Being a Mental Health Nurse

With a Mental Illness: An Autoethnography

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Submitted in Partial Fulfillment

of the Requirements for the Degree of

Master of Psychiatric Nursing

Brandon University

2015
Abstract

In this research, I explore my own experience of being a mental health nurse with a mental illness. A review of the nursing literature reveals that little has been written about this topic. I have chosen autoethnography as a research method for this study, as it offers the opportunity to provide both a subjective account, in which the self is very visible in the research, and an examination of the interrelationship among self, other, context, and culture. Narratives are intermingled with analysis, in which I draw together my own experience and relevant literature and theory. This study is grounded in social constructionist theory, with a view that our understanding and perception of reality is based on social knowledge and influences.

Analyzing the narratives I generated, four themes became the focus for this research: stigma, disclosure, meanings and identities, and returning to work. My narratives related to stigma are used to illustrate dominant cultural beliefs and the existence of power differentials between the stigmatizer and stigmatized. While expectations of silence around mental illness are noted in the literature, I have opted to disclose my illness, and in this research I have explored potential benefits and downfalls of this exposure. Meanings related to illness are closely tied to the identities one constructs, and my identities as nurse and patient and well and ill self are explored. I also consider the biomedical model as a source meaning that is relevant to nursing culture. Finally, I consider my experiences of returning to work, with particular emphasis on perceptions of risk and labeling of deviance.

There is no neat and tidy conclusion to this work; rather, it serves as an invitation to the reader to join me on a journey of exploration and questioning.
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A note on semantics:

Across the literature, various terms are used for those who have experienced mental illness, including patient, client, consumer, service user, etc. For this thesis, I have opted to use the term patient, with the primary goal being to achieve greater consistency between the construct of physical illness and that of mental illness. In an autoethnography aiming to be emancipatory, the purpose in using this term is not to limit the potential of those with mental illness to the role of patient, but rather to acknowledge that role as one of many that a person with mental illness plays, as suggested by Corrigan (2005) and Thoits (1985). The intention is to attempt to be consistent with Frank’s (2000b) distinction between “ill person” and “patient”, where being a patient is only one part in the life of an ill person.
Little is known about nurses’ experiences of mental illness, and Ross and Goldner (2009) suggested that:

This almost complete lack of acknowledgement or investigation of the issue may in itself lend support to the contentions in the existing literature – that nurses are most judgmental and stigmatizing of their own when it comes to mental illness, and “turn a blind eye”. (p. 564)

In this study, I will examine how being a mental health nurse has impacted my own experience of mental illness and recovery, and consider the broader sociocultural context which gave rise to that experience. Autoethnography is a research method well suited to this type of research problem, and it is grounded in social constructionist theory, which considers the human experience of reality to be socially constructed. The ultimate aim of this work is to give voice to the silenced through the telling of my own story, by encouraging other nurses with mental illness to find their own voices and tell their own stories.

Chapter 1: Review of the Literature

This chapter includes an overview of some of the relevant existing literature on the phenomenon of mental illness in nurses, related theoretical concepts, and autoethnography as a research method. Details of the most relevant findings from the literature review are covered in the chapters on findings and analysis, and thus are not included in this chapter.

Search Strategy

For literature related to mental illness in nurses, the CINAHL database was searched using combinations of the following subject headings: nurses, disabled; attitude
to mental illness; nurse attitudes; stigma; mental disorders; truth disclosure; impairment, health professional; and nurses as patients. Google Scholar was searched using “mentally ill nurses”, and the “cited by” and “related articles” features were used to identify additional works. It was challenging to effectively narrow down the results based solely on search terms, and long results lists were narrowed down by manually reviewing titles to identify potentially relevant works; results were further narrowed by reviewing abstracts. The reference lists of relevant works were reviewed to identify additional works of interest.

For methodological articles, the CINAHL, Medline, and PsycInfo databases were searched using the term autoethnograph*. Reference lists of identified works were reviewed in order to identify additional relevant articles. The University of British Columbia (UBC) library book catalogue was also searched using the term autoethnography.

For theoretical articles, the SocINDEX and Sociological Abstracts databases as well as the UBC library book catalogue were searched using the terms “social constructionism”, “sociology of emotions”, and “sociology of illness”. Additional literature was drawn upon based on concepts identified within these search results as being relevant to this study.

**Mental Illness in Nurses**

As already noted, there is limited literature available on the topic of mental illness in nurses. This literature includes both first person reflections and academic research, but little work that combines first person narratives with academic rigour. There is also a gap in literature focusing on the interplay of being a nurse and having a mental illness. In this
section, an overview of the existing literature will be given, divided by key themes that have emerged. This will be elaborated upon later in this work in the analysis of the narrative accounts.

**Experiences of stigma.**

Stigma is a major challenge faced by nurses with mental illness, and mental health professionals are an important source of this stigma (Anonymous, 1993; Hinshaw, 2008). Hinshaw (2008), Seggie (2007), and Weiss (2001) described an “us versus them” attitude that exists among mental health professionals towards those with mental illness. This can be fostered by a status differential (Hinshaw, 2008), and in Seggie’s (2007) case only became apparent to her after she herself was diagnosed with a mental illness. “The professionals were sane, competent and intelligent, while service users were the opposite – almost a different species” (Seggie, 2007, p. 29).

Nurses tend to demonstrate more negative attitudes toward nurses with mental illness compared to those with physical illness (Glozier, Hough, Henderson, & Holland-Elliott, 2006; Tei-Tominaga, Asakura, & Asakura, 2013). In a survey of nurses who self-identified as having experienced depression, those who had stopped working due to their illness were more likely to report hostile rather than supportive responses from colleagues compared to those who had remained in the workplace (Caan, Morris, Santa Maria, & Brandon, 2000). In a study of nurses and nurse managers in Japan, stigma scores were significantly higher for participants who had worked with someone with mental illness compared to those who had not, although the reason for this finding was unclear (Tei-Tominaga, Asakura, & Asakura, 2013).

In a study of nurses with mental illness, participants reported that other nurses
would try to enforce expected standards of nurse conduct by subjecting them to such things as heavier workload, gossip, and denigration (Joyce, Hazelton, & McMillan, 2007). Coworkers seemed to perceive mental illness as dangerous and unpredictable (Joyce, Hazelton, & McMillan, 2007). Gossip has been identified as a strategy nurses use to cope with the challenge of providing support to colleagues with mental illness (Joyce et al., 2012). Kidd and Finlayson (2010) described symbolic violence that nurses with mental illness face in the workplace, involving a refusal to recognize their stories as legitimate, rendering both the story and its teller worthless. This symbolic violence goes hand in hand with bullying, and together, “they can demolish the lives of nurses who have experienced mental illness” (Kidd & Finlayson, 2010, p. 26).

Smith and Hukill (1996) found that personal weakness or character defect was cited by 21% of respondents as the cause of their mental health issues, suggesting internalized stigma. Internalized stigma among nurses with mental illness was also apparent in a study by Kidd and Finlayson (2010); nurses felt they were not entitled to mental health care while still holding on to their identity as nurses.

**Silence vs. disclosure.**

Joyce, McMillan, and Hazelton (2009) found that maintaining silence was a way for nurses with mental illness to represent themselves as normal, as non-disclosure was associated with “goodness” in nursing in collegial support. The belief that nurses must choose between “silence as a nurse or receiving care as a patient” (p. 26) is reinforced through nursing education and socialization (Kidd & Finlayson, 2010). Ross and Goldner (2009) found that many nurses felt that they should not disclose their mental illness in order to avoid being ostracized by colleagues. When Kottsieper (2009) disclosed her
mental illness to colleagues, she received advice, which she believed was well-meaning, from some colleagues to be careful about such disclosures. Anonymous (1993) cautioned that “because coming out can destroy one’s professional career, the safest place for a nurse with a history of [psychiatric] hospitalization… may be ‘in the closet’” (p. 17).

Based on interviews with thirteen employees at a Canadian post-secondary institution, Toth and Dewa (2014) found that the default position regarding mental illness in the workplace was nondisclosure, due to fears of stigmatization and being stereotyped as incompetent to do one’s job. Participants described nondisclosure as helpful in maintaining boundaries between work and personal lives and maintaining confidentiality (Toth & Dewa, 2014). Those who did choose to disclose did so in response to a triggering incident along with a perceived “good” reason to disclose, which led to a weighing of risks and benefits (Toth & Dewa, 2014). Interpersonal factors were identified as being most important in the decision-making process regarding disclosure (Toth & Dewa, 2014).

Moll, Eakin, Franche, and Strike (2013) suggested that in the institutional discourse on what a good worker is, workers were framed as healthy and competent, whereas employees who did not meet this standard were marginalized or silenced. While in the short term silence may be seen as a way of protecting confidentiality, in the longer term unaddressed issues may give rise to greater social tensions (Moll et al., 2013). Colleagues’ silence may also be even more distressing than overt bullying (Kidd & Finlayson, 2010).

Moll et al. (2013) found pervasive, active practices of silence undertaken across a
large healthcare organization, including both implicit and explicit messages to maintain silence until the situation had reached a point of crisis. Direct discussion of issues was replaced by rumours and gossip (Moll, 2014). These practices of silences appeared to arise from a “dynamic process embedded within a complex web of social relations” (Moll et al., 2013, p. 174). One participant reported that a colleague had warned her that it would be “career suicide” to publicly disclose her mental illness (Moll et al., 2013), and fear of stigma and discrimination made many reluctant to disclose their mental health problems (Moll, 2014). Moll (2014) found that “the prevailing discourse seems to be related to a responsibility to maintain an image of professional competence, rather than disclosing any need for support” (p. 6).

