarly, in “Memoirs: Rewriting the Social Construction of Mental Illness,” Elizabeth Young examines four memoirs in which the authors counter hegemonic discourse “about mental illness as a sign of personal weakness, about the shame or stigma mental illness carries, and about the isolation and disenfranchisement mental illness causes” (63). By writing their experiences narratively and by “presenting details of their own experience which are at odds with the social construction of what it means to be mentally ill” (63), the authors gain agency in resisting hegemonic discourse. Young finds the authors’ vivid presentation of their “symptoms, diagnosis, treatment, and acceptance of the illness” (52) rhetorically effective; they not only boost their credibility, but they also demonstrate that they are self-assured and socially and professionally competent. One of the authors, Young says, “[r]ather than losing himself, or being overcome by personal weakness as the social construction of mental illness assumed he would,... has converted his mental illness into strengths that serve not only himself but other people” (62). Young extends an invitation for others with mental illness to “experiment with different narratives, in search for those that best empower us in dealing with our circumstances” (Young 55).

#### *The Effects of Stigma on Rhetoricability*

Jenell Johnson considers the history of mental illness stigma, or “kakoethos” (461), in “The Skeleton on the Couch: The Eagleton Affair, Rhetorical Disability, and the Stigma of Mental Illness” by examining the Eagleton Affair in which vice presidential

candidate Thomas Eagleton was "rhetorically disabled" after being outed with depression during the 1972 presidential election. Johnson observes that mental illness is a "permanent identity" (468); Thomas Eagletons will be judged as having poor character regardless of the circumstances of their illness. But the fault does not lie with the rhetor. Rhetorical disability, Johnson says, is defined "not as the property of an individual rhetor, but as a failure of the rhetorical environment, a product of the conditions that grant or deny rhetors what Catherine Prendergast has termed 'rhetoricability'" (qtd. in Johnson 461). It is the responsibility of non-stigmatized, rhetorically privileged others to create an environment in which those with mental illness can thrive or, at least, be granted entry. Although she does not specify how we might accommodate those whose rhetoricability is threatened by "a tied tongue, trembling hands, an 'unshapely' face or body, mental illness, or other contributors to kakoethos" (476), Johnson suggests that accommodations should be made nonetheless.

N. Renuka Uthappa, conversely, has concrete strategies for securing rhetorical agency for sufferers of mental illness. In her article "Moving Closer: Speakers with Mental Disabilities, Deep Disclosure, and Agency through Vulnerability," explains the strategies used by members of the Speakers Bureau, an organization that educates students on mental illness. It is through "deep disclosure," or detailed and sometimes disturbing accounts of how they experience their illnesses, that speakers are able to reach their audiences. Deep disclosure, Uthappa says, bolsters speakers' ethos; it is "through credible narrative constructions of mentally disabled selves" that they are able to "contradict the cultural notion that the crazy are not to be believed" (166). Speakers Bureau presentations create vulnerability in both the speaker and the audience, thus

encouraging openness. “[O]penness includes the acknowledgement of the fact that mental disability can touch their own lives in some fashion. [Audience members] open themselves up to believing in the existence and acceptability of realities they cannot completely understand (173). The goal of making themselves vulnerable through narrative self-disclosure, Uthappa says, is to “help audience members reach through the barrier thrown up by stigma and draw closer to us as human beings” (165).

### *“Coming out”*

Scholars agree that coming out with mental illness is empowering for the discloser and does much to undo stigma, but it is not without risk. Stephanie Kerschbaum discusses in “On Rhetorical Agency and Disclosing Disability in Academic Writing” how she has disclosed her deafness in academic scholarship and to what ends. She initially resisted pressure by colleagues to disclose her disability on the grounds that she does not “do disability studies” and concern that their insistence “reflect[s] a kind of invasive curiosity about disability” (56). Kerschbaum is also concerned about the effects of stigma on her professional relationships, as she is likely to face “infantilizing responses, dramatic changes in attitude, and negative repercussions” (57) after disclosing her illness. But, after considering the benefits of disability disclosure in her academic writing, she names three uses: “developing a disability perspective, making theoretical and empirical claims about disability, and highlighting rhetorical skill in the construction of identity” (62). Each of these, she says, is “concerned with rhetorical agency as speakers and writers make claims that they hope will be taken seriously by others” (62). It is for developing a disability perspective that I disclose my illness, as I seek to tell a different

story of disability, “to contest a presumed understanding, and to involve readers in the work of interrogating disability” (61). But, as Kerschbaum so aptly says, “it is only when I find my interlocutors willing to respond to me and take seriously my version of things that I can speak to them” (68).

Kimberly Myers shares some of Kerschbaum’s concerns and comes to similar conclusions. In her autopathography “Coming Out: Considering the Closet of Illness,” she reflects on the professional and social implications of coming out with illness. She frames her arguments in Queer Theory and Disability and Cultural Studies, as she finds parallels between coming out with illness and coming out as a queer person. “[B]oth involve a norm (or norms) and varying degrees of deviance from that norm; both operate on a continuum ranging from denial to self-acknowledgment to self-disclosure; both potentially involve significant risks in personal, social, and professional spheres; and both can include internalized shame and guilt” (255). Myers has engaged in both “covering,” or hiding her illness, and in what she calls “protective disclosure” (as opposed to being spontaneously outed by her illness). Covering, in her experience “compound[s] the impact of the disease, physically as well as psychologically. Moreover, such attempts to act (if not *be*) normal all too often end in frustration and an even greater sense of isolation and alienation” (265). Protective disclosure, on the other hand, has garnered empathy and understanding from her peers and has led to a greater sense of control over her environment. Further, she says, “Many people with illness similarly view coming out as a means to understand an altered physical reality in the community of others with similar experiences; it is a form of empowerment for self and others” (269).

Patrick Corrigan et al. champion coming out with mental illness on the same grounds. In “Reducing Stigma by Coming Out Proud,” they explore the constructions of identity and disclosure as they relate to stigma, particularly internalized stigma, or “a subjective process, embedded within a socio-cultural context, which may be characterized by negative feelings (about self), maladaptive behavior, identity transformation, or stereotype endorsement resulting from an individual’s experiences, perceptions, or anticipation of negative social reactions on the basis of their mental illness” (e1). The authors investigate mental illness in context with queer theory, comparing the benefits and risks of self-disclosure by those who have mental illnesses to what is already known about the implications of “coming out” for members of the LGBTQ community. They cautiously argue in favor of self-disclosure on the grounds that “keeping secret and suppressing such important aspects of identity...can have egregious effects...on mental and physical health, relationships, employment, and well-being” while strategic self-disclosure can help mentally ill persons minimize these negative effects and gain a sense of empowerment (e2). Strategies include social avoidance, secrecy, selective disclosure, indiscriminate disclosure, and broadcast experience. The last, they say, has the goal of educating people about mental illness by “seek[ing] out people with whom to share past history and current experiences with mental illness” and often foster the person’s “sense of power over the experience of mental illness and stigma” (e3). Finally, the authors present an opportunity for those who wish to “broadcast” to do so by participating in “Coming Out Proud,” a social intervention program that combats stigma in local communities.

Further exploring issues of stigma, Michalak et al. conducted a qualitative study titled “‘It’s Something That I Manage but It Is Not Who I Am’: Reflections on Internalized Stigma in Individuals with Bipolar Disorder,” in which they seek to understand how 32 participants with bipolar disorder manage stigma. Participants self-selected interview or focus group methods in which they discussed their experiences with internalized stigma and its correlation with distress, disability, and quality of life. Themes of expectations and experiences with negative social responses, sense of self/identity, judicious disclosure, participants’ having moved beyond internalized stigma emerged, and researchers were able to gain insight into participants strategies for self-management of the disease. They found that persons with bipolar disorder benefit from judicious disclosure in that, because they no longer have the stress of hiding their illness, they have “the ability to be more open, encouraging engagement with people are supportive or who share similar experiences, and playing a role in combatting public stigma” (220). Further, highlighting positive experiences with bipolar disorder versus the traditional research that focuses on those who are struggling can provide opportunities for “transformative processes” and can highlight “diversity as opposed to homogeneity of experiences” (221).

### **Summary**

These sources point to obvious interests in illness narratives and mental illness. However, as evidenced by the scarcity of research that combines the two, mental illness is and has always been a cautiously guarded subject. With few exceptions, much of the mental health discourse to which we currently have access uses clinical language and is meant for clinicians in conversation with one another. Similar to how patients are often

denied access to their medical charts, people with mental illness have traditionally been excluded from these conversations. However, with the recent autoethnographic turn in qualitative research, there is now occasion for academics with mental illness to bear down on issues of agency in self-representation. Because of the connections between mental illness, counternarratives, and “rhetoricability,” scholars in the field of rhetoric and writing are positioned to help shift the conversation from “the chart” to language that is more inclusive and humanizing.

The purpose for my study is fourfold and reflects values in rhetoric (“rhetoricability”) and composition (narrative and counternarrative). Through the recursive process of recalling, reflecting, writing, and listening, I hope to gain a critical understanding of my experience with bipolar disorder; to compare my experience to the stories that are being told about mental illness; to flesh out ways that my experience counters the dominant narrative that has led to stigmatization of persons with mental illness as permanently ill, socially and professionally incompetent, spiritually lost, depraved, dangerous, or weak; and to discover how my individual account of bipolar disorder can help bridge differences between those who suffer from mental illness and those who do not. My study necessitates autoethnographic research.

Although I do not yet know how my autoethnography will function, the literature gives me reason to believe that autoethnography has the power to bridge trust and understanding between individuals within stigmatized and non-stigmatized groups. My study will emphasize the role of autoethnography in helping ourselves and others understand what having mental illness means so that we may speak authoritatively for ourselves and our communities, and so that when we come out, we are met with the same



“emotionality, warmth, cognitive openness, individual agency, and depth” afforded to those who don’t have mental illness (Chung 895).

In the next chapter, I will thoroughly explain autoethnography as a method and my autoethnographic research process. The third chapter will feature my autoethnography. And, in the final chapter, I will explore the value of my autoethnography to those in the academy who have experienced the effects of stigmas associated with mental illness or to those who simply wish to understand what it means to have bipolar disorder.

## II. METHODOLOGY

### **Autoethnography as a Method**

Carolyn Ellis et al. define autoethnography as “an approach to research and writing that seeks to describe and systematically analyze (graphy) personal experience (auto) in order to understand cultural experience (ethno)” (273). It is both a process and a product. It exists on a continuum—it can be analytic, evocative, or somewhere in between. Autoethnographers determine their approach by asking, “who reads our work, how are they affected by it, and how does it keep a conversation going?” (Ellis 284). They “must not only use their methodological tools and research literature to analyze experience, but also must consider ways others may experience similar epiphanies; they must use personal experience to illustrate facets of cultural experience, and, in so doing, make characteristics of a culture familiar for insiders and outsiders” (276). Autoethnographers “view research and writing as socially-just acts; rather than a preoccupation with accuracy, the goal is to produce analytical, accessible texts that change us and the world we live in for the better” (284).