Nurses who have recovered from mental illness and choose to maintain silence must face the prospect of being accepted by those prejudiced against what the nurse actually is, i.e. someone with a history of mental illness (Goffman, 1963, p. 42). While the nurse’s behaviour may demonstrate to others that he or she is part of the normal in-group, there is the possibility that others may come to discover that the nurse is in fact not a “mentally untainted person like themselves” (Goffman, 1963, p. 42).

Moll et al. (2013) found that workers in a mental health organization who themselves had mental health issues were selective and strategic in their disclosure of their illnesses. At times, disclosure was precipitated by questions about the worker’s performance of job duties (Moll et al., 2013). Brohan et al. (2012) conducted a systematic review examining factors related to workplace disclosure of a mental illness. Several themes emerged around expectations of and experiences of discrimination, including unfair treatment in the workplace, loss of credibility, gossip, and rejection
(Brohan et al., 2012). Working in a mental health setting was an independent predictor of disclosure; however, on the whole data was quite limited on factors related to disclosure (Brohan et al., 2012).

Disclosure of the stories of those with mental illness is an important strategy for promoting change and addressing stigma (Hinshaw, 2008). However, this can be fraught with challenges. Hinshaw (2008) described the experience of a social work instructor with bipolar disorder who disclosed her illness to her students, believing that modeling openness was part of normalizing mental illness and counteracting stigma. However, a colleague suggested that this was a burden that she should not share with her students (Hinshaw, 2008). Hinshaw (2008) added that “from the official stance… the reality of my mental illness was something to be minimized into nonexistence” (p. 63).

Anonymous (1993) stated that “if I ever work again I will not reveal that I have been hospitalized” (p. 20).

**Experiences of treatment.**

In a survey of nurses with mental illness, most participants described hospitalization as being overwhelmingly counter-therapeutic (Joyce, Hazelton, & McMillan, 2007). The participants observed a sense of power imbalance between nurses and patients, with arbitrary exercises of control, suggesting that nursing interventions were authoritarian rather than aimed at therapeutic engagement (Joyce, Hazelton, & McMillan, 2007). Anonymous (1993) described controlling behaviours by nurses while she was an inpatient, including the application of restraints with no apparent reason and physical and verbal assaults.

Burnard (2007) suspected that the manner in which she was treated was influenced
by her identity as a fellow health professional, particularly with regards to the openness for negotiation around treatment options. As she already knew the consulting psychiatrist on a fellow professional basis, she wondered if their relationship would be changed when they met again in a fellow professional capacity (Burnard, 2007). During the interview itself, Burnard (2007) reflected that she was evaluating the skill of the psychiatrist based on her own experience as a mental health clinician.

**Impact on nursing practice.**

Several authors recognized the challenges of being both clinician and patient. Joyce, McMillan, and Hazelton (2009) described a divide between the healthy nurse and the unhealthy nurse: the healthy nurse was good, predictable, in control, and reliable, whereas the unhealthy nurse was bad, unpredictable, not in control, and unreliable.

Personal experience of mental illness may provide mental health professionals with a unique empathy and sensitivity (Hinshaw, 2008). In a survey of nurses who self-identified as having experienced depression, many participants described their illness as benefiting their nursing practice in various ways, including improving understanding (85%), empathy (78%), and compassion (60%) (Caan et al., 2000). Similarly, several respondents in a study by Kidd and Finlayson (2010) identified that they were better nurses as a result of their experiences of mental illness, and were better able to understand their patients’ perspectives. Kotin (1993) also believed that her own illness experience made her more empathic with patients and gave her a greater understanding of what they were going through.

Carlowe (1997) suggested that often nurses who become mentally ill don’t return to work because of a lack of clear guidelines on dealing with mental illness among nurses.
A nurse’s right to confidentiality can be a barrier to returning to work, as a lack of information about the mental health problem and the reasons for poor work performance as a result may negatively impact work relationships with colleagues (Joyce et al., 2012). However, knowledge of a nurse’s mental illness may also negatively impact work relationships; after Schmidt (2004) disclosed her bipolar disorder diagnosis when she returned to work following a psychiatric hospitalization, some colleagues stopped consulting with her on complex cases, even though providing this type of consultation was her job. After Anonymous was told that she couldn’t return to work because she was on antidepressants and thus her judgment was impaired, she filed a human rights complaint, and was promptly terminated (Anonymous, 1993).

Related Theoretical Concepts

While social constructionism, which is used as the theoretical framework for this study, will be discussed in the following chapter, there are a number of theoretical concepts informed by social constructionist theory that are highly relevant to understanding the experience of nurses with mental illness. A social constructionist view of the nature of mental illness and the role of emotion cultures and stigma will be discussed here.

Nature of mental illness.

In this study, the focus is on the illness experience, i.e. the ascribed cultural meaning (Conrad & Barker, 2010), rather than the physiological and biochemical disease process of depression. From a social constructionist perspective (which will be discussed more fully in the next chapter), health and illness are created and sustained by social practices and norms, and often serve the interests of dominant societal groups (Burr,
Illnesses are socially constructed based on the ways in which individuals “come to understand their illness, forge their identity, and live with and in spite of their illness” (Conrad & Barker, 2010, p. S76). Fee (2000) stated that “there is a pressing and often practical need for regarding mental disorder as entangled with social life and language, as well as a palpable, felt condition which damages mental functioning, interpersonal relationships, and other aspects of thought and behaviour” (p. 3).

Those with chronic illness struggle to keep illness from invading and overwhelming their self-concepts, as well as to “maintain control over the defining images of self” (Charmaz, 1991, p. 5). When they do experience loss of control and certainty, suffering may result (Charmaz, 1999). Richards (2008), writing about her own kidney disease, stated:

I find it hard to escape a medicalized view of my life. That view comes to me largely through other people, which makes me wonder if it can really be called my story, although it is about me. And yet, identity – how I see myself – cannot be decontextualized. That medical narrative is part of me, but to what extent? (p. 1721).

Hewitt (2007) stated that the label of mental illness derives from role-taking failure, and as a result of negative stereotypes attached to the person, the individual’s entire identity is seen as being defined by deviance from social norms. As mental illness is often associated with a perception of threat, those with mental illness are often seen to be dangerous and inconvenient (Hewitt, 2007). The concepts of deviance and perceived dangerousness will be discussed further in subsequent chapters.

Hewitt, Fraser, and Berger (2000) suggested that the antidepressant Prozac has been
successful because it “produces an actor capable of role-making and role-taking in a way that is culturally preferred and even practically necessary in the contemporary world” (p. 174). Meanings are attached to taking medication, and these are tied to societal views of mental illness and the biomedical view that conditions like depression can be medically treated (Hewitt, Fraser, & Berger, 2000; Karp, 2006).

The idea of a socially constructed reality of mental illness does not, however, preclude the existence of a biological disease. Karp (2006) cautioned that the idea that mental illness is socially constructed should not extend to a social deterministic view wherein mental illness is dismissed as a myth, adding that this is as problematic as biological determinism, which attributes mental illness only to brain chemistry. Aneshensel, Phelan, and Bierman (2013) pointed out that many symptoms of mental illness have been described across diverse cultures, environments, and epochs, suggesting that there is a component of objective reality to mental illness, although differing interpretations of this reality point to a socially constructed aspect. Fee (2000) added that “raising issues about the construction of disorders, then, does not deny ‘real’ forms of pathogenic experience in the world, but it does suggest more multidimensional modes of conceptualizing and representing that experience” (p. 10).

**Emotion cultures.**

From a social constructionist perspective, emotions have social meaning and are rooted in culture (Holstein & Gubrium, 2008). Emotion cultures include expectations of certain emotions in certain situations from certain social actors, beliefs about which emotions can be controlled, and expectations about whether emotions should be displayed and which emotions are good or bad (Holstein & Gubrium, 2008; Thoits, 1989;
Culture also generates a corresponding vocabulary of emotions, which forms a basis for emotional experience (Hewitt, 2007; Thoits, 1989). Society expects that the emotional experiences of emotionally competent actors will be consistent with the emotion culture (Turner & Stets, 2006). Feeling rules refer to beliefs about the range, intensity, and duration of emotions that are considered appropriate for a given situation (Thoits, 1989). Emotion work can also be practiced on others in an attempt to induce them to feel a particular way that is consistent with social expectations (Holstein & Gubrium, 2008; Turner & Stets, 2006).

There are cultural expectations that individuals should be in a positive mood, be energetic, have high self-esteem, and take interest in their own and others’ pursuits (Hewitt, Fraser, & Berger, 2000). For individuals with depression, these expectations may be impossible to meet (Hewitt, Fraser, & Berger, 2000). Low mood “influences identity by making it more likely that the person will imagine situational definitions and role structures that constitute him or her as rejected, unwanted, or unworthy” (Hewitt, Fraser, & Berger, 2000, p. 177). Individuals engage in impression management in an attempt to meet the social expectations of a “happy face” (Karp, 1996).

**Stigma.**

There is no inherent aspect of any given condition that leads to stigma; instead, stigma is derived from the associated social response (Goffman, 1963). Several theories exist around the nature of stigma, and some of the most relevant will be summarized here.

Goffman (1963) conducted pioneering work on stigma. He observed that when an individual possesses a discrediting attribute that is different from others in the socially
available categories, that individual is “thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its’ discrediting effect is very extensive” (Goffman, 1963, p. 3). He added that “by definition… we believe the person with a stigma is not quite human” (Goffman, 1963, p. 5). Given the rewards of being considered normal, individuals possessing a stigmatizing attribute will often at some point try to pass as part of the normal group (Goffman, 1963).

Scheff (1966) developed a labeling theory of mental illness that was driven largely by social factors including social determinations of deviant behaviour. This theory was rooted in symbolic interactionism (Corrigan, 2005). Scheff suggested that the behaviour of deviant individuals such as the mentally ill tends to conform to social expectations of the behaviour of other individuals identified as mentally ill (Corrigan, 2005). Once a person is labeled, social forces encourage an enduring pattern of “mental illness” (Aneshensel, Phelan, & Bierman, 2013).

Modified labeling theory, developed by Link and colleagues in the 1980s, drew upon Scheff’s theory but rejected the notion that labeling is a cause of mental illness (Aneshensel, Phelan, & Bierman, 2013). The theory also acknowledged the deleterious effects of stigma on life circumstances (Aneshensel, Phelan, & Bierman, 2013).

Link and Phelan (2001) described stigma as multi-step process that is dependent on a power differential between the stigmatizers and the stigmatized. First, there is a distinguishing and labeling of human difference (Link & Phelan, 2001). Dominant cultural beliefs are then applied to link labeled persons to undesirable characteristics, i.e. negative stereotypes (Link & Phelan, 2001). Finally, categorical distinctions are made to create a separation between “us” and “them”, resulting in status loss and discrimination
(Link & Phelan, 2001). Throughout, culture plays a key role in identifying those human differences that will have social consequences, and both creating and sustaining labels and categories (Link & Phelan, 2001). This conceptualization also recognized the overlap and interrelatedness among the concepts of stigma, labeling, stereotyping, and discrimination (Aneshensel, Phelan, & Bierman, 2013). Newman (1975) described stereotyping as involving the downgrading of a “highly complex identity to a grossly simplified social version” (p. 207).

Phelan, Link, and Dovidio (2008) identified three key reasons why people stigmatize: 1) exploitation/domination or “keeping people down”, 2) enforcement of social norms or “keeping people in”, and 3) avoidance of disease or “keeping people away”. In the case of mental illness, the latter reason is most applicable.

As most individuals within a society are raised with similar beliefs around those traits that are likely to be stigmatized, self-stigma tends to be common among individuals holding a stigmatized trait (Lively & Smith, 2011). For example, when someone socialized to believe stereotypes linked to the label of mental illness, involving inferences about unpredictability, competence, dangerousness, and trustworthiness (Link & Phelan, 2014), then goes on to develop a serious mental illness, the possibility of devaluation and discrimination becomes something one fears will apply personally (Link & Phelan, 2001), and this is consistent with the literature on self-stigma among nurses with mental illness.
Chapter 2: Research Approach

This chapter will address the theoretical framework underlying the research, autoethnography as a research method, and ethical issues pertaining to autoethnographic research.

Theoretical Framework

Social constructionism is the epistemological basis for autoethnography (Holstein & Gubrium, 2008). Symbolic interactionism, which has also influenced social constructionist thought (Burr, 2003; Conrad & Barker, 2010), will also be briefly discussed in relation to the construction of meaning.

Social constructionism.

Berger and Luckmann (1966), who were pioneers in social constructionism, posited that human reality is socially constructed, and humanity and sociality are inextricably intertwined. Subjective reality is dependent upon the social base and the social processes that maintain it (Berger & Luckmann, 1966). Objectivity is considered impossible, as the questions we ask about the world and the hypotheses we generate arise from the perspective from which we encounter the world (Burr, 2003). Therefore, research involves a “co-production” between the researcher and the researched (Burr, 2003). Fee (2000) believed that one of social constructionism’s strengths is that it “allows modes of interpretation and renderings of knowledge that collapse naturalized dichotomies between subject and object and knower and known” (p. 4).

Language is the basis of the categories and concepts which people use to create a framework of meaning (Burr, 2003), and is one of the key ways a society’s members constitute and uphold the social order (Hewitt, 2007). It is not only representative but
also formative (Shotter, 1993). It is the most important element of both making and modifying or remaking our social worlds and our selves (Berger & Luckmann, 1966; Shotter, 1993). Language is involved in determining the subjective meaning of experience, and allows for subjective experiences to be anonymized so that typifications can be applied (Luckmann, 1989).

Typification occurs when individuals automatically, and often without judgment, recognize recurrently relevant aspects of experiences (Luckmann, 1989). Types become appresented to the actual experience, so that perceptions of the seen are paired with an apperception of the unseen based on past experiences (Luckmann, 1989; Schutz, 1973). These typifactory schemes affect interactions with others on an ongoing basis unless they are challenged in some way (Berger & Luckmann, 1966). Thus, when an individual meets a nurse, that individual perceives the individual nurse in front of them and then pairs this with apperceptions based on past experiences with others of the nurse type. Appresentation is also involved in understanding language; in listening to another speak, the words are taken apprehensively as expressing their meaning, which is not connected with the words in any external away (Schutz, 1973).

Primary socialization occurs in childhood and is mediated by significant others, whereas secondary socialization involves the internalization of institutional subworlds; the latter type of learning carries less subjective inevitability than learning from primary socialization (Berger & Luckmann, 1966). Unsuccessful socialization occurs where one’s subjective reality poorly reflects the socially defined reality (Berger & Luckmann, 1966). When such individuals congregate into socially durable groups, a counter-reality begins to be objectivated, and individuals can be successfully socialized into this counter-
Identity, which refers to one’s location in the world, can only be understood along with that world (Berger & Luckmann, 1966). It includes the “traits and characteristics, social relations, roles, and social group memberships that define who one is” (Leary & Tangney, 2012, p. 69). It is formed by social processes and is maintained and altered by social relations (Berger & Luckmann, 1966). Identities are not fixed, but rather are “dynamically constructed in the moment” (Leary & Tangney, 2012, p. 70). We are able to make our remake our social worlds, and in the process make and remake our selves (Shotter, 1993).

From a social constructionist viewpoint, mental disorders and perceptions of deviance are dependent on cultural rules and value systems governing appropriate behaviour rather than on any particular behaviour itself (Aneshensel, Phelan, & Bierman, 2013).

**Symbolic interactionism.**

Symbolic interactionism will be very briefly discussed here, as it is the foundation of a number of other theoretical concepts that will be examined, such as identity theory (Burke & Stets, 2009). From a symbolic interactionist view, individual identities are constructed and maintained through social interaction with others and culturally available discourses (Burr, 2003). Individuals are actively involved in the construction of their own social worlds (Conrad & Barker, 2010), while they are at the same time products of their society and its culture (Hewitt, 2007).

Human conduct depends on the creation and maintenance of meaning (Hewitt, 2007). It is self-referential, as one is both acting subject and an object in one’s own
experience (Hewitt, 2007). Additionally, human conduct is always situated; that is, people act on the basis of their definitions of situations, which are organizations of perception (Hewitt, 2007). Meaning shapes how individuals interpret and respond to events, others, and themselves (Lively & Smith, 2011). Meaning is not static, but changes with new understandings due to new events, self-reflection, or social interactions (Lively & Smith, 2011). Meanings are not inherent in things, signs, or elements of language, but instead are products of our responses to those things and their relationship to other signs (Burr, 2003; Karp, 1996).

Methodological Approach

Autoethnography will be discussed as a research method, and consideration will also be given specifically to the use of autoethnography in nursing research. As narratives form an important element of autoethnographic research, attention will also be given to literature focused on narrative methods. The research method for the current study will then be presented, along with a discussion of ethical considerations and strategies that have been utilized in this study to mitigate potential ethical concerns.

Autoethnography.

The term autoethnography was first used by Hayano (1979) to describe ethnographic work conducted by researchers who are full members of a group being studied, as recognized by both themselves and other members of the group. While autoethnography has several names and forms, all involve the inclusion of self (auto) into an investigation (graphy) of cultural processes (ethno) (Liggins, Kearns, & Adams, 2013). It is a methodology that challenges the conventional separation between researcher and participant, the notion of neutrality and objectivity on the researcher’s part
(Ellis & Bochner, 1999; Liggins, Kearns, & Adams, 2013), and the search for a single truth about the social world (Schneider, 2005; Spry, 2001).

Autoethnography involves an examination of the interrelationship among self, other, context, and culture (Clough, 2000; Spry, 2001; Turner, 2013), and the use of personal experience to create descriptions of cultural experience in order to facilitate understanding (Holman Jones, Adams, & Ellis, 2013). It is the study of one’s own culture, “integrated with one’s rational and inward experiences” (p. 448), and it involves “intentionally blur[ring] the lines between self and others, between the author’s particular experiences and the universality of those experiences” (Holstein & Gubrium, 2008, p. 456). Autoethnography also draws upon culture to locate the self in the world (Grant, 2010). It is used to demonstrate how a culturally situated individual comes to understand a situation (Holman Jones, Adams, & Ellis, 2013), and how an individual’s culture defined the ways in which he or she was able to react (Tierney, 1998). This calls for a reflexive, introspective process involving careful and rigorous thought (Holman Jones, Adams, & Ellis, 2013). The researcher moves back and forth between inward and outward lenses, displaying multiple layers of consciousness and in the process blurring the distinctions between the personal and the cultural (Ellis, 2004). Jago (2002) described the “muddled complexity” that results rather than a coherent, unified whole.