Leon Anderson writes, “all competent researchers must acquire not only the ability to use various research skills but also the acumen to judge when some kinds of research are likely to prove more productive than others” (390). Although I knew at the start that my questions drive evocative autoethnographic research, it occurred to me that I could have used narrative inquiry to find answers. Like autoethnography, narrative inquiry allows room for both internal (“headnotes”) and external (literature, artifacts, etc.) data; it allows space for theory but doesn’t require it; it evokes emotional reactions and

therefore fosters empathy. However, autoethnography is arguably more rigorous than narrative inquiry because it more often leans on existing research. Further, because narrative inquiry doesn't require the researcher to reach outward toward cultural intersections, it leaves room for readers to view her experiences as exceptional and therefore not demanding change. Autoethnography, on the other hand, must reveal connections to a culture that includes others with similar experiences. If the researcher demonstrates that many people are experiencing the same problem, change is more likely to be perceived as warranted. Thus, autoethnography is more capable of driving prosocial change.

It also occurred to me that if I were an ethnographer, I could have studied others in my community from a distance, asking some of the same questions and maybe getting some of the same answers, and I wouldn't have to come out with mental illness. But, I wondered, is it ethical or even possible for me to omit myself from research that is definitively my business? I doubt it. Autoethnography—even evocative autoethnography—is more ethically sound than ethnography for my study as it resolves the “crisis in representation” by requiring that I acknowledge biases and predispositions *within* the primary text, not in a separate “confessional tale.”

### **Criticisms of Autoethnography**

Not all researchers are on board with autoethnography, and some are especially critical of evocative autoethnography. According to these critics, evocative autoethnography is “insufficiently rigorous, theoretical, and analytical, and too aesthetic, emotional, and therapeutic” (Ellis 283). Autoethnographers are accused of “doing too

little fieldwork, for observing too few cultural members, for not spending enough time with (different) others” (283). According to Ellis, however, these criticisms “erroneously position art and science at odds with each other, a condition that autoethnography seeks to correct” (283).

Anderson, a proponent of *analytic* autoethnography, seeks to “reclaim” autoethnography for those who he believes can be trusted with it: experienced analytic ethnographers. It seems to me, though, that someone who is so concerned that the successful advocacy for evocative autoethnography will overwhelm “other visions of what autoethnography can be” (Anderson 374) that he would dissuade graduate students from using it may be holding too tightly to a method that should be explored to its full potential by anyone who finds it appropriate for their research. As a competent researcher working under the supervision of a seasoned (and even more competent) researcher, I judge evocative autoethnography as the most appropriate method for my research.

Through evocative autoethnography, I have the authority to confront the incredibly pervasive stigmas linked to mental illness, especially in academia, where personal accounts of bipolar disorder are few and where mental illness is discussed largely in third person. While autoethnography of any kind can be a powerful tool for fleshing out one’s sense of self in context with other selves and for interrogating difference, evocative autoethnography has potential for creating empathic bonds between writer and reader and for challenging the master narrative.

## **Data Collection, Analysis, and Interpretation**

My autoethnographic research project was broken into steps to be completed over fourteen weeks. These steps included a heuristic exercise, critical narrative, secondary research, primary research, and finally, synthesis into a complete autoethnography. As I collected data (by completing these steps), I followed Chang's ten strategies for analysis and interpretation of the data, as it was collected, for each step of the process (131):

1. *Search for recurring topics, themes, and patterns.*
2. *Look for cultural themes.*
3. *Identify exceptional occurrences.*
4. *Analyze inclusion and omission.*
5. *Connect the present with the past.*
6. *Analyze relationships between self and others.*
7. *Compare yourself with other people's cases.*
8. *Contextualize broadly.*
9. *Compare with social science constructs and ideas.*
10. *Frame with theories.*

In most research methods, data collection and data analysis and interpretation occur separately and linearly. However, according to Heewon Chang, author of *Autoethnography as a Method*, autoethnography is not a linear process; in fact, "research steps overlap, sometimes returning you to previous steps. One activity informs and modifies another" (121). Because data collection, analysis, and interpretation are recursive and iterative in autoethnographic research, I often circled back to previous steps in order to narrow, expand, or refocus my research. In doing so, I shifted "between self

and others, the personal and the social context” while recalling, writing, analyzing, interpreting, and consulting the literature (126). Although I break the assignments into neat sections below and provide a detailed explanation of my process for each, for the sake of brevity and clarity, I do not explicitly mention the points at which I revisited previous steps.

### *S/CI Ideas Paper*

My autoethnographic research project began with a heuristic exercise. According to the assignment sheet, “When a research topic is selected, the most important questions should be what to do with it. The minimum requirement is that autoethnographers must be willing to

- dig deeper into their memories
- excavate rich details
- bring them onto examination tables to sort, label, interconnect
- and contextualize them in sociocultural environment.

“Commitment to cultural analysis and interpretation is the key in proceeding with any topic” (Qtd in Chang 51).

The S/CI Ideas paper”<sup>1</sup> was to begin with a “central memory, narrated briefly,” followed by the “thoughts/emotions the central memory raises for you now” and, finally, an inquiry into “the larger cultural narratives/issues the memory may shed light on” (“S/CI Ideas”). In my paper, I wrote that I wanted to explore “my experience as a college student and an IA/TA with Bipolar I disorder who wishes to continue working in

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<sup>1</sup> See Appendix A, “S/CI Ideas Paper”

academia.” The central memory was one from Fall, 2013, during my undergraduate studies, in which I was experiencing anger, dejection, extreme paranoia and other symptoms typical of a bipolar “mixed mood state.” (I talk more about this in my autoethnography.) I concluded this memory with a reflection: “I lost a great deal that semester—respect from my Honors College mentors and several of my peers, the culture of caring and goodwill that I had been a part of since I first joined them and, most terrifying, confidence in my understanding of reality.” I followed with the thoughts and emotions that surfaced while recalling the incident: “Bipolar breakdown has happened to me since, and it will happen to me again, and I worry incessantly that, at some point, bipolar will cost me the fruit of all my endeavors—friendships, professional connections, my future in academia—and I feel helpless to do anything about it, preemptively or otherwise.” What is remarkable about the memory I chose is that in Fall, 2013, I didn’t know that I was experiencing a psychotic break; it was only after then—when I sought treatment for paranoid delusions and “anger issues”—that I accepted a diagnosis. Even more remarkable is that I intentionally avoided exploring a memory of a more recent psychotic break, one that had serious professional implications. I rationalized that I didn’t yet have the clarity to write about it, or that my writing about it might make some people in the class who were also part of that memory uncomfortable, or that my admissions of mental instability would compromise my future in the academy.

Finally, in my assessment of the larger cultural narratives/issues that surround my experience led to my initial research questions, I wrote “My experience could shed light on the university’s support structure—or perhaps the lack of one—for faculty and students who struggle with bipolar.” Questions emerged from this assessment. Initially, I

asked, how is my experience with bipolar like others' and what can we learn from our collective experiences? How, if at all, do faculty members with bipolar thrive in the academy? Who, if anyone, helps them?"

In response to my Ideas paper, my professor wrote, "Intersections I see include self/medical community, self/university, self/INSTITUTIONS which encompasses all, self + the effects of trauma, self/bipolar and discourses about bi polar" (personal correspondence).

### *Critical Narrative*

The second assignment for the class was a critical narrative, one that expands on the central memory I explored in my Ideas paper and reaches outward to further explore cultural intersections. The assignment<sup>2</sup> was as follows:

Elaborating on data from systematic reflections and other invention strategies we will discuss (and practice) inside and outside of class, you will write a critical narrative related to one of your self/culture inquiry ideas. Ideally, the self/culture inquiry ideas themselves have arisen from experiences and/or epiphanies that continue to bother, perplex, fascinate, or challenge you. The key word here is "critical." Your narrative should do more than tell a story or express an opinion. Instead, your narrative should be purposeful and appropriate to the task at hand—an attempt to "translate public knowledge into personal meaning—and back again" (France, "Dialectics," 164). Victor Villanueva calls this the

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<sup>2</sup> See Appendix B, "Critical Narrative"



“autobiographical as critique,” a mode of “generalizing, theorizing, and questioning the systemic based on the personal” (*Boostraps* xvii) (“Critical Narrative”).

To write my narrative, I first needed to acquire a critical understanding of my personal experience with mental illness by “retrospectively and selectively writ[ing] about epiphanies that stem from, or are made possible by, being part of a culture and/or by possessing a particular cultural identity” (Ellis 276). During this process, I sifted through raw memories, or “headnotes” (Wall 45), of my experiences with mental illness in search of ones that shed light on how the groups to which I belong have shaped those experiences. (For instance, I am a graduate student who has suffered symptoms of bipolar disorder on campus, therefore the academy has shaped my experience of mental illness.) Specifically, I wanted to remember the details of the psychotic breaks I have had since first being diagnosed with bipolar disorder. For this step, I was to write purely from memory, reflexively, but without conducting outside research.

The memory of my Fall, 2013 psychotic break brought to mind other times I’d experienced mental instability. I remembered and reflected as I wrote, and what initially made it onto the page was a sort of shapeless freewriting in which I switched between recalling (past tense) and reflecting (present tense). When I couldn’t recall the actual words exchanged during a remembered conversation, I said so. For instance, regarding a telephone conversation with my husband, I wrote, “I imagine a strained conversation because I can’t recall our actual one.” I made similar disclosures for incomplete memories: “Like most of my memories of this sort, I can’t remember the pieces that

might help me understand why I ended up in this state. It's almost always a blur." As I revised, the following sections emerged:

- "A Fluke" a memory of and reflection on the events that led to my first diagnosis, which, at the time, I believed was a one-off experience with no future implications
- "Losing Touch" an expansion of and reflection on the central memory from Fall, 2013 I'd written about in my S/CI Ideas paper
- "Lost" a memory of the months-long fallout that followed my Fall, 2013 psychotic break
- "Average Jane" the memory of and reflection on a psychological evaluation that led to my most recent diagnosis, my acceptance of the diagnosis, and subsequent treatment
- "I'm Okay (For Now)" commentary on my current (as of then) emotional and psychological states and concerns over instability

It was difficult to resist the urge to analyze, to look for patterns in what I was writing as I was writing it. I saw psychotic breaks narrated chronologically with the exception of the most recent one (that I was still avoiding). I saw the multiple times I have been diagnosed with bipolar disorder, and the times I sought treatment, also narrated chronologically. I saw a survey of my symptoms: invisible insects crawling all over my body, classmates "out to get me," devastation at every turn. I wondered at my need to end with a note about fleeting stability, realizing that it reflected my anxiety over the copious reminders that, "for me and other people with Bipolar disorder, stability is fleeting."

Further, I worried that my narrative was much too “dark” for others to be able to relate, or that I still didn’t have the clarity to write convincingly about my bipolar cycles, or worse, that I was only reinforcing the misconceptions about bipolar disorder that I was hoping to deflate. By the time I finished writing, I was a mess of emotions. Even after I turned in my critical narrative assignment, memories (and the insecurities that accompanied them) continued to flood my notes. Knowing that my narrative would continue to evolve, I began keeping a personal diary to separate manic ramblings from important memories. At this point, however, I paused my narrative and began conducting secondary research.

### *Secondary research synthesis*

For the third step of the process, I was to use themes from my critical narrative (identified through early attempts at labeling and coding) to conduct secondary research. This research would be synthesized into an essay that reads much like a literature review. The assignment instructions<sup>3</sup> were to:

gather and synthesize secondary sources related to your narrative (and to your evolving understanding of your larger autoethnographic project).

This secondary research will help you situate personal experience within scholarly and research conversations about the subject of your personal experience or related areas—theoretical frames, methodological approaches (“Secondary Research Synthesis”).

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<sup>3</sup> See Appendix C, “Secondary Research Synthesis”

To see what people have said about coming out with bipolar disorder through narrative self-representation, I conducted searches in ComPILE, PsychINFO, and Project Muse and found a few sources in writing and rhetoric, but most were published by researchers in the social sciences. My search yielded a wealth of literature that helped me better understand how those with bipolar disorder might approach the writing of personal narratives and how those narratives can function within larger cultures. As detailed in the previous chapter, some discuss psychopathology and the narrative self. One foregrounds trust and self-trust in the bipolar narrative and emphasizes collaboration between self/other and self/self to engender trust and make sense of “chaos.” Another source does not mention mental illness at all but discusses more generally the “illness narrative” for persons with ill *bodies* (as opposed to ill minds). Still others discuss mental illness stigmas and ways one with bipolar disorder might use rhetoric to confront and unravel them. The eight original sources that make up my secondary research synthesis include:

- Debra Bielke, “The Language of Madness”
- Kay Redfield Jamison, *An Unquiet Mind: A Memoir of Moods and Madness*
- James Phillips, “Psychopathology and the Narrative Self”
- Grant Gillett, *The Mind and Its Discontents*
- Arthur Frank, *The Wounded Storyteller*
- Nancy Nyquist Potter, “Narrative Selves, Relations of Trust, and Bipolar Disorder”
- Patrick Corrigan, “Reducing Stigma by Coming Out Proud”
- Michalak et al., “‘It’s Something That I Manage but It Is Not Who I Am’: Reflections on Internalized Stigma in Individuals with Bipolar Disorder”

I cite some of these sources extensively in my autoethnography, Frank especially. While I do not use all of them explicitly, each informed my research in some way. For instance, after writing my first critical narrative, I analyzed Jamison's work as an example of mental illness narrative, specifically of bipolar disorder, and it allowed me to see more clearly some of the intersections that my subsequent drafts should be reaching for. Like Jamison, I was interested in exploring how my mental illness has affected social and professional relationship. Potter's ideas lingered in my consciousness; I worried that my illness would cause my recollections (and therefore, my writing) to become "chaotic" or "fragmented." (That didn't happen, thankfully, because I was stable as of the writing.) These sources served as a solid foundation for my research, but they did not completely support the direction my autoethnography ultimately took. I continued my secondary research even after turning in this assignment. As my focus evolved, the literature grew from eight sources to fourteen, not including those that guided my methodology. Further, the questions that drive my research changed. To reiterate, those questions are, how does a person with bipolar disorder carve out a narrative space for herself in a culture that shames, devalues, distrusts, or otherwise ignores the mentally ill? What can she do to bridge trust and understanding between those within academic institutions who do not struggle with mental illness and those who do? How does she embed what may be seen as a "deviant" self-representation into the larger cultural narrative in order to confront and unravel stigmas associated with Bipolar disorder? Finally, what are the implications of "coming out" to the academy as having Bipolar disorder?

### *Primary research*

After finishing my secondary research synthesis, I began conducting primary research “designed to further illuminate the issue [I] explored through narrative and secondary sources.” For this assignment<sup>4</sup>, I was instructed to do two artifact analyses. For each of these, I would be “identifying [the artifact], contextualizing it, describing it, writing about the feelings, realizations, memories, stories that it provokes, and offering tentative analysis of how this artifact and your writing about it might be useful” (“External Data”).

Through primary research, I had the opportunity to examine the culture in which my memories are entrenched and to tease out fragmented or blurred memories that were key to insight. In addition to verifiable facts, I used facticities that “describe how ... facts were lived and experienced by me” (Sparkes 467). As I worked through primary data, it became clear that I would need to revise my critical narrative. I was not surprised. The assignment sheet read, “Additional primary research will no doubt prompt revisions of your earlier understandings and analyses. This is the rigorously reflexive and iterative nature of autoethnography: we gather data, reflect and write, reassess, gather more data, write, refine, revise” (“External Data”).

Although I wasn’t sure at the start how I would use the primary data, I kept in mind that “[external data] can be integrated into your autoethnography, used to help you refine your autoethnography focus and purpose, deepen your awareness and

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<sup>4</sup>See Appendix D, “External Data and Tentative Analyses”

understanding of situations and events, fill in gaps, sharpen your interpretations, or a combination of all of these” (“Primary Research”).

The personal artifacts I analyzed included emails to and from a confidant, a psychological evaluation report, a midterm performance review, therapy notes, photos, a song that has reflected or shaped my feelings about some aspects of mental illness, and social media posts in which I have “tested the water” for coming out. Although only a few of these artifacts are mentioned in my final autoethnography, each served a specific purpose. I used them in the following ways:

- *2014 psychological evaluation.* In my critical narrative, I discuss a time I submitted to evaluation and treatment after a serious psychotic break. While analyzing the report, I summoned the feelings of anxiety and helplessness that I felt during the evaluation. This helped me to recall details that I had forgotten and to more accurately relay those details in my narrative.
- *Lyrics from “Into the Ocean”.* Playing this song helped me recall thoughts and feelings I’ve had during my most severe experiences with bipolar depression. Writing about it gave me an increased awareness of what happens to me as I go into these cycles. In my autoethnography, I cite one stanza to evoke in the reader a reaction similar to what I experience when I hear it.
- *Social media posts.* While analyzing several social media posts that I made after my 2014 diagnosis and treatment in which I share links to mental health resources but do not comment on them, I realized two things: I was not committed to coming out, and the fact that those posts were “seen by” many but received little

or no feedback could be an indication of a general awkwardness or detachment surrounding the topic of mental illness.

- *Photos*. I used photos taken during Fall, 2013 to recall specific details that I initially overlooked while writing my critical narrative. Seeing these photos helped me to flesh out the thoughts and feelings I had while in conflict with my peers and adviser. In my autoethnography, the Fall, 2013 events are more detailed and thus more revealing of my state of mind at that time.
- *2017 midterm performance review*. It was upon rereading my Fall, 2017 midterm performance review that I decided to write about my most recent psychotic break. The review, written by my then-supervisor based on information gathered from other supervisors and my peers at the writing center where I worked, gave me the clarity I needed to write about my struggle with “mixed mood state” that semester. When I first read the review that semester, I was devastated. Reading it again while stable helped me not only to remember more accurately the events as they unfolded, but also to see more clearly how others perceived my symptoms. I cite parts of the review in my autoethnography.
- *Emails*. I read these alongside the midterm performance review because they were written around the same time period and add context to the review.
- *Therapy notes*. I sought therapy from the university counseling center on several occasions—twice during my Fall, 2013 cycle and three times during the Fall, 2017 semester. Reading these notes, which included self-assessment charts and notes by my clinicians, helped me remember the specific thoughts, impressions, and behaviors I experienced and also allow me to pin down dates for contrast and



comparison. This functioned as a sort of reality check. Although I do not cite these clinical notes in my autoethnography, I do relate some of the feelings and impressions that I recalled while analyzing them.

Once I had collected and analyzed my secondary and primary data, I began labeling according to “simple identifiers by which the data set can be easily located” (Chang 116). Data sets had emerged as a series of memories of several types of events: coming out with mental illness, plunges into bipolar depression or mania, and conflict with others during those cycles. I further labeled each with the types of artifacts I used for recollection. These data sets grew as I worked through the recursive process of reality testing, writing, and reflecting on each memory.

Once I finished labeling data sets, I coded and sorted them. According to Chang, “Coding and sorting are used to fracture each data set into smaller bits on the basis of topical commonality and to regroup the data bits into topical categories” (119). For instance, because I wrote about the times I self-disclosed, my data sets were coded and sorted into chronological events, e.g. “first disclosure,” “second disclosure,” and so on. Other emergent themes pertained to the response a person had to my disclosure (e.g. “indifferent,” “awkward,” or “supportive”) or to the environment in which I disclosed (e.g. academic, social, professional, clinical). I also looked for subtle “data bits” that only imply belonging to a particular category and for ideas, events, memories, or pieces of memories that I had omitted. (Investigating omissions and my reasons for omitting led to the inclusion of several important memories, including my Fall, 2017 bipolar cycle.)

As I coded the data, I refined and reduced it, keeping in mind that in autoethnographic research, “you sometimes allow your gut feelings and broadly defined research goals to take a lead in your data collection” (Chang 121). According to Chang, “this exploratory approach gives your forgotten memories and submerged thoughts a chance to surface during your data collection” (121). At the end of this process, not only did I feel that my narrative was complete, but I also had ideas for how I would organize my autoethnography.

### *Autoethnography*

Although the previous steps may seem to indicate that my autoethnography could now be pieced together from several finished products (of other assignments), this was not the case. My autoethnography had been forming gradually throughout as I sifted, sorted, and revised. In the tenth week (of fourteen), the final autoethnography was assigned<sup>5</sup>. For this final step, I was to:

compose a critically reflexive autoethnography of 10-12 single-spaced pages that draws and *builds upon* work you’ve done throughout the semester. Composing the autoethnography will require much more than simply merging the work you’ve already done in the course. Instead, the final autoethnography will require you to (re)examine and (re)analyze existing data in light of new research and the insights that arise from that research; gather new data as needed to flesh out areas of the autoethnography that need development; experiment with organizational

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<sup>5</sup> See Appendix E, “Autoethnography”

strategies, styles of writing, and voice; and write and revise to meet the criteria we establish for effective autoethnographies (“Autoethnography”).