Ellis (1991) described introspection as a systematic sociological technique used in creating autoethnographies. Introspection is an active reflection on one’s thoughts and feelings that emerge from social interaction and in response to internal processes and external stimuli (Ellis, 1991). Introspection can be used to access private experience, which in turn can be used to study the fusion of private and social selves and the details
of socially constructed experience (Ellis, 1991). Emotional recall, which involves imaginatively resituating oneself emotionally in a scene from the past (Ellis, 1999), is an element of sociological introspection (Ettorre, 2005). Ellis (1999) described the process of moving in and out of that emotional setting as necessary for the production of an effective autoethnography.

As the past will by necessity be interpreted from the author’s current position, verisimilitude rather than exact accuracy should be the goal (Ettorre, 2005). Ellis and Bochner (1999) referred to narrative truth as pragmatic truth. It is impossible to fully capture experience, so instead the goal should be to convey the meanings the researcher attaches to the experience (Bochner, 2000; Ellis, 2004). Medford (2006) argued that while writing an objective account of reality, or truth, was not possible, authoethnographers should attempt to present “truthful” accounts that capture the essence of their experience. Turner (2013) observed that anything she wrote involving others would represent only her own experience, filtered through her own selves, of others’ words or actions. Frank (1995) stated that “the truth of stories is not only what was experienced, but equally what becomes experienced in the telling and its reception” (p. 22).

Jago (2002) explained that, like her depressive illness, her autoethnography offered: no neatly packaged rationality, no linear timeline, no clear explanations. Rather, my layered account reflexively explores the multiplicity of experiences, voices, and emotions that inform my depression and recovery… in hopes that my story can shed light on the emotional, relational, biological, cultural, and historical forces shaping my experiences. (p. 733)
Banks and Banks (2000) suggested that the “the contexts for interpreting and applying an autoethnographic text should be – perhaps can only be – supplied by readers, not by the author” (p. 233). The reader is expected to be active, engaged, and reflexive (Bochner, 2001). Readers may not learn what the author intends, as they come to stories with their own experiences and meanings which guide their interpretations (Charmaz, 1999). However, autoethnography can inspire readers to reflect critically upon their own life experiences, constructions of self, and interactions with others (Spry, 2001).

Anderson (2006) promoted an analytical approach to autoethnography, which maintained a commitment to analytic reflexivity with a goal of improving the understanding of self and others as well as the theoretical understanding of social phenomena on a broader scale. Using analytic reflexivity, one examines one’s actions and perceptions and their interaction and dialogue with those of others (Anderson, 2006). Freeman (2015) urged that autoethnographies should be “as analytically sound as they are evocatively rich” (p. 927). Jago (2002) included an analytical element in her autoethnography, with “a metanarrative about the process of crafting my story, including the voices of others, both theoretical and experiential, whose writings have informed my thinking about depression and identity” (p. 734).

Effective autoethnographies are evocative (Charmaz & Mitchell, 1996; Ellis, 2004; Sparkes, 2000), and should move readers emotionally, critically, and intellectually (Richardson, 2000; Spry, 2001). Autoethnographies should also be authentic, credible, and truthful (Ellis, 2004; Richardson, 2000; Sparkes, 2000), and recreate the power of the author’s experience while striving to be faithful to that experience (Charmaz, 1999). The writing should be well crafted and contain thick description of the personal and cultural
(Spry, 2001). Skilled autoethnographers are creative and thoughtful, but also ethical in their writing (Medford, 2006).

Autoethnography aims to be emancipatory, giving voice to the stigmatized and silenced (Liggins, Kearns, & Adams, 2013; Wall, 2006) and illuminating shared humanities (Foster, McAllister, & O’Brien, 2006; Sealy, 2012). It can also be used to promote social action (Holman Jones, Adams, & Ellis, 2013). Ellis (1999) described autoethnography as “action research for the individual”. Sparkes (2000) suggested that if autoethnographies stimulate readers to think about the issues they raise and about research in general, then they have made a significant contribution to that field. Richardson (2000) added that effective autoethnographies should contribute to our understanding of the social world, while Ellis (2004) described good autoethnographic writing as therapeutic.

Ellis, Adams, and Bochner (2011) described layered accounts, a type of autoethnography that includes the author’s personal experience as well as relevant literature and broader analysis. Layered accounts offer readers “layers of experience so they may fill in the spaces and construct an interpretation of the writer’s narrative” (Ronai, 1995, p. 396), so that they are able to gain more from the writer’s story. They include multiple reflexive voices that both produce and interpret the text (Ellis, Adams, & Bochner, 2011; Ronai, 1995). A dialogue about the written self emerges as the writer adjusts and rewrites the self with each reflection on and rewriting of the text (Ronai, 1995). Jago (2010) used this type of approach as she interspersed stories woven together in “a multiplicity of scenes” (p. 205) with metanarrative, moving back and forth in time and using multiple voices of herself in different roles.
The role of the self and subjectivity.

The researcher’s self and the subjective viewpoint play a fundamental role in autoethnography, and this is used as a basis for exploring broader sociocultural issues (Foster, McAllister, & O’Brien, 2006). An individual’s identity is understood to be “enmeshed in a context… of embodied social relationships” (Holman Jones, Adams, & Ellis, 2013, p. 565), and the researcher is recognized as having multiple selves (Spry, 2001). While the self is very visible in autoethnography, there is also an “explicit and intentional directedness toward others” (Holman Jones, Adams, & Ellis, 2013, p. 35).

Karp (1996) believed that only a subjective viewpoint could allow for true understanding of human experience. The subject and object of knowledge and observation are considered inextricable, and there is no inherent distinction between them (Clough, 2000). Autoethnography allows narrators to be both subject and object, with a tension between these states that reflects that tension inherent within the identity of individuals with an illness or disability (Richards, 2008).

People with disabilities are often “othered” by the writings and research of outsiders, including health professionals (Richards, 2008). Participants and researchers are never quite on the same level, and participants are “not us” while outsiders are only ever onlookers (Richards, 2008). Autoethnography, though, serves as a way for the researcher to resist becoming the “other” (Foster, McAllister, & O’Brien, 2006). Narratives are also a way of bringing the individuality back into human stories, as traditional research methods may render the individual with chronic illness invisible by the telling of stories of disease rather than of individual experience (Richards, 2008).

Sell-Smith began her research on women who had lost pregnancies intending to be
the objective academic, but when she herself lost a pregnancy during the conduct of the research, her perspective changed (Sell-Smith & Lax, 2013). She observed that:

I cannot maintain a safe distance from this subject material and explore it from the lens of an “objective” researcher. I am heavily situated within the context of my study and will ‘taint’ the results with my own experience, interpretations and feelings. Instead of trying to keep a facade of objectivity, I realize that I am more authentic when I acknowledge my own “situatedness” and draw awareness to the role I play in creating and shaping knowledge (Sell-Smith & Lax, 2013, p. 14).

Vickers (2002) questioned why it would be considered acceptable for participants to share their life experiences with a researcher when it would generally not be considered acceptable for that same researcher to examine his or her own life. She suggested that if we are willing to acknowledge the value of another’s experience, we should also be able to value our own experiences, particularly given that insider status can offer insights into cultural dynamics that outsiders are unable to witness (Vickers, 2002). Vryan (2006) agreed that a skilled autoethnographer could study aspects of human experience that outsiders could not normally observe, whether that be due to communication norms, embarrassment, guilt, limited self-awareness, or lack of trust.

In keeping with the importance of the researcher’s self, reflexivity is a key element of autoethnography (Medford, 2006; Richardson, 2000; Spry, 2001). Because autoethnography sanctions self-reflexive critique and the dismissal of a firm characterization of truth and reality, it can and should feel risky (Spry, 2001). Writing autoethnographies involves giving up a certain amount of personal safety (Berger, 2001) and allowing oneself to become vulnerable (Bochner, 2000; Holman Jones, Adams, &
This vulnerability, and the willingness to expose one’s own pain, hurt, and betrayal, is what makes autoethnography compelling (Ngunjiri, Hernandez, & Chang, 2010). Emotional experiences are almost impossible to capture neatly, and as a result autoethnographies tend to be messy (Kidd & Finlayson, 2009; Sell-Smith & Lax, 2013).

**Narratives.**

While scholarly writers have generally been expected to keep their voices out of their work, Charmaz and Mitchell (1996) expressed a belief in the value of “audible authorship” as part of “using all we can of our imperfect human capacities to experience and communicate something of others’ lives” (p. 286). Ellis and Bochner (1999) described a narrative approach to medical sociology with the acknowledgement that “what we write happens not only to other people but also to ourselves” (Ellis & Bochner, 1999, p. 235).

All self-stories contain pieces gathered from others’ stories, so that there are no true self-stories but only self-other stories (Frank, 1995). Individual voices in narratives are inextricably tied to a societal framework of co-constructed meaning (Wall, 2006), and there is a dialogical tension that results from the inclusion of the voices of others without assimilating them into one’s own voice (Frank, 2000a). Individual biographies can only develop within communities, and as such an author’s standpoint is both individual and communal at the same time (Frank, 2000b). Narratives can be used to transform an individual phenomenon into a collective experience that is part of the social context (Hydén, 1997).