Per the assignment instructions, I was “free to write a primarily evocative autoethnography (foregrounding the personal in the personal-cultural continuum) or foregrounding the cultural (in the personal-cultural continuum).” Initially, I kept the analytic portion of my autoethnography separate from the narrative. In one draft, I opened with the evocative (narrative self/other) and ended with the analytic (theory). The idea was to avoid interrupting readers’ emotional response to the evocative writing and to “finish strong” by backing up the claims and ideas in my narrative with an analysis of relevant existing research. In another draft, one that I sent for workshop, analysis preceded narrative. However, based on feedback I received regarding organization—some mentioned feeling that I had written two autoethnographies—I decided to weave the theory into the narrative. All who read my autoethnography agreed that, either way, it was more evocative than analytic. Although I was drawn to the more evocative autoethnographies I had read in the previous weeks, I did not make a conscious decision to write my own autoethnography evocatively based on my reading preferences. Rather, because the nature of my topic, my purpose for writing, the questions that drove my research, and the answers to those questions warranted an affective response, an evocative autoethnography naturally emerged.

### *Evaluating Autoethnography*

Before resubmitting my autoethnography for final workshop, I needed to evaluate it. Combining what I had learned about autoethnography from readings throughout the

semester with a handout<sup>6</sup> listing scholars' views of what constitutes autoethnography, I evaluated my autoethnography according to the following criteria:

- Autoethnography is evocative to some degree; it reflects story craft (Schroeder).
- It “extends knowledge, generates ongoing research, liberates, empowers, improves practices, and/or makes a contribution to social change” (Le Roux)
- It resonates; it is impactful: “readers are able to enter into, engage with experience or connect with the writer’s story on an intellectual or emotional level” (Le Roux, Richardson, Adams, Jones, Ellis)
- Autoethnographers value ethics of care; they ask, “Does the contribution of the story outweigh conceivable ethical dilemmas and pain for characters and readers?” (Ellis 2011 276).
- In autoethnography, the self is prominent, however subjective; readers get a “fleshed out, embodied sense of lived experience” (Richardson) and “the text enables the reader to enter the subjective world of the teller—to see the world from her or his point of view” (Adams, Jones, Ellis)
- Autoethnography is credible: “there is evidence of verisimilitude, plausibility, and trustworthiness in the research” (Le Roux)
- There is evidence of reflexivity, or “of the researcher’s intense awareness of his or her role in and relationship to the research which is situated within a historical and cultural context”; the author demonstrates “self awareness, self exposure, and self conscious introspection” (Le Roux)

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<sup>6</sup>See Appendix F, “Evaluating Autoethnography”

- In autoethnography, self/culture intersections are rigorously and reflexively studied, and there is the added probability that researchers will clarify and augment narrative by analyzing primary data, leaning into existing research, and exploring current or emerging theories (Jackson)
- Finally, autoethnography is best suited for “contact zones,” or the “social spaces where cultures meet, clash, and grapple with each other, often in contexts of highly asymmetrical relations of power” (qtd. in Brodkey 28).

After a last round of revision, I was confident that my autoethnography meets all the criteria above. My workshop group agreed. The following chapter contains the final version, the one I submitted to my professor in the fourteenth week.

### III. HER OWN VOICE: AN AUTOETHNOGRAPHY

*“In stories, the teller not only recovers her voice;  
she becomes a witness to the conditions that rob  
others of their voices. When any person recovers their  
voice, many people begin to speak through that story”*

(Frank xiii).

#### Stories of Bipolar Disorder

The story goes that a person with mental illness is “quite thoroughly bad, or dangerous, or weak” (Prendergast 3). Further, she is wildly irrational, unpredictable, and incompetent. She is lost, often unaware or in denial of her illness.

If one were to ask a person with mental illness her thoughts on this story, she would say that while some of these things are true some of the time, her symptoms are not permanent, and her illness does not make her bad or dangerous or weak. She is more than just her illness; in fact, she is a dynamic and complex human, much like anyone else (Myers 58). Perhaps no one would listen, though, because the story has damaged her ethos.

How can one with bipolar disorder command an audience so that she can tell the true story of her illness? Much of the literature on the subject says she cannot, because mental illness “supplants one’s position as a rhetor;” her personal expression has “no bearing outside of itself, no transactional worth” (Prendergast 57). It rarely matters if a

stigmatized person has a wholesome or valuable message—they are silenced by their “kakoethos,” or mark of “bad character.” Jenell Johnson writes,

If one’s attributes make a claim, it is a claim of character—a stigmatized attribute breaks that claim by offering a more persuasive argument for a particular audience, and much like the ancient Greek mark [of stigma], it drowns out other forms of ‘speech’ about character. One might be unfailingly kind, breathtakingly beautiful, and a whiz at calculus, but if one walks with a cane, wears the hijab, or is known to have bipolar disorder, these attributes tend to shout down the others in rhetorical environments where cane use, the hijab, or bipolar disorder are stigmatized (465).

It is no wonder that people with bipolar disorder are so hesitant to accept a diagnosis. While they might have felt relief initially at finally having a name for their monster, relief turns to denial as “the internalized concept of ‘what it means’ to be mentally ill comes to the foreground of their thoughts” (Young 58). Not least on the list of what it means is that stigmas associated with bipolar disorder can rob them of voice, for “the cultural stigmatization of mental disability guarantees that the challenge to a speaker’s credibility begins the minute she reveals her condition” (Uthappa 165). Johnson might say that narrative self-representation of mental illness for confronting stigma is a waste of time because mentally ill people aren’t trusted to speak for themselves. (Because, you know, they’re crazy.)

But there is transactional worth in an alternative story of mental illness. If a person with bipolar disorder dares to “refute the cultural ideology of mental illness as personal weakness, as something shameful, utterly destructive, and permanent” (58), the neurotypical in-group may find in her a protagonist, even if she does have a fatal flaw; given an audience, she can show that she is not weak, that she “do[es] not necessarily, nor passively, accept the negative consequences of this group membership” (Michalak 222).

### **The Story According to the Chart**

There is an official story of bipolar disorder, one that clinicians tell. In this story, it is a randomly-occurring cycling of mood states “between the extremes of mania and depression” (Guest 79). Assessed behaviorally, people with bipolar disorder have “distinct period[s] of elevated or irritable mood that can take the form of euphoria.” These cycles are linked to an “apparent increase in energy, a decreased need for sleep, racing thoughts, poor attention span, increased risk taking, increased self-importance and a heightened sex drive” (80). A case study might present the bipolar patient in a manic state as crazed and promiscuous, noting that these patients often believe they are brilliant or invincible. When in depression, also called “mixed mood state” or dysphoria, she is unpredictable, potentially a danger to herself and others. In this confused state, she “frequently experience[s] additional symptoms such as agitation, anxiety, guilt, impulsiveness, ideas of suicide and paranoia” (80). The clinical language of bipolar disorder extends beyond behavioral assessments and, in fact, becomes even more detached from the individual’s experience of her illness. According to Guest, definitive



evidence of bipolar disorder lies in “altered glucose metabolism and insulin signaling, growth factor pathways and immunological alterations” (79) and can be observed in “abnormal function in the prefrontal cortex, hippocampus and amygdala emotion-processing circuits” (80).

While there is value in describing bipolar disorder in clinical terms, particularly to clinicians, it does little to fight stigma. “If stigma is a matter of values rather than facts, whether mental illness has its origins in genes, chemistry, biography, environment, bad character, God’s will, or the cycles of the moon is of little importance” (Johnson 475). But clinical stories of bipolar disorder “are not the only stories there are to tell or the only languages in which to tell them” (Kafer 6). By augmenting our understanding of bipolar disorder with stories of *and by* individual selves, we prevent the chart with its dehumanizing language from writing the official story of the illness (Frank 92).

### **Another Story**

I grew up barefoot in the pines where Texas and Louisiana meet, the middle of three children. My pawpaw was an alcoholic, and so were his children, all but two. My mom was one of those two. My sister, brother, and I were luckier than some of our cousins, except we didn’t know our father or his family. So, if mental illness other than addiction runs in our family, well, there is no way of knowing it.

I didn’t know I was sick. I knew, though, *I always knew*, that I was off.

People who suffer from mental illness often don't know they have it. I was fully a woman—a wife and mother of three—when I was diagnosed with bipolar disorder in the Spring of 2009.

James was out of town on business. It was rare that he left home for several days at a time, but it wouldn't be a problem, we said. With family nearby, I and our children had plenty of support. We were doing well, only missing him, when I abruptly found myself in our garage, hysterical, suicidal. Like most of my memories of this sort, I can't remember the important pieces that might help me understand why I ended up in this state. It's almost always a blur. There is music in this memory, a song. In Blue October's "Into the Ocean," the chorus goes:

I want to swim away but don't know how  
Sometimes it feels just like I'm falling in the ocean  
Let the waves up and take me down  
Let the hurricane set in motion  
Let the rain of what I feel right now come down  
Let the rain come down

While my young children watched cartoons just steps away, I lay screaming and sobbing violently on the cold concrete floor of my garage as the song played on repeat. I remember not wanting to hear it anymore, but also not wanting to hear anything else. Over and over, it was calling me "Into the ocean" to "end it all." I don't know how long I was there. It was dark when I called James—I imagine a strained conversation because I can't recall our actual one—and he came home quickly. In the weeks following, there were fits of screaming, broken things, tears. My torment became James' torment; he

carried our children on eggshells for me. We kept my instability from our family and friends, but there were times when hiding out would have given away our secret. I went to family dinners. Smiled for pictures. Said all the things a normal, not-crazy person would say. It wasn't working. I was sure they knew.

I had to see someone.

I went alone to the psychiatrist's office, arrived early, and sat in my car for a very long time, deliberating on whether I should go inside. I didn't want to. I wanted to hide—from the psychiatrist, from James, from the crazy that welled up in me randomly, angrily. A burly, sour-faced woman greeted me from the other side of a thick, plexiglass window as I entered the office. It was dark and smelled of leather. There seemed to be a fog coming from somewhere, or there was a fog in my head. "The doctor is with a patient. Wait there." I heard men's voices through the wall. I tried not to listen. *Will someone overhear me talking with the doctor, too?* I was embarrassed.

He motioned for me to sit. *The couch? The chair?* I opted for the couch and regretted it. A precariously tall stack of papers shifted as I sat, and it's all I thought about as I answered stock questions for what felt to me like hours. "History of violence?" *No.* "Criminal record?" *Not really.* "Neurological disorders?" *Not that I'm aware of.* "Thoughts of harming yourself?" *Yes.* "Others?" *No.* When the questions stopped, there was a long pause as he scratched at his notepad. I asked for a copy of what he had written. I don't think he answered, or I didn't ask aloud. Bipolar disorder, he said finally, as he handed me a prescription. I was exhausted. As I walked to my car, I considered what I might say to James. *Which one of the characters in Girl, Interrupted has bipolar*

*disorder?* My diagnosis didn't register; I didn't see myself in the images I had of mental illness.