Narratives of the self call on the reader to “’relive’ the events emotionally with the
writer” (Richardson, 1994, p. 521), and offer the opportunity to voice what may otherwise be unspeakable (Richardson, 1994). Effective narratives should include abundant details, including both facts and feelings; a nonlinear temporal framework; emotional credibility and vulnerability of the author; a moving story; and an ethical concern for how other members of the story are portrayed (Bochner, 2000).

**Illness narratives.**

Illness narratives often demonstrate a struggle with adversity, feelings of stigma and marginalization, and an urge to speak out to assist a community of fellow sufferers (Bochner, 2001). Personal narratives can have therapeutic value by helping to repair one's self-image by reducing stigmatization (Bochner, 2001) and aiding in the process of remoralization following the demoralizing effects of illness (Frank, 2000b). Jago (2002) stated that “if I am writing for any reason, it is to demystify and demythologize depression; the best way to promote understanding and fight ignorance is to speak out, to make my version of the story part of the permanent record” (p. 754). Bochner (2001) pointed out the courage involved in developing illness narratives and transgressing taboos against speaking out.

Frank (1995) identified three types of illness narratives, which are made available by culture; these stories have both a personal and social side. In any illness, all three of these types of narratives are told, alternately and repeatedly (Frank, 1995). Restitution narratives focus on a return to health, and are learned from institutional stories that model how illness is to be told, with a focus on the expertise of others (Frank, 1995). Chaos narratives lack coherent sequence and are anxiety-provoking. In quest narratives, illness is accepted, and the teller seeks to use it to gain something through the experience (Frank,
One type of quest narrative is automythology, which fashions the author as one who has not only survived but also been reborn (Frank, 1995). The phoenix is the predominant metaphor of automythology (Frank, 1995).

Clark (2008) suggested that other myths and metaphors become drawn into stories of depression:

The teller will often draw on the quest or journey narrative, which organizes the real experience of depression… into a story of trials, helpers, ogres, or sorcerers (often psychiatrists offering meds), and a return as a subdued but wiser person… More than healing the self or bearing witness, these stories reproduce a dominant order that emphasizes certain identities (healthy, or physically ill) and marginalizes others (mentally ill) (p. 4).

**Autoethnography in nursing research.**

Burnard (2007), Olson (2002), and Short, Grant, and Clark (2007) conducted autoethnographic research examining several of the authors’ own experiences with mental illness. In the work by Short, Grant, and Clark (2007), Short and Grant’s narratives were complemented by Clark’s analysis, thus combining evocative and analytical elements. Olson (2002) observed:

To be sure, this is not an unbiased undertaking, as I am still in the midst of understanding and struggling with my situation. However, I believe I can make my biases known, and in so doing, add richness and meaning to my account. After all, my preconceptions are an important part of the story (p. 436).

Kidd and Finlayson (2010) conducted a collective autoethnographic study which was based on the independently written narratives of nurses who had experienced mental
illness; analysis of these narratives was influenced by the lead author’s own experience with mental illness. Vignettes were created to represent the motifs that emerged from the data and capture the “messiness and confusion” (Kidd & Finlayson, 2010, p. 23) included in the autoethnographic accounts.

Foster, McAllister, and O’Brien (2006) argued that autoethnography has not yet been embraced to its full potential in the discipline of nursing. Plant et al. (2011) believed that the use of autoethnography as method strengthened their nursing research on nurses’ experiences delivering a particular supportive intervention for families. Muncey (2005), in her autoethnographic account of her own teenage pregnancy, “did what I believe all good nursing research should aim to do: contribute to a body of knowledge to help inform practice” (p. 2).

Whybrow (2013) conducted an autoethnographic study of her experience doing psychiatric nursing in a combat zone. She described maintaining a reflexive journal, and then using line by line coding to formulate the core themes that became the framework for the autoethnography (Whybrow, 2013). Gardner and Lane’s (2010) autoethnographic work exploring the nurse-student relationship was also broken down into several key themes, with each theme-based section containing a reflective narrative account from each author. Sealy (2012) used autoethnography to explore the connections between past trauma and dealing with advanced breast cancer, while Wright (2008) used an autoethnographic approach to consider her creative identity as a nurse in the context of her cultural, social, and ethnic background. She suggested that autoethnography is relevant to nurses working in psychiatry as well as other areas of practice, because all nurses must understand the impact of one’s personal and professional cultural identity.
Methodological considerations for this study.

This research focuses on the ways in which being a mental health nurse has impacted my own experience of mental illness, specifically major depressive disorder, and recovery. Several other questions will also be addressed, including what has been the impact of my professional identity on the meanings I attach to my illness and its treatment; how has my experience of mental illness in turn shaped my identity and experience as a nurse; and how has stigma, the culture of silence, and the disclosure of my mental illness have impacted my experiences of illness and being as a nurse.

Autoethnography has been chosen as the research method due to a good fit with the research question, as well as a number of potential benefits it offers to nursing research. Autoethnography engages researchers and readers both emotionally and cognitively (Liggins, Kearns, & Adams, 2013). It offers transformative potential, allowing readers to create efficacy and healing (Spry, 2001), and also promotes social change (Holman Jones, Adams, & Ellis, 2013) by reclaiming voice and confronting dominant forms of representation and power (Tierney, 1998).

Liggins, Kearns, and Adams (2013) suggested that autoethnography was very relevant to mental health research in particular as privacy issues, power dynamics, and stigma can otherwise limit the researcher’s ability to access the intimate information of others. In using autoethnography to examine the experience of mental health professionals with mental illness, Short, Grant, and Clark (2007) hoped to “contribute to the project of destroying the boundaries/borders/walls between self-other, professional-layperson, sane-mad, worker-user, teacher-learner, professional knowledge-experiential
knowledge” (p. 767-777).

Unlike Ellis’s (2004) highly evocative approach to autoethnography, this autoethnography will utilize a more analytical approach incorporating some of the ideas put forth by Anderson (2006). Like Jago’s (2002, 2010) autoethnographic works, there will be a sense of moving back and forth in time, much like the “roller-coaster ride of depression” (Jago, 2002, p. 374), with a metanarrative drawing on the literature to add to the reader’s understanding of the stories. Ronai’s (1995) layered narrative approach will be used in which three asterisks mark a shift in time, space, or attitude within the work.

**Ethical Considerations in Autoethnographic Research**

There are mixed views in the literature regarding how best to address ethical concerns in autoethnography. In this type of research, those included in the author’s story are considered participants (Holman Jones, Adams, & Ellis, 2013), although the type of participation involved tends to be quite different from other types of research, in that the participation often consists solely of their day-to-day interactions with the researcher. Ellis (2007) described relational ethics, which “recognizes and values mutual respect, dignity, and connectedness between researcher and researched, and between researchers and the communities in which they live and work” (p. 4). Researchers must also recognize the reality that their relationships with individuals included in the research will change over time (Ellis, 2007).

Holman Jones, Adams, and Ellis (2013) and Tolich (2010) gave particular attention in their work to ethical issues in autoethnography, and agreed on several key points: autoethnographers should consult with an institutional research ethics board; they should be prepared that participants may eventually view what they have written; and they
should consider non-maleficence as a key ethical principle. Issues around consent as well as protection of participants are also important (Holman Jones, Adams, & Ellis, 2013).

Referring to ethical issues in autoethnography, Jago (2002) stated:

There are always gaps in the telling. Names withheld. Details left out. Conversations kept in confidence. Secrets protected. Intersecting with other lives as it does, the story isn’t only mine to tell. So I can’t tell you everything. But that doesn’t really matter. The ‘truth’ is still here. (p. 737)

Consent.

Holman Jones, Adams, and Ellis (2013) suggested that it is difficult to predict how and when researchers need permission from participants in their work. Decisions regarding the approach to obtain consent should consider whether the researcher is writing about the past or the present, whether the topic is potentially stigmatizing or controversial, and how prevalent others are in the text (Holman Jones, Adams, & Ellis, 2013). Where “feasible, safe, and desirable” (Holman Jones, Adams, & Ellis, 2013, p. 278), consent should be obtained from participants, and this is best done early in the research process. However, Ellis (2004) also raised the issue of “interpretive authority”, which is used when qualitative researchers do not seek consent to reframe and interpret participants’ experiences, and likened this to the research process in autoethnography.

Ettorre (2005) did not see it as necessary to seek ethical approval for autoethnographic research, as there are no research participants “nor anyone identified as a conventional respondent from whom gaining informed consent is required” (Ettorre, 2005, p. 537). However, she did inform all significant others included in her story that she was able to contact (Ettorre, 2005).
Jago (2010) struggled with whether or not to share her autoethnographic work with her teenaged stepdaughter who was included in her stories. In the end, after consulting with both family members and colleagues, she decided that the potential harms of showing her stepdaughter greatly outweighed the potential benefits (Jago, 2010).

Turner (2013) observed that anything she wrote involving others would still only represent her experience, filtered through her own selves, of their words or actions. She suggested that once words are spoken within the context of a shared interaction, they become part of her own experience, and “‘ownership’ of these words and actions are passed out into the wider world to be interpreted and reinterpreted until they fade into dust” (Turner, 2013, p. 221). She also pointed out the challenges of seeking permission from those who are estranged from her, or even deceased (Turner, 2013). A similar challenge was noted by Ellis (2004), who observed that in some cases the researcher may not even have known some of the participants involved.