Lithium and Cymbalta, and I felt nothing. "You're a zombie," James said. "Come back to us." It was unsettling for him, restful nothingness for me. For months, we tried to get used to the new me. Finally, though, we agreed it was the wrong way and I stopped taking the medication. To our relief, nothing happened. *I'm fine. I'm better.* I stopped seeing the psychiatrist too. *Talking to him is difficult, anyway.* White coat, notepad, too little or too much eye contact.

By the following Summer, I was no longer fine. It began with lists. Lists for everything. Chores, sorted spatially and re-sorted by estimated time to completion. Shopping, sorted by where I would put things, again by price, and again by where I would find them in the store. I began writing my lists in pencil. I was compelled to buy an abundance of certain items: notebooks, hand sanitizer, batteries. *Batteries, because it's hurricane season, and we need to be prepared.* When there was no money to buy things, I shoplifted. *Batteries and groceries, groceries and clothing.* By the time James knew that there was a problem, I was in crisis.

I needed to talk to someone who could help me understand what was happening to me. I knew I shouldn't, but I had to. While talking with a family member who I knew had been diagnosed with bipolar disorder, I said that I was sick and that I had been shoplifting. Instantly, I regretted it. His expression when I told him was enough to shut me up. *Disgusting.* James was angry with me. "Why would you tell him, of all people?" I

was ashamed all over again. We were still pretending that it was only post-partum depression.

I returned to the psychiatrist's office to find that Dr. Achilles was gone, there was a new sign on the door. The receptionist couldn't tell me anything. Along with my medical records, my doctor had just vanished. James wanted me to find someone else, this time someone who wouldn't be so quick to prescribe drugs. Our health insurance did not cover mental health services, but through James' employee assistance program, I was entitled to three therapy sessions. I was surprised at the relative ease of getting in with no wait to see a therapist at a small, non-profit clinic. The receptionist had a kind voice. No judgement from her.

On the day of my appointment, I pulled into one of the four parking spaces in front of the small brick building that housed Samaritan Counseling Center. *This is it. Fix it or you'll lose everything.* My counselor's office was long and narrow with windows that opened to the low branches of an old oak tree, the leaves reflecting off the walls and giving the air a green hue. There was a single bookshelf, tidy and full. Throughout our sessions, she talked with me about self-care, motherhood, and spirituality. To my relief, she respected my reluctance to take medication and my aversion to the diagnosis. She suggested self-help books that I never looked for, but mostly only listened as I worked through feelings of guilt and worthlessness, fear that I would do nothing, be nothing, fail at everything. After my last session, I felt buoyant, as if I was floating on hope, but I couldn't point to any specific thing my counselor said that made my world seem brighter. When anyone asks, I half-joke that she used magic. Within a month of my last visit, I was

enrolled in college. I was fine again. I packed the diagnosis away and focused my energy on my studies.

In the Fall of 2013, toward the end of the final semester of my undergraduate career, I took a playwriting course in the Honors College. For our final project, Professor Hood split us into groups of three. Because it was a mixed enrollment course, each group included a graduate student. Our assignment was to adapt a stage play for the screen, and we chose *Trifles*. For some reason, or for no reason at all, I felt uneasy about the group dynamic, specifically about Carol, the graduate student. *She doesn't like that I have talent. She feels threatened.* Early in the project, I came to firmly believe that she intended to sabotage our project and take my ideas for her own.

I fought fiercely to protect the integrity of my work, my creative property, just as anyone else would do in those circumstances, I thought. I called my professor. I had taken two other classes with him. He was my thesis director. He knew me. I was certain that he would intervene on my behalf. I was stunned by his response. In my mind, I can still hear him.

“Tiffany, do you have anger problems?”

That conversation marked the very beginning of a suspicion that it was me, not her. It made no sense at all that another student—a graduate student—would disrupt her own progress in the course for forty-two mediocre pages of *Trifles*, the screenplay. *But she would, wouldn't she?* I couldn't make out the truth. *If this isn't reality, what is it?*

At that time, I was Historian for the Honors Student Association. My fellow officers were my friends. We got along well, and I cherished their deference to my insight as a first-generation, non-traditional, seasoned student. *I'm needed, valued.* I was motherly with them, and they encouraged me to be. But because I was graduating, we needed a new Historian. Mari was older than the others, a non-traditional student like me, and more assertive than any of us. I don't know that I had any specific reason to believe she disliked me, but I felt she wanted me to know that she did not need my help settling into her new position. I was offended, and I was hurt that my friends didn't notice her animosity toward me. For a while, I heeded the small voice in my mind. *Let it go.*

It got worse. When the time came to recruit members for the following year, the officers came together to make decisions on such particulars as recruitment strategies, meeting times, and membership dues. We agreed on the design of the flyers. We agreed on a meeting place and time. We did not agree on one thing: I felt that recruits should have the option to pay a lower amount if they were willing to forgo the t-shirt, that we would recruit more members by setting dues lower. When several of the officers disagreed, I convinced myself that they were "elitists," that they were using dues to limit membership to only those who could afford t-shirts. I obsessed. I couldn't let it go.

The change in our relationship was sudden. Some of the officers began to look at me pityingly, others were aloof. Alex, who had deferred to me the most, spoke to me curtly, as if annoyed. It was infuriating. I blamed Mari. *She's whispering in their ears.* Mari blamed me. "You're doing this to yourself, Tiffany. It's you." With hard feelings, I resigned. But when the smoke began to clear, a confusion washed over me. *How could this have happened? Why?*

When I couldn't make sense of it, I tearfully confided in my husband—who had been my champion through it all, who had encouraged me to stand up for myself, who had been equally as puzzled at their behavior as I, and who was offended on my behalf—that I wasn't sure anymore if Mari and Carol had been the problem. *Maybe it's me.* I was losing my mind.

When it became clear that what I was experiencing would delay the completion of my undergraduate thesis, I confided in my committee that I believed I was having a mental health crisis.

Then, crickets.

*They don't care about me.*

Ironically, the Common Experience theme that year was mental health, professed to “explore how perceptions of mental health and illness affect our thinking, laws, actions, and quality of life.”

*Destructive. Impulsive. Obsessive. Distrustful. Angry. Wretched. Vile. Shameful. Worthless. Me.*



I didn't hate myself always, and I don't hate myself all the time. The self-loathing came over me in my adolescence as I began making terrible mistakes, ones with consequences far more serious and lasting than an ass whooping from Mimi, ones we didn't talk about openly. I was often aware that I was making a mistake even as I made it, unable to stop, and when held to account, I made no apologies. They were my mistakes. *I am a shitty person. This is what shitty people do.* For years, I begged God to fix me. *Cleanse my heart and mind, oh Lord.* As a teenager and into adulthood, I sometimes fantasized about my death. *Close your eyes, yank the wheel, let go, die.*

Standing in the ruins of my undergraduate career, the thing I spent more than a decade building, I began to hate myself again. For everything. Since the beginning of time. For the relationships I destroyed. The people I hurt. *I'm so sorry, love.* The things I took that weren't mine to take. The pieces of me I threw to the dogs. I was disgusted with myself. Furious. I raged. I lay in bed at night, hating, sobbing, cursing myself. Quietly so I wouldn't wake James, quietly so I wouldn't have to lie about why I sobbed. *How can I tell him the reasons why he shouldn't love me?* I couldn't. I was alone.

And in my hatred, I made more ruins to hate myself for.

*Poor babies. They deserve a mother, but they got you. You're shit. That's why Brooke wouldn't stay. That's why Kiersten doesn't try to hug you anymore. That's why Logan won't make eye contact with you. What have you done to James? He didn't sign up for this. You're shit. Fuck you. Load the gun, pull the trigger, die.*

For months after graduation, I didn't sleep. I went days, weeks without leaving home. There were bugs crawling on me—I saw them, I felt them, and no one could convince me that they weren't there.

*Something has to give.*

I made an appointment with Dr. Heller, the psychiatrist at the Student Health Center. The receptionist said they could treat me for three months, until my grace period ended. The doctor wouldn't speculate on the name of my affliction without a psychological evaluation, but she agreed to treat my symptoms. *Ambien, 5 mg by mouth at bedtime. Store the bottle in a cabinet away from the bed. Lamotrigine, 50 mg by mouth at bedtime.* It wasn't working. *Lamotrigine, 100 mg. 150 mg. 300 mg.* The bugs were gone. The anger turned to a deep sadness and regret. *Better.* Still, over and over, I saw myself die. As I wept and trembled quietly on the floor of my closet, the music played on.

Now floating up and down  
I spin, colliding into sound  
Like whales beneath me diving down  
I'm sinking to the bottom of my  
Everything that freaks me out  
The lighthouse beam has just run out  
I'm cold as cold as cold can be

Then, my grace period ended. I couldn't see Dr. Heller anymore. James was working under contract, so we had no health insurance. *Health Insurance Marketplace?* Those plans didn't cover mental health beyond hospitalization. Dr. Heller said to make an

appointment with the Department of Assistive and Rehabilitative Services. DARS, a place where people with *disabilities* go for help getting jobs. “Get the diagnosis,” she said, “and the rest will follow.” Simple.

It was a run-down building, smelling of insecticide and mildew. The people there didn’t look like me. I was sure they noticed. I, with fully functioning arms and legs, able to see, hear, and speak, was not there for help finding a job. *Just say that’s why you’re there.* I felt guilty, ashamed. I told her the truth. *I can’t afford a psychiatrist. I can’t work. I can hardly function.* She was reassuring. “Treatment first, job later.” She said I would need an evaluation. We scheduled an appointment at Austin Center for Therapy and Assessment. I looked forward to the evaluation. I was finally ready to call my monster out by its name.

I arrived an hour early. The waiting room was confining. I waited in my car, smoking cigarettes, one after another. It was a yellow day—red is worst, green is best—and I was especially anxious. I called my husband. *Maybe today isn’t a good day for this. Maybe my anxiety will skew the results.* “Perfect,” he said. “They need to see you in a bad place, they need a baseline.” I heard a hint of desperation in his voice. He needed me to stay.

The evaluation took four hours. I wasn’t warned that I would be coaxed into talking about my mistakes, the traumas of my childhood, my absentee father, *my mistakes, my mistakes*, everything I hate about myself. Then there was an IQ test. I wasn’t prepared for it.

My entire life, I believed I was especially intelligent. I had internalized how my family saw me, what they said about me. *Jaime is the pretty, mature one. Robbie is the charming one. I am the smart one.* It was part of my identity. But the report read, “Ms. Rainey’s current level of overall intellectual functioning lies in the average range, scoring higher than 66% of same age adults.” James laughed. “It’s a silly, irrelevant test.” I didn’t laugh. *If I’m not the smart one, who am I?* For the next several weeks I obsessed. *I wasn’t ready. This is wrong.* I wanted a do-over. I left half a dozen messages for my counselor. Finally, she returned my call. “When can you come in for a therapy session, Ms. Rainey?”

On my second visit, the therapist handed me two vibrating, egg-shaped, silver balls. “Concentrate. Find the little girl whose needs went unmet. Tell her she’s going to be okay.” I couldn’t concentrate. I was holding what looked to me like a sex toy. *They can’t help me.* I didn’t return.

Perhaps I should have. Shortly after that therapy session, I was invited to apply for a directorship at a local education non-profit. I was qualified and experienced, and I wanted and needed that job more than anything. A phone interview turned into a second, then a third interview with the founder of the organization. “Can you come in for a working interview?” I hesitated. “Of course.” The task was to prepare and conduct a thirty-minute lesson on a topic of my choice to a small group of non-traditional college students. I chose resilience. The interview came on a red day, and I bombed it spectacularly. I cringe at the memory of it. Me: wild-eyed and flushed, disheveled, paralyzed by anxiety. Today I wonder, if I had disclosed to them that I have bipolar disorder and asked for a second chance, how would they have responded? Would I be

directing a non-profit now? Or would they have at least been gentler in their rejection of me?

One Sunday in May, James said, through tears, that he'd been laid off from work the week before. He couldn't tell me sooner because he worried that I would sink further into my madness. As he said it, something in his eyes startled me. *He's afraid.* Like a snap of the fingers, I was suddenly able to see outside myself. *He's hurting.* It was surreal. I realized at that moment that, for the first time since we married, my husband couldn't tell me something important. *I did that.* "It isn't your fault," he said. "There's nothing to be ashamed of." It didn't feel that way to me, but it mattered that he said it.

It was then that the crazy began to subside. For the first time, I accepted my diagnosis completely, but as something outside me. *It isn't who I am. I'm not a shitty person.* Things began to look up. James got a new job, and eventually, I did too. We had health insurance. It didn't matter that psychiatry wasn't covered—my primary care doctor agreed to manage my medication. The medication affected my memory and focus, made my lips and fingers numb. It zapped my creativity and I could swear I'd lost a dozen IQ points because of it. But the real me, the me who loves herself, wouldn't miss a dose because she knows it helps to keep her safe. I replaced negative self-talk with new mantras. *They're not out to get me. I am loved. Darkness isn't permanent; light will shine on me too.* I worried that it would happen again, and I was afraid, but I also knew that if I tried, I would recognize my symptoms in time to stop the spiral. *From now on, I will have more control.*

In the Fall of 2017, two weeks before my first semester in graduate school began, it was happening again. This time, though, the stakes were much higher. It started with a hum as I busied myself with preparing for what was to come. I made lists. I would need books, notebooks, pens, pencils, highlighters, paper clips, a lamp. A new desk. A moderately professional wardrobe. *What do instructional assistants wear?* I cleaned and reorganized my house. *Who knows if I'll have the time later?* The hum became more frenzied as I cleaned and reorganized again. High on adrenaline, I became irritable, impatient. My husband recognized the mania. So did I. *Woosahhhh*. Then, the old familiar self-doubt began to creep in. It had been four years since I was in school. I would be surrounded by smart people, most of whom had either just finished undergraduate studies or were continuing their careers. In the time since I was an undergraduate, I'd done nothing significant.

My apprehension mounted at the orientation for new instructional assistants. As I listened to the previous years' instructional assistants talk about the ups and downs of teaching, their strenuous schedules, and balancing coursework with job expectations, I was hateful to myself. *You don't belong here. They'll know it soon.* Then, during introductions on my first day at the writing center where I had been assigned, I rambled. On realizing that I was rambling, I rambled more. I was losing control. I scribbled mean things to myself on a handout. *You're an idiot. Shut up. Shut up. Shut up.* I was sure they were rolling their eyes when I looked away. *Who could blame them?* At home, James said, "Stop it. You're doing that thing again."

Each day was worse than the last. I watched as the other instructional assistants grew more confident. They seemed to be transitioning into their positions and taking on

projects with ease. When a lead tutor turned the session over to me, I rambled. My peers were taking over their sessions, and I was still watching. I was forgetting important meetings. I couldn't tell them why, so I offered partial truths: "I had class, I was finding parking." Supervisors noticed. By the middle of the term, it was obvious that I wasn't adapting. My midterm performance review was a testament to my failure. The director of the center wrote,

A lead staff member provided "mixed feedback." Tiffany "seems eager to do well, but that doesn't necessarily translate into productivity or effective tutoring sessions." The most common bit of constructive feedback from lead tutors is that she sometimes goes on tangents. It is more than halfway through the semester and she is not, yet, tutoring on her own.

I was devastated, but it seemed fair. I was derailing co-tutoring sessions, and the lead tutors were fed up. The review very concisely summed up the problem. "The problem escalates, then, because tutors become irritated and, thus, send nonverbal signals that they are frustrated...[W]hen she reads their behavior, it undermines her confidence, thus interfering with her ability to focus." It was exactly that. The review crushed me—even more so because I knew it would be sent on to the director of the writing program—but I couldn't have described the situation more accurately. I was sinking. I wandered around campus in a heavy fog, inspecting roof tops and estimating which buildings were tallest. *Climb to the top, jump, die.*

Then I remembered—*It isn't me.*

What I did next had could have either salvaged or promptly ended my career prospects: On an impulse, I confided in my supervisor that I have bipolar disorder, that I was in a cycle, and that I was overwhelmed with anxiety. I said all the things I could never tell anyone, and I asked for mercy.

Instead, she gave me grace and said, “Tell that cruel inner bitch to fuck off.”

An impulsive decision made in the throes of a bipolar cycle had fully changed my trajectory. It wasn’t bravery. It was serendipity. I was thrust into coming out by the same invisible source that has compelled me to make lists and steal batteries. All the same, I was out to someone, and instead of distancing herself, this someone picked me up and drew me closer. The fog began to dissipate. After losing nearly an entire semester and with it my credibility as a graduate student and instructional assistant, I was on my way up.

I am now in my second year in the Rhetoric and Composition program, and my cruel inner bitch isn’t speaking to me. The fog has cleared; I walk on a well-lit path. I’m teaching and learning. I have allies who recognize the value of my voice, not despite my mental illness, but because of it and all the other things that make me, me. As much as my psychological evaluation report hurts—I imagine cruel things being whispered about me—I still look at it sometimes. There’s a happier part that I carry around with me. It says, “Based on the results of this evaluation, Ms. Rainey has the cognitive and academic abilities to obtain gainful employment in her chosen field...[She] will likely do well in



positions that allow her to work independently and emphasize her strong academic skills.” I belong in the academy. It’s my home.

My cycles aren’t all of me; the memories I share here aren’t everything. In between, there are long stretches of green days, yellow days. On yellow days, when I feel the madness creeping in, I chastise myself. *Snap out of it, Tiffany. Don’t go back there.* I sometimes feel helpless to stop it, but I try anyway, and most times it works. Right now, I’m okay, I’m well, I’m stable. These memories are reminders that, for me and other people with bipolar disorder, stability is fleeting. But it gets better. Awareness makes it better. Having allies makes it better. Being able to talk about it makes it better.

### **Coming Out**

There are obvious problems with coming out to the academy as a graduate student, teaching assistant, and hopeful candidate for hire with bipolar disorder. I know that I risk “infantilizing responses, dramatic changes in attitude, and negative repercussions” (Kerschbaum 57). I know that there is a possibility that I won’t get the job or be invited to the party after disclosing my mental illness to many “who do not know [me] personally and therefore cannot see the ways in which [I] competently navigate professional and social responsibilities” (Myers 258). I understand that I may be passed over because disability is understood as incompetence (Kerschbaum 69). Still, there are good reasons for coming out.

The anxiety that has resulted from keeping secret my struggle with mental illness has had harmful effects in many areas of my life: my jobs, my relationships with others.

Masking my illness has also affected my sense of self. Sometimes I feel isolated, lonely, like no one knows me. I mask as far as I am able but worry that something will slip, I'll be found out. Because "there is no rhyme or reason, no pattern, to how the fatal flaw works itself in and through my life" (Sparkes 483), eventually, a public coming out will happen with or without my permission, as it nearly did in the Fall of 2017. If I hadn't engaged in what Kimberly Myers calls "protective disclosure," my reduced capacity to do my job might have cost me the opportunity to join the in-group as faculty at my university. To some extent, I was in "complete control...of when and how I would tell my story and which details I would include" (Myers 263). When I could no longer mask my symptoms, I disclosed my diagnosis to a key member of the faculty, and she protected me as far as she could. But rather than continue worrying over how I will manage my next bipolar cycle, I prefer to come out in my own way, while I am well. I want to say, "I am a face of mental disability. I represent what mental disability looks like although I am not experiencing what are known as 'symptoms' right now." (Uthappa 167). Myers writes about her own experiences with coming out as a person with disability:

Coming out is often easier when one is able to do so 'in the abstract'—that is, when one's disease is well-managed and does not significantly compromise her personal or professional life...

When the degree of disruptiveness is low, so is the threat of stigmatization; a person can more safely admit to having a debilitating disease because she does not actually appear disabled (260).

Corrigan et al. believe that self-disclosure “proves to be a protective factor against self-stigma’s effects on quality of life and to augment a sense of personal empowerment that enhanced well-being” (e3). But there are gains to coming out beyond protecting and improving myself; others may benefit as well. Michalak et al. found that disclosure gave persons with mental illness “the ability to be more open, encouraging engagement with people who are supportive or who share similar experiences, and playing a role in combatting public stigma” (220). And, according to Myers, “coming out with illness can be liberating—a move from a ‘resistance identity’ of defensiveness stemming from a devalued sense of self, to a ‘project identity’ where one proactively constructs a new identity that redefines her position in society” (268).

Researchers have found that narrative self-disclosure of mental illness works against stigma by presenting opportunities for the formation of empathic bonds between self and other. These empathic bonds allow readers to experience others’ humanity in ways that bring us closer as humans. (Young, Chung, Uthappa, Frank). Young notes that “Reading the narratives of people with mental illness and incorporating them into our own life stories is an act of inclusion and empowerment that challenges the dominant story of mental illness as something shameful and isolated. In that way, the acts of writing and reading narratives of mental illness contribute to the incremental but essential shift in the social construction of mental illness” (67). Chung’s study found that neurotypical viewers of mental illness entertainment narratives engaged in “perspective-taking.” The importance of perspective-taking, she writes, “is that it can motivate audience members to perceive stigmatized characters as individuals reminiscent of ourselves, who face challenges and experience a colorful range of emotions, thus

encouraging greater in-group perception” (906). Through those experiences, viewers can “reformulate their understanding of stigmatized others” (898). Further, “When we speak through the vulnerable stance that makes our individual realities more palpable to people who, for the most part, do not know them, we open up possibilities for ... the acceptance of life truths that need to be heeded in order for the public to better recognize all of its citizens” (Uthappa 174). Most poignantly, Frank writes, “Through their stories, the ill create empathic bonds between themselves and their listeners. These bonds expand as the stories are retold. Those who listened then tell others, and the circle of shared experience widens” (Frank xii).