Foster, McAllister, and O’Brien (2006) observed that “an autoethnography invariably involves others who may be recognizable and who may not have provided consent or permission for their inclusion in the writer’s story” (p. 48). Autoethnographers, then, should carefully consider who should be included in their stories, keeping in mind whether a participant’s inclusion is important in understanding the story or social issue (Foster, McAllister, & O’Brien, 2006).

Kidd and Finlayson (2010) used informed process consent in their autoethnographic study to protect the rights of their study participants. As a collective autoethnography, though, the design was different from the more typical individual autoethnographic works. In their study, participants were involved both during prospective data collection
and after submission of their stories (Kidd & Finlayson, 2010).

Tolich (2010) expressed concern that retrospective informed consent could potentially be coercive, as participants may consent out of a sense of obligation to the author, or there may be a conflict of interest. He instead suggested the use of process consent at each stage of the research process (Tolich, 2010). Where data is retrospective and process consent is impossible, Tolich (2010) recommended that consideration be given to ethical issues prior to writing the manuscript.

**Anonymity.**

Participants’ anonymity can be protected through the use of pseudonyms, changing demographic or geographical details, changing the setting, or fictionalizing parts of the narrative (Foster, McAllister, & O’Brien, 2006; Holman Jones, Adams, & Ellis, 2013; Kidd & Finlayson, 2010). The use of a nom de plume can be considered to protect anonymity (Foster, McAllister, & O’Brien, 2006; Holman Jones, Adams, & Ellis, 2010; Tolich, 2010), but Ellis (2004) suggested this should be used as a last resort, because those connected to the story would often know the identity of the author anyway.

**Protection of participants.**

Ellis & Bochner (1999) stated that “we must consider our responsibilities to those who become characters in our stories in terms of privacy and informed consent, and we are obliged to continually question and situate our own interpretations, presenting alternative viewpoints and expressing self-doubt” (p. 235). Ellis (2004) pointed out that “autoethnography is never solely about the author; it always includes relationships with other people” (p. 257), and thus the researcher has responsibilities towards the participants in the work.
Similarly, Berger (2001) believed her participants’ needs had to take priority over her own. She revealed ambivalence about the reactions of herself and the participants, thus conveying an uncertainty about the correctness of her own reactions (Berger, 2001). She believed she owed readers “a truthful account that includes my understandings as a social scientist”, but she also acknowledged to readers that her participants did not necessarily agree with her interpretations (Berger, 2001).

Holman Jones, Adams, and Ellis (2013) cautioned researchers to consider how much detail would be necessary to successfully articulate the story’s purpose, and what the effect will be on the researcher’s relationship with those included in the stories. Researchers must in particular consider whether the work is “outing” others by exposing vulnerabilities (Holman Jones, Adams, & Ellis, 2013; Medford, 2006). Medford (2006) suggested that authors should expect that they may have to disclose the information in the autoethnography to their subjects and confront their reactions, including disagreement (Medford, 2006).

**Ethical considerations for this study.**

In this study, the database has come from a retrospective analysis of life experience that occurred prior to the decision to undertake autoethnographic research. Therefore, obtaining prospective consent from participants was impossible. Obtaining retrospective consent would also have posed significant challenges, as I do not recall, and in some cases never knew, the names of many of the health professionals who have treated me over the years. Therefore, rather than seeking consent, other strategies have been utilized to protect those individuals who are included in this autoethnography. In the narratives accounts, pseudonyms have been used exclusively, and only as much detail as necessary
to convey the essence of an encounter was used. Identifying details such as place and
time have either not been included or have been changed.

As an overarching consideration, I anticipate that all participants may eventually
read my work. I have attempted to convey ambivalence and self-doubt, and acknowledge
that my stories only represent my own perspective, my own interpretation, and my own
reality.

Ethical approval for this study was obtained from the Brandon University Research
Ethics Committee.
Chapter 3: Stigma

I lay on a stretcher in the ER, my thinking rather cloudy after an overdose on pills. The psychiatry resident was standing over me perusing my old chart from my last admission, and he said “I see you were romantically involved at one point with someone who has schizophrenia. Why would you do that?”

Even in my drug-induced haze, I knew he was asking why I, being a psych nurse, would have dated another psych patient. So much for being non-judgmental about one’s patients!

I tried to formulate a coherent response that would demonstrate that the question wasn’t appropriate. After a pause, I responded “Because he truly accepted me for me.”

The resident raised an eyebrow, then moved on with the assessment. I have mulled this over many times, and I still can’t figure out why would my choice to have dated someone else with a mental illness several years in the past would even have warranted mention in an emergency psychiatric assessment. Was this an attempt to ascertain whether my judgment was flawed? It was certainly a reminder that anything in my medical chart could pop up at unexpected times.

* * *

I was passing through the waiting room of the clinic where I worked when I saw Kevin sitting next to a client. My heart began to pound and it became difficult to breathe. Kevin had been one of my nurses when I was hospitalized, and all I could remember was him reprimanding me for not following ward rules or limits. He glanced at me, and I could see the recognition in his eyes. This was to be the first of several encounters I had with Kevin at work, and it never got any easier, as I was absolutely convinced he must
think I wasn’t fit to be a nurse based on what he had seen of me when I was ill. I also felt an irrational fear that he would scold me as I felt he had previously. I knew logically that this would never happen, but I couldn’t get rid of that gut feeling.

The first shift I worked with Nathan, he told me that he recognized me. He thought we might have worked in the same office at some point, and he named a mental health clinic where I’d been a patient several years prior. “Did you ever work there?” he asked. I said no and quickly changed the subject, not wanting his first impression of me as a colleague to be that I’m a psych patient. Yet there it was again, that same kind of fear that I had felt when I encountered Kevin.

I realized at the time that the strong reactions I experienced were rather incongruent with my decision early on to disclose to others that I have a mental illness. I guess there’s a difference, though, between neatly disclosing and having people witness the messy and sometimes downright ugly bits. Some of that is about control – when I disclose, I am in control, but when I’m hospitalized, I have no control. I want people to see me during wellness, not illness.

* * *

One Saturday, I was sitting in my hospital room when I heard from down the hall the familiar voice of Dr. Francis, a psychiatrist with whom I worked. I realized he must be on call that weekend. I felt a sense of panic, and caught the attention of the first nurse that walked by. I pleaded, “Don’t tell Dr. Francis that I’m here!” and hid out in my room with the door closed until I was certain he must be gone.

Dr. Francis told me months later that he’d realized I was there because he’d seen my name on my chart. He had wanted to talk to me, not as part of the treatment team but
as a colleague, but hadn’t wanted to make me uncomfortable. While it didn’t bother me that he knew I was there, I was very relieved he didn’t end up seeing me that way.

* * *

In my jurisdiction, the College of Nurses must be notified any time a nurse is hospitalized for mental health or substance abuse reasons. I faced this upon two of my hospitalizations, and it deeply bothered me. I was given the non-choice of giving up my license or having it taken away from me. This was one of the most blatantly judgmental distinctions I’ve ever seen between mental and physical illness. There was no question or judgment of whether or not I presented a risk to patients. If I’d been hospitalized for a brain tumor or a neurological condition such as epilepsy, there would be no reporting requirement. But because I have depression, I was automatically assumed to be a risk to the public, or more specifically to patients. I see this as legislated stigma, and it has been horribly frustrating and disheartening that I have tried and failed to bring about change in this. It has made me feel like an outcast when I am discharged from hospital, on the path to recovery, and faced with having to jump through hoops to prove I’m not a risk to my patients. It’s a disheartening twist on the burden of proof; they don’t have to prove I’m a risk, but I have to prove that I am not.

* * *

I had applied to work at a new program that was looking to hire several nurses. When I was informed that I wasn’t hired, although I had years of experience and most of the positions hadn’t been filled, my first thought was that it must have something to do with my illness. I decided to go to my union and file a grievance, because I was confident that I was a very good nurse and would excel at that job. A few days later, I got a call
from my union steward, who had talked to human resources. “The employer may be willing to reconsider their decision, but first they want to know if there would be any concerns about you working closely with the police.”

“I worked with police a lot at my last job. Why would they ask that?” I inquired.

“I don’t know; they didn’t say,” she responded.

I was fairly certain, though, that I knew what the issue was. There had been an incident in the not so distant past when my employer had called police in relation to concerns about my mental health. I saw no reason why this wouldn’t have made it through the leadership grapevine. Could I be sure this was preventing me from getting this job? No, but I could think of no other plausible explanation. I felt manipulated, betrayed, and outraged. What had I done that was so wrong that it was deemed better to be very short on nurses than to hire me?

I was convinced that the manager would not be able to come up with any sort of defensible reason why I shouldn’t get the job, and perhaps I was right, because the day after the conversation with my union steward, I was offered the job. Did I really want it at that point?

* * *

At one point I experienced some strange repercussions after Justin, a good friend of mine who also has a mental illness, expressed concern to his own treatment team about me. Justin had been unable to contact me, as I had ended up in hospital, and he wasn’t sure what to do about this. Over a period of about 6 weeks or so, Justin’s concern was passed from his nurse, who was a one-time coworker of mine, to the manager at his team, on to my own manager, and finally on to me, when my manager accused me of having
improper contact with a client. My manager expressed concern that I should not be having contact with someone who was a patient of the mental health service, as I should consider him to be my patient. “But I’m a patient of the mental health service!” I pointed out, unable to keep the frustration out of my voice. “And Justin has never been even close to being my patient!” Yet the manager adamantly held to his position, and handed me a copy of the nursing standard for nurse-patient boundaries, as if that solidified his argument. Did he think that it meant that as a nurse, I wasn’t allowed to have contact in my personal life with anyone with a mental illness? Was that his idea of “proper” nurse behaviour? Yet having recently been in hospital, any idea of me being a “proper” nurse had gone out the window.

* * *

In a confused state brought on by a medication overdose, I had discarded my urine-soaked pajama pants, and when there was a loud knock on the front door, I went to open it wearing only a t-shirt. I was faced by two police officers. Despite my confusion, I still remember the officers telling me they’d gotten a call after I didn’t show up for work that morning. I still feel disconcerted by that. Is it normal to call the police when an employee doesn’t show up for work? I’m inclined to think it isn’t, and it makes me wonder why my manager would have decided to initiate such a drastic invasion into my personal life. Is it because calling the police would be a typical course of action if I was a patient?

* * *

**Stigma Theory**

Stigma is not inherent in mental illness, but rather comes from the associated social
response to it (Goffman, 1963). Link and Phelan (2001) described stigma as multi-step process that is dependent on a power differential between the stigmatizers and the stigmatized. First, there is a distinguishing and labeling of human difference (Link & Phelan, 2001). Dominant cultural beliefs are then applied to link labeled persons to undesirable characteristics and negative stereotypes (Link & Phelan, 2001). Finally, categorical distinctions are made to create a separation between “us” and “them”, resulting in status loss and discrimination (Link & Phelan, 2001). Throughout this process, culture plays a key role in identifying those human difference that will have social consequences, and both creating and sustaining labels and categories (Link & Phelan, 2001).

In the context of nursing culture and mental illness, there is a power differential between nurses (i.e. those without mental illness) and patients (i.e. those with mental illness). The social construction of mental illness leads to a labeling of differences, and negative stereotypes are connected to those labeled as mentally ill. These differences lead to a separation between “us” and “them” that can exist between nurses and patients (Hinshaw, 2008; Seggie, 2007; Weiss, 2001). Mentally ill patients are viewed as “Other”, while nursing staff are seen as being sane and holding power (MacCallum, 2002). When nurses themselves suffer from mental illness, they become both “us” and “them”, while at the same time not fitting neatly into either group. MacCallum (2002) described being “caught in between the two worlds of the staff and the patients, neither belonging to ‘Us’ nor to ‘Them’” (p. 88). The power differential necessary for stigma becomes more complex, as those nurses who would generally be considered peers move into a position of power when a nurse with mental illness is in the patient role. When the
nurse is in the workplace setting, stigma from fellow nurses is associated with less of a power differential than stigma from those nurses who are in leadership positions associated with greater power within the profession or the workplace. If the effects of stigma are highly dependent on the existence of a power differential (Link & Phelan, 2001), it would seem reasonable to conclude that stigmatizing attitudes of nurses managers, who hold greater power than fellow nurse clinicians, would have greater consequences for the nurse with mental illness.

Conceptions about mental illness are developed as an early part of primary socialization, and people form expectations based on these conceptions, such as whether people with mental illness are likely to be rejected or devalued (Link & Phelan, 2001). For nurses, secondary socialization (Berger & Luckmann, 1966) occurs as they are socialized to nursing culture. This learning through secondary socialization carries less subjective inevitability than learning from primary socialization (Berger & Luckmann, 1966). This suggests that stereotypes learned through primary socialization may continue to be applied by an individual nurse even if they are not entirely consistent with the secondary socialization within nursing culture, and any attempts at targeting stigma that are directed solely at nursing culture cannot be expected to be entirely effective.

According to labeling theory, while an individual may have potentially stigmatizing characteristics, the individual is only stigmatized if he or she is labeled as being deviant in some way (Lively & Smith, 2011). Hewitt (2007) suggested that the label of mental illness derives from an inability to understand a person’s behaviour, seen as role-taking failure. This comes to be applied to the whole persona and not just the behaviour, and as a result negative stereotypes attached to mental illness become attached
to the entire person (Hewitt, 2007). This deviance may become a controlling identity that
tends to subsume the presence of any other identities in the minds of others (Corrigan,
2005; Hewitt, 2007), so that the nurse who is also a patient is seen predominantly as a
patient. Thoits (1985) suggested that “for the label ‘crazy’ or ‘mentally ill’ to be
applied… there must be some degree of cultural agreement regarding the rule-breaking
behaviours involved” (p. 223). Thus, the perception of deviance depends not on
individual behaviour but rather on collective value systems and rules for appropriate and
inappropriate behaviours within nursing culture as well as the broader cultural context
(Aneshensel, Phelan, & Bierman, 2013). Additionally, the definitions of what constitutes
deviant behaviour tend to be imposed by more powerful social groups in a manner that
preserves the power group’s interests (Corrigan, 2005).

If deviance becomes a controlling identity, then I, as a deviant nurse, lose a sense
of control as a result. This translates into the sense of fear that emerges in some of the
narratives around what others will think of me and how they will judge me. This
controlling, deviant identity is also likely to have resulted in me being treated as a patient
would be, even in the context of my work as a nurse; the deviant identity remains
controlling regardless of the role I’m functioning in.

**Stigma in Nursing**

Stigmatizing attitudes of mental health professionals are a major challenge faced by
nurses with mental illness (Anonymous, 1993; Hinshaw, 2008). Nurses who espouse
negative stereotypes around mental illness both contribute to and are influenced by
broader societal suspiciousness toward those with mental illness (Joyce, 2009). Attitudes
toward nurses with mental illness include fear, blame, and attribution of illness to
behavioural causes (Glozier et al., 2006; Ross & Goldner, 2009). Joyce (2009) described a prevailing viewpoint among nurses that those nurses with mental illness do not adhere to rules of normality. They are seen as unpredictable, unreliable, and a risk to both themselves and others (Joyce, 2009).

McNeil (2008), a nurse who developed a mental illness, described himself as becoming “the person nurses fear. The pal who became a patient, the colleague who was now a client, the sensitive nurse who was now the service user” (p. 37). Weiss (2001) believed that colleagues “see my visits into consumerland as some form of betrayal – can I be trusted again?” (p. 88). Nurses with mental illness often work painstakingly to be a “safe practitioner” and avoid being identified as “one of them” (Joyce, 2009).

I was very lucky that I generally did not experience stigma directed at me from nurse colleagues, and in fact most of my peers were extremely supportive. However, there were many times that I feared stigma, and the uncertainty that went along with that was troubling. Fear of stigma was something nebulous that couldn’t be addressed in any concrete way. Rather, it was something that hovered over me because I knew that I was both an insider and an outsider.

Cloyes (2008) remarked on a stigmatizing double standard in professional nurse licensing; in her jurisdiction, applicants for nursing registration were asked to disclose a history of treatment for mental illness, but there were no such questions regarding past treatment of physical illness. Cloyes (2008) suggested that this “represents a deep and culturally entrenched contradiction, a core belief that is antithetical to our professional dialogue about recovery” (p. 394). This suggests that stigma around mental illness remains part of nursing culture, but it is considered less acceptable for overt displays
given the current popularity of the concept of recovery.

Similarly, after Miles (1998) disclosed on a physician relicensing questionnaire that he had been treated for bipolar II disorder, the licensing board insisted on reviewing all of his psychiatric records as part of investigating a “complaint” against him. When Miles and his psychiatrist refused, on the grounds that there was no cause to believe he was professionally impaired and the request was discriminatory, the matter became a protracted legal standoff (Miles, 1998). Bright and Krahn (2011) observed that physicians often hesitate to seek psychiatric treatment due to concerns regarding licensure, and the same could reasonably be expected to be true for nurses. One of my key motivators for wanting to avoid future hospitalizations is fear regarding losing my nursing license.

Cloyes’ experience was very similar to my own with regards to professional licensing. Mental illness and physical illness were considered and treated differently by my licensing body, clearly reflecting underlying stigmatizing beliefs regarding what it means to be a nurse with a mental illness. This is consistent to findings that attitudes tend to be more negative toward nurses with mental illness compared to those with physical illness (Glozier et al., 2006; Tei-Tominaga, Asakura, & Asakura, 2013). For me, the experience described in my story triggered a deep sense of injustice, as I felt that I was being judged not for my individual situation but for what I was, specifically a mentally ill person who was therefore unsafe and unpredictable. As Cloyes described, such an approach is not consistent with the professional dialogue promoting recovery, but it seems that perhaps nurses who are also patients are held to a different standard than other patients.
Burnard (2007) observed that paradoxically she was concerned about meeting other nursing colleagues when she went to her own consultation appointment with a psychiatrist, but at the same time she was willing to write publicly about her experience. Similarly, one of my stories describes the apprehensiveness I felt about a colleague seeing me in a patient role, but yet I later chose to be very open about my illness. Much of this stems from my sense that I am not in control when I am ill, and I prefer for my colleagues to know me when I’m well and know about my illness from a distance. When I am unwell, my concern about stigma is greater I know that I am more likely to actually fit some of the negative stereotypes associated with mental illness.

Forty-four percent of nurses in a study by Smith and Hukill (1996) reported having lost a job at some point due to their mental illness. When I was denied a job because of, as far as I can ascertain, my mental illness, it was a sharp reminder that stigma is present within the nursing profession, and even if I was not subjected to it on a horizontal level, I was still vulnerable on a vertical level. What made it especially frustrating was how blatant it was; there was no other plausible explanation for why I was not hired, and no attempt made to offer one. If the manager made no attempt to disguise the stigma, that must mean it was considered socially acceptable, which makes me wonder how nursing culture can be fixed to change this.

Short, Grant, and Clark (2007) wrote an autoethnographic account of the first two authors’ experiences with mental illness; both were mental health professionals. Discussing one author’s transfer to a treatment facility in another geographic area, another author wondered:

Does there remain, still, a concern to distance the psychiatric problems of
practitioners, metaphorically as well as geographically, from the true awfulness of their occurrence in the presence of that audience that knows, and has known, one as a “non-other” (Short, Grant, & Clark, p. 2007, 774).

Yet as much as possible I have tried to have my hospitalizations take place in cities other than that where I live and work, given the anxiety that I have experienced when facing those who treated me in a fellow professional context. Perhaps this is the inverse of the remark made by Short, Grant, and Clark (2007); perhaps it is I that wants to distance the true awfulness of illness from the audience that has known me as a nurse.

As a nurse, there is also stigma around connecting in my personal life to other individuals with mental illness, as demonstrated in the story of the psychiatry resident who asked about my dating choice. It seems that when fellow health professionals discover I have a personal relationship with someone with mental illness, the stereotypes linked to mental illness seem to apply doubly to me: not only am I a person with a mental illness, but I am a person who chooses to socialize with someone who is also considered dangerous and unpredictable. I am seen not as someone who chooses to have a friend in my life, but as a nurse who chooses to have a connection with an undesirable, unpredictable entity. In that choice I myself become more undesirable and unpredictable. In one of my stories, a manager attempted to counter this unpredictability by imposing order: I should have no contact with my mentally ill friend, who should be heretofore understood as my patient. It took me a long time to come to any sort of understanding of why the manager would attempt to dictate my personal life; now, though, I suspect he was frightened by my unpredictability, and the only response he could come up with was to attempt to impose control in some way.
Summary

As Link and Phelan (2001) described, stigma involves the attachment of negative stereotypes to a person labeled as different, and the resulting discrimination is dependent upon a power differential between the stigmatizer and the stigmatized. Because of such differences and the resulting stereotypes, there is a separation between “us” and “them” that can exist between nurses and patients (Hinshaw, 2008; Seggie, 2007; Weiss, 2001). This results in a power differential between nurses who would normally be peers, as the nurse with mental illness is labeled as “Other”. There also exists a power differential between staff nurses and nurse managers, leading to potentially greater impacts from discriminatory behaviour. Hewitt (2007) pointed out that deviance is associated with role-taking failure, and this deviant identity tends to become the predominant identity perceived by others, suggesting that the nurse with mental illness would tend to be seen predominantly as a patient, as that is her deviant identity.

A number of authors have described the stigma directed by mental health professionals at those colleagues who have mental illness. Negative stereotypes include unpredictability, unreliability, and a risk to both themselves and others (Joyce, 2009). My narratives show that for the most part my fear of stigma from my colleagues was unfounded. However, like Cloyes (2008) and Miles (1998), I was faced with stigma from my professional licensing body, and this is consistent with existing literature that attitudes toward nurses with mental illness tend to be more negative than those toward nurses with physical illness. As Cloyes (2008) pointed out, this is inconsistent with the professional dialogue on recovery related to mental illness, and tends to reflect the idea that nurses with mental illness are dangerous.
When I was denied a job due, to the best of my knowledge, to the fact that I have a mental illness, it became shockingly clear that clear displays of stigma were tolerated within nursing. I suspect Smith and Hukill’s (1996) figure that forty four percent of nurse participants had lost a job at some point due to their mental illness would be lower if the same study were conducted today, but my own experience shows that such discrimination still exists to some extent.
Chapter 4: Silence and Disclosure

Ariel and Jack both cautioned me to be very careful about whom I chose to disclose my illness to. They warned that others may try to use the knowledge against me, and they thought it was best to keep quiet. I felt conflicted by that. I was convinced that Ariel and Jack were just trying to protect me, but it made me uncomfortable to have the vague culture of silence become more explicit and in my face.

Every time I disclose my own mental illness to a patient when a colleague is present, I worry that they will judge me for choosing to disclose. Often I will opt not to disclose solely because a colleague is present, even if the colleague is aware of my illness. I worry that the act of disclosure to a patient may be deemed a violation of proper nurse-patient boundaries. Even though I believe I have a strong case for selective disclosure, I don’t want to face colleagues’ judgment, because I fear that they will think that I’m being a bad nurse.

* * *

When I told Marina that I’d been off work due to depression, she quietly told me that she too had a mood disorder, but had never told anyone at work due to concerns about negative repercussions. She was not the only one of my colleagues to privately tell me about their own experiences with mental health issues that they had otherwise kept silent. It was as though there was an informal but exclusive club, and if one became a member of that club, one was able to be privy to certain information that was not made available to outsiders.

* * *

Disclosure and the breaking of silence wasn’t always a choice that was under my
control. At one point, conditions were put on my nursing license, which included attending appointments with my mental health team and complying with their treatment recommendations. I was obligated to share these conditions with my employer, so when I returned to work, I didn’t have the option of concealing the nature of my illness from my manager. I would never have voluntarily chosen to disclose this to her, but in this case the choice was not mine to make; I did not have control over my health information.

* * *

Silence

The need to maintain silence around mental health issues is a recurring theme in the literature, although it does not play a significant role in my own narratives. Kemble (2014) referred to the “intolerable taboo in our society of professional caregivers themselves being susceptible to mental illness” (p. 20). Hinshaw (2008) stated that mentioning one’s personal experience with mental health issues seems to be “completely out of bounds” in medicine and psychiatry and Smoyak (1993) described a game of “adult hide-and-seek” (p. 5) that mental health nurses play to conceal their own mental illness and thus maintain safety. Karp (1996) pointed out that there is a strong motivation to maintain secrecy for possessing feelings that others cannot understand or accept, because “despite the popularity of biological explanations for mental illness, as a society we expect people to manage their emotions, and we have very little tolerance for those who cannot” (p. 104).

Marina was not the only colleague who admitted to me, after I had disclosed my own illness, that they had a mental illness as well but were maintaining silence. Jago (2002) observed that one of her colleagues, who also had a mental illness, expressed that
she was comforted by Jago’s own disclosure. It may be easy to believe that one is suffering alone, but if one individual breaks silence, this may then act as a catalyst for others to speak up.

Sometimes in the workplace, an individual with an illness may face “explicit disclosure of his condition, which may result in workplace discrimination of some sort, or an implicit disclosure through his ongoing workplace behaviours, which may also lead to consequences” (Davis & Manderson, 2014, p. 110). This occurred when I was required to disclose the conditions on my nursing license to my employer, and it was very distressing, as it meant a loss of control around my own ability to maintain silence.

What did bother me about the idea of staying silent, though, was that it would allow other people to control what I did. I didn’t want to cede that control to others; that was something I’d had enough of when I was unwell. I wanted to take ownership of my illness. However, a culture of silence is certainly alive and well in nursing. Ariel, Jack, and Marina all show that.

* * *

Disclosure

I carefully considered what to tell my colleagues when they asked why I’d been off for months on sick leave. I fairly quickly came to the conclusion that inevitably people were going to talk, and I’d rather they talk about the things I told them rather than speculated nonsense. I decided not to be timid about it; I was the one in charge of this illness. I actually found this very empowering. By disclosing my illness to others, I felt that I was not only taking ownership of my illness, but also utilizing it with a strategic aim of fighting stigma. After my first episode of illness, it was hard at first to tell others
about what happened, but it quickly became easier as people continued to respond supportively.

To me, staying silent feels like giving up, and letting my illness be in control. Instead, I have chosen to speak up, and it feels like a way for me to take control of my own life and my own illness story. There are many things I can’t change, but I am going to do the best I can.

* * *

It has amazed me how supportive the vast majority of my front-line clinician colleagues have been. I have not been subjected to bullying or other forms of horizontal violence. Some people have even taken on a caretaking role, checking in periodically around how I’m doing in terms of my illness and its treatment. Many have given me positive feedback for having the courage to be open about my illness. I’m not sure how much of my positive experience with coworkers has been luck at working with great people, and how much might stem from my own decision to be radically open. What’s to gossip about when I’ve already told everyone the truth?

Yet sometimes there was gossip. At one point, I was telling Julie, a former colleague, that I hadn’t been hired for a job that I applied for, and I suspected that this was related to my mental illness.

“Probably,” she acknowledged. “Especially since the emergency mental health service has been out to see you before.”

“What? They didn’t come see me. The police did, but not the emergency mental health service.”

Julie didn’t seem overly concerned about the discrepancy. “Oh? That’s just what
I’d heard at work when you were off on sick leave.”

“From who?”

Julie shrugged. “I don’t remember.”

I was not upset with Julie, who I knew was supportive of me, but it felt very strange to realize for the first time that people actually had been gossiping about me when I was off sick.

* * *

Kidd and Finlayson (2010) remarked that nurses’ decisions around disclosure are “rendered more complex by questions of the relationship between clinical competence and mental illness” (p. 26). Disclosure to colleagues is accompanied by a fear that one’s competency will be questioned as a result, as “apparently to many people, even within our own profession, a mental disorder diagnosis, or treatment for mental health problems, appears to equate with professional incompetence” (Kottsieper, 2009, p. 188).

In a story in the chapter on stigma, I described the fear I felt about the prospect of those who had seen me in a patient context then having contact with me in a professional context. This has been a very different experience from my voluntary