### **Afterword**

I believe in the power of story. In fact, it was story that drew me into autoethnography. Narratively reliving memories of the plunges into alternating manic and deeply depressive madness was rewarding, as I knew it would be, in that I reached a sort of catharsis. And as a bonus, I was finally able to see the patterns of my illness and the ways I have managed it. As a rookie autoethnographer, however, I sometimes had no clue what I was looking for. But as my research grew, I reminded myself that in autoethnography, it’s okay to not know exactly where it’s going. Although “what is quested for may never be wholly clear,” one persists with the belief “that something is to be gained through the experience” (Frank 115). I also struggled with doubts as to the potential value of my research to scholars in my field, or to anyone at all. I wanted to throw it out and start over with a safer story. But then something happened. I imagined

someone like me reading this autoethnography—a student with bipolar disorder just treading water—and I felt brave.

I want to say to that person, “You belong. Your voice matters.” And I want to tell the academy that people with mental illness are humans worthy of the same “emotionality, warmth, cognitive openness, individual agency, and depth” afforded to everyone else (Chung 895). If through this autoethnography I have managed to humanize myself in a culture where stigma dictates that we must mask our symptoms and forfeit our full personhood to be accepted, I have humanized anyone like me.

## **IV. IMPLICATIONS**

As with most research, this project was guided by a specific set of questions. I wanted to know, how does a person with bipolar disorder carve out a narrative space for herself in a culture that shames, devalues, distrusts, or otherwise ignores the mentally ill? What can she do to bridge trust and understanding between those within academic institutions who do not struggle with mental illness and those who do? How does she embed her “deviant” self-representation into the dominant cultural narrative in order to confront and unravel stigmas associated with bipolar disorder? What are the implications of “coming out” to the academy as having bipolar disorder? While I feel that the answers to these questions are implicit in my autoethnography, I can add to them.

### **Carving Out a Narrative Space**

Autoethnography as a method made it possible for me to sweep away the layers of dust that had been accumulating on my bipolar self for so many years. Before I began this research, I had only allowed myself brief glimpses of that self; when I looked too long at my illness, I had been overwhelmed with shame. Autoethnography allowed me to investigate rather than look. With a new sense of purpose, I asked, what am I ashamed of? Why? Throughout the process, I was in a perpetual state of self-reflexivity. In turns, I was able to see the patterns of my illness both introspectively and from detached perspectives. It was often uncomfortable and sometimes painful, but it was enlightening and encouraging as well. Through my research, I learned more about my illness in fourteen weeks than I had in the decade since my first diagnosis. Like Jamison, I am now

“a student of moods” who wants “to try and make a difference in the lives of others who also suffer from mood disorders” (5).

And not only that, I found allies in the literature: Jamison, Potter, Frank, Uthappa, Myers, Kerschbaum, Young, Corrigan, Michalak, Chung—all of them, really. It was only upon discovering these allies that I decided to share my own account, one that has opened a door for “*her own voice*, a personal voice telling what illness has imposed on her and seeking to define for herself and new place in the world” (Frank 7), one with which others might identify. In some way, each of these scholars give me permission to tell my story. There is space near them. I fit. Anyone who engages in autoethnographic research, whether evocative or analytic, in order to explore mental illness *fits*.

But there is one *caveat*. Sometimes, when experiencing symptoms, people with mental illness have difficulty with introspection; deafening negative self-talk, a distorted view of themselves or others, or myriad other complications of mental illness may prevent introspection. Obviously, this can affect our ability to write critical narratives. (It has nothing to do with skill. When our minds are in chaos, so are our stories.) For instance, when I began, I was at the tail end of a manic cycle. I feared that I would only be able to write a “chaos narrative” (Frank). Despite this looming narrative crisis, though, I was not lost. Borrowing from Jamison, I asked, “Which of my feelings are real? Which of the me's is me?” (68). Through reality testing—the objective evaluation of my memories, thoughts, and feelings against what I know from context to be true—I methodically sorted and separated the notes I had made for my critical narrative. Further, I shared my narrative with people who know me well and were present for many of the

experiences I share in my autoethnography. Based on their feedback, I trust that everything I include is grounded in a shared reality.

All this is not to say that there is no value in chaos narratives. In fact, they may be more valuable for use in primary research than any other artifact as they provide insight into the bipolar mind, not through recollection but in real time. These artifacts can be contrasted with narratives written once one is stable again. (To the reader who is suffering mania or depression now, know that it can't rain all the time. You *will* eventually be stable again.) Also, somewhere on the continuum between chaos narrative and critical narrative lies Potter's "hinge narrative," an exercise in which one works with a therapist to evaluate constructions of self with reflexivity (63). While there has been no further research indicating that psychotherapists have adopted Potter's hinge narrative as a way for persons with bipolar disorder to make sense of their narrative selves, it is a promising concept that should be further explored by Mad studies.

### **Bridging Trust and Understanding**

I took a calculated risk with my approach to this project. As I mention in Chapter Two, many scholars take issue with autoethnography, especially evocative autoethnography, on the grounds that it is subjective and resists generalization. Given that the sciences prize *logos* and *ethos* while rejecting *pathos*, I anticipate a swift dismissal. However, narrative is more than a rhetorical device. To build trust and understanding between those of us who know the struggle and those who don't, I have to let readers into my head, and I have to keep them there for a while. There can be no narrative empathy without narrative, and a narrative devoid of story craft is boring and unmotivating (Ellis).



Through “strategic narrative empathy” (Keen 20), I hope to establish a bond with readers that will drive prosocial action. Specifically, I am asking readers to engage in perspective-taking, to view someone who suffers from mental illness as a real person who, despite their differences, deserves the same kindness and respect they would extend to anyone else. If empathy isn’t enough, note that my narrative is backed with bonified, scientifically-grounded research by well-known scholars of disability theory.

### **Embedding a “Deviant” Self-representation**

When I began this project, embedding my autoethnography in the dominant cultural narrative seemed tricky. It was only supposed to be an assignment. However, that changed when I decided to pursue this research as part of my thesis. It’s simple. Once published, my “deviant” self-representation will literally be embedded in the larger narrative of the academy, which has thus far been oblivious to the scrape of academics who suffer from mental illness. I will also submit my autoethnography to journals and to whomever else will endorse it. Personally, I will do everything I can to meet stigma in academic contact zones. I will encourage others to do the same, to write and share their autoethnographies on mental illness. At the moment, other, more persuasive conversations on mental illness are being whispered by those who have nothing nice to say. If we don’t demonstrate through rigorous and ethical research how *we* experience mental illness, those conversations won’t change and stigma will continue to thrive.

## **Coming Out to the Academy**

Mental illness, one's own mental illness anyway, is not at all a safe subject for study. The idea of presenting my research is frightening. For example, I passed on this year's 3MT, or three-minute thesis competition because-I have a very real concern that no amount of time will be enough to convince myself that I have rhetoricability. Further, Corrigan et al. warn that while "broadcast experiences," or "seek[ing] out people with whom to share past history and current experiences with mental illness" can foster personal empowerment and add momentum to the Mad studies movement, the disclosed information can also be misused or misinterpreted by others (e4). It isn't a stretch—recently, a former classmate who read a draft of my autoethnography publicly "outed" me to make a point. There's also the matter of my career. At worst, I'll be unemployable after coming out. (Scenes of volatile "crazies" are ever present in many peoples' images of mental illness.) At best, I'll have to endure awkward conversations about my portfolio, which will undoubtedly (though unapologetically) include my autoethnography. Although I've heard that no one reads these things, I'm told that it is standard practice for one to submit their graduate thesis when applying for faculty positions and doctoral programs. A mentor suggests I choose my title wisely. Finally, although some have said that I am brave, others might secretly (or openly) question my intelligence. Regardless, I'm nothing if not determined.

The implications of coming out are many and significant, but in this moment, I do not judge them so many or so great that I should be dissuaded. If, after all, it turns out that I have ruined myself professionally, that I have not made a dent in stigma, or that I have failed to demonstrate that people who suffer from mental illness are not "thoroughly

bad, or dangerous, or weak,” wildly irrational, unpredictable, incompetent, or lost, at least my autoethnography can be used as an example of what *not* to do. From where I stand, though, it seems there is good in having done *something* rather than nothing about this problem too few scholars are talking about.

Recent research and scholarship focused on mental health opens an obvious space for autoethnography. Although the field of rhetoric and writing could easily claim this genre once and for all as a legitimate form of research (knowledge-making through writing is *our* domain, after all) I see less of the autoethnographic turn there. It is my hope that others in the field who are touched by mental illness will go on record making their own revisions to the cultural narrative. Through autoethnography, we have a chance “not to speak for [those with illness], but to speak with them as a fellow sufferer who...has a chance to speak while others do not” (Frank 132).

## APPENDIX SECTION

### Appendix A

#### SELF/CULTURE INTERSECTIONS

##### Ideas for Literacy Autoethnography

For your first assignment in the course, you will propose at least one but not more than three possible self/culture intersection ideas for your final autoethnographic inquiry.

**Drafts of this document are due by class time on Wednesday, September 12.** Please bring a hard copy with you to class on September 12.

Here's what Chang has to say about getting started with autoethnography: "When a research topic is selected, the most important questions should be what to do with it. The minimum requirement is that autoethnographers must be willing to

- dig deeper into their memories
- excavate rich details
- bring them onto examination tables to sort, label, interconnect
- and contextualize them in sociocultural environment.

Commitment to cultural analysis and interpretation is the key in proceeding with any topic" (51)

For each self/culture intersection you propose to examine (remember: at least one but not more than three), you will include the following information:

- A central memory, narrated briefly
- What thoughts/emotions the central memory raises for you now
- The larger cultural narratives/issues the memory may shed light on

Here's an example from my own life:

1. Self/Culture Intersection Idea 1
  - a. A particular moment while teaching college writing courses in prison. (If I were turning this in I would narrate the experience at least briefly.)
  - b. Even now, this memory elicits particular emotions and thoughts. I feel embarrassed, foolish, naïve, guilty. The experience makes me think about the power of context to shape reality—to make "ordinary" activities less than ordinary, possibly dangerous. It makes me think about the power I have as a teacher in being responsible for selecting particular readings. It makes me think about how students might experience particular readings. It makes me think about education as surveillance. It makes me think about the power of names and naming. The memory makes me think about gender and it makes me think about what it means to be a "good" teacher.

- c. Explored further, this experience could shed light on identity—what does it mean to be a teacher? A teacher of writing? Where do my experiences clash with or complicate what it means to be a teacher. Explored further, this experience could compel me to examine the power of naming—how it is used to define and delimit what we can be and how others will see us. Who has power to name? Who has power to resist naming? Can we undo and revise naming?

## Appendix B

### CRITICAL NARRATIVE (CN) PROJECT

#### IMPORTANT DATES

Drafts due for workshop: September 26, 2018

Final CN due: October 3

#### PROJECT GUIDELINES

Elaborating on data from systematic reflections and other invention strategies we will discuss (and practice) inside and outside of class, you will write a critical narrative related to one of your self/culture inquiry ideas. Ideally, the self/culture inquiry ideas themselves have arisen from experiences and/or epiphanies that continue to bother, perplex, fascinate, or challenge you. The key word here is “critical.” Your narrative should do more than tell a story or express an opinion. Instead, your narrative should be purposeful and appropriate to the task at hand—an attempt to “translate public knowledge into personal meaning—and back again” (France, “Dialectics,” 164). Victor Villanueva calls this the “autobiographical as critique,” a mode of “generalizing, theorizing, and questioning the systemic based on the personal” (*Bootsstraps* xvii). Linda Brodkey’s “Writing on the Bias” is an excellent example of this kind of personal, highly reflexive writing.

Narratives should be approximately 4 pages, single-spaced throughout, with double spacing used to signal paragraph breaks (as I’ve done in this document). I strongly encourage you to experiment with form and to mix genres if you feel comfortable doing so at this stage. At the very least, I would like to see you use headings or other visual elements—as they are relevant—to guide readers through the text and/or to help them understand *how* to read various sections (again, if relevant).

CRITICAL NARRATIVE ASSESSMENT (from Adams, Jones, and Ellis. 2015.  
*Autoethnography: Understanding Qualitative Research*)

1. Does the critical narrative extend existing knowledge while also recognizing that knowledge is situated, contingent, and contested?

2. Does the critical narrative use the personal and experiential to share insights about the social?
3. Does the critical narrative demonstrate the power, craft, and responsibilities of storytelling?
4. Does the critical narrative reflect a commitment to relational ethics?

## Appendix C

### SECONDARY RESEARCH SYNTHESIS TEMPLATE

The following is a template for the secondary research synthesis. Why a template, especially when I'm not a big fan of them? Two reasons. One, you may not have much experience with this genre; the template helps you see the genre conventions. Two, the genre, while variable to some degree, is less elastic than some other genres. In other words, most secondary research syntheses (also known as "literature reviews") have the same overarching objective—to help readers understand the scholarly terrain of your inquiry—and have largely stable genre features:--an introduction, sections of research categorized by topic or approach or some other categorization scheme, and careful arrangement and discussion of the sources within categories.

#### Introduction

The introduction tells readers the focus of your inquiry as it has arisen from your personal narrative. It then helps readers understand your methodology—how you went about your research for secondary sources. Last, the introduction then provides readers with an overview of the nature of the secondary sources you've found and how you've decided to categorize sources.

*In the narrative I wrote as part of the larger autoethnography project, I focused on a specific teaching encounter I had that I've always found disturbing. Writing this experience as a narrative helped me focus my areas of interest on the role of emotionally-charged readings in the writing classroom. Phrased as a research question, I now ask "How do students and teachers experience emotionally-charged reading in the writing classroom?" Related questions include "What role, if any, do or should emotionally-charged readings about "difficult" topics play in the writing classroom? What are sound pedagogical strategies for using emotionally-charged reading in the writing classroom? How might conversations about "trigger warnings" be used to understand my inquiry? Once I'd written my personal narrative and identified my research question, I began to search for relevant secondary sources. To see what people in rhetoric and writing studies had to say about emotionally-charged issues, I conducted searches in X and Y databases. To examine the issue of trigger warnings, I searched for sources in rhetoric and composition and in mass communication. My search yielded numerous articles that helped me better understand how others have talked about emotionally-charged reading in the writing classroom. Many discuss the fundamental connection between rhetoric and difficult social questions. These researchers and scholars foreground rhetoric as the means to address civic concerns. Researchers in various disciplines and writers in popular culture have examined the role of trigger warnings on university syllabi. Last, researchers in*

*rhetoric and writing offer pedagogical strategies for addressing difficult topics in the writing classroom. For this synthesis, I organize sources into categories that move from general to specific--Rhetoric and Writing's Obligation to Discuss Emotionally-Charged Subjects in the Writing Classroom, Trigger Warnings in the University Classroom, and Pedagogical Strategies for Addressing Emotionally-Charged Subjects in the Writing Classroom. Within each section, I identify the argument and main claims in each source and discuss how sources relate to each other.*

### **Category 1**

- Sources 1 and 2 (because they focus on essentially the same idea)

### **Category 2**

- Source 3
- Sources 4 and 5

### **Category 3**

- Source 6 and 7
- Source 8

### **Conclusion**

Sums up the sources and explains how they have been and might be useful to you.

## **Appendix D**

### **EXTERNAL DATA AND TENTATIVE ANALYSES**

#### **DUE**

Any time during Week 10 (October 29-November 2)

#### **OVERVIEW**

In this third stage of the larger autoethnography project, you will gather two forms of what Chang calls “external data.” External data includes

- Interviews
- textual artifacts about you or written by you—official documents, notes, diary entries, programs, letters, journals, poems, certificates, etc.
- visual artifacts—photographs and personal videos
- objects—souvenirs, shoes, clothing, trophies, trinkets, heirlooms, etc

For each of these forms of external data, you will need to collect the data (do the interview or write about actual artifacts). You will then offer tentative analyses of these forms of external data that identify potential uses of the external data for your final autoethnography.

External data can be used in a number of different ways. It can be integrated into your autoethnography, used to help you refine your autoethnography focus and purpose, deepen your awareness and understanding of situations and events, fill in gaps, sharpen your interpretations, or a combination of all of these. This is the rigorously reflexive and iterative nature of autoethnography: we gather data, reflect and write, reassess, gather more data, write, refine, revise.

## DETAILS

Below are requirements for each type of external data:

### Interviews

You will need to gather informed consent, develop an interview guide, conduct the interview, transcribe portions of the interview, and offer a tentative analysis

### Artifacts

You will need to locate the artifact, photograph the artifact (for final submission), and write about the artifact—identifying it, contextualizing it, describing it, writing about the feelings, realizations, memories, stories that it provokes, and offering tentative analysis of how this artifact and your writing about it might be useful.

## Appendix E

### AUTOETHNOGRAPHY

#### IMPORTANT DUE DATES

You'll spend the entire month of November working on your drafts of the autoethnography. We'll decide in class how we'd like to use our time both inside and outside of class. Final autoethnographies are due the latter part of Week 14 (November 30-December 1)

#### OVERVIEW & REQUIREMENTS

For your final project in the course, you will compose a critically reflexive autoethnography of 10-12 single-spaced pages that draws and *builds upon* work you've done throughout the semester. Composing the autoethnography will require much more than simply merging the work you've already done in the course. Instead, the final autoethnography will require you to (re)examine and (re)analyze existing data in light of new research and the insights that arise from that research; gather new data as needed to flesh out areas of the autoethnography that need development; experiment with



organizational strategies, styles of writing, and voice; and write and revise to meet the criteria we establish for effective autoethnographies.

You are free to write a primarily evocative autoethnography (foregrounding the personal in the personal-cultural continuum) or foregrounding the cultural (in the personal-cultural continuum). Regardless of approach to the final product, your autoethnography must arise from a rigorous autoethnographic methodology and reflect definitions of autoethnography we've discussed all semester. Ellis, Adams, and Bochner (2011) offer a useful overarching definition:

Autoethnography is an approach to research and writing that seeks to describe and systematically analyze personal experience in order to understand cultural experience. This approach challenges canonical ways of doing research and representing others and treats research as a political, socially-just and socially-conscious act. A researcher uses tenets of autobiography and ethnography to do and write autoethnography. Thus, as a method, autoethnography is both process and product.

The documentation style you choose is up to you, but should be connected clearly to the purposes you have for your autoethnography and the communities (disciplinary and otherwise) you are writing for.

Within or as an addendum to your autoethnography, you must also

- discuss your methodology—what data you gathered, how you gathered your data, and how you interpreted your data
- situate your autoethnography within the scholarly literature (minimum 7 sources) about autoethnography and/or the cultural issues your autoethnography draws attention to, extends, or interrogates.

There are several ways you might choose to include all of these requirements. We'll discuss these in class and create a list for reference.

## Appendix F

### **EVALUATING AUTOETHNOGRAPHY**

#### **Subjectivity**

- The self is primarily visible in the research. That is, the researcher re-enacts or re-tells a noteworthy or critical personal relational or institutional experience—generally in search of self-understanding (Le Roux)
- The researcher is self consciously involved in the construction of the narrative which constitutes the research (Le Roux)
- The text embodies a fleshed out, embodied sense of lived experience (Richardson)
- The text reveals the self (Schroeder)
- The text enables the reader to enter the subjective world of the teller—to see the world from her or his point of view (Adams, Jones, Ellis)

### **Credibility**

- The experiences the narrator describes are believable; they could have happened (Adams, Jones, Ellis)
- The text seems “true”—a credible account of cultural, social, individual, or communal sense of the “real” (Richardson)
- There is evidence of verisimilitude, plausibility, and trustworthiness in the research (Le Roux)
- The research process and reporting should be permeated by honesty (Le Roux)

### **Reflexivity**

- There is evidence of the researcher’s intense awareness of his or her role in and relationship to the research which is situated within a historical and cultural context (Le Roux)
- There is evidence of self awareness, self exposure, and self conscious introspection (Le Roux)
- The author is committed to ethical practices in research and representation (Richardson)

### **Resonance or Impact**

- The text affects me emotionally and/or intellectually (Richardson)
- The text generates new questions (Richardson)
- The text moves me to write, try new research practices, act (Richardson)
- Readers are able to enter into, engage with experience, or connect with the writer’s story on an intellectual and emotional level (Le Roux)
- There is a sense of commonality between the researcher and the audience—an intertwining of lives (Le Roux)
- Readers are encouraged to think about how lives are similar and different and the reasons why (Adams, Jones, Ellis)

### **Contribution**

- The piece contributes to our understanding of social-life (Richardson)
- The writer demonstrates a deeply grounded human-world understanding and perspective (Richardson)
- The piece extends knowledge, generates ongoing research, liberates, empowers, improve practices, and/or makes a contribution to social change (Le Roux)
- The piece is useful (Adams, Jones, Ellis)

### **Aesthetic Merit**

- The piece (or relevant sections of the piece) succeeds aesthetically (Richardson)
- The use of creative analytical practices opens up the text and invites interpretive responses (Richardson)

- The text is artistically shaped, satisfying, complex, and not boring? (Richardson)
- The text reflects story craft (Schroeder)

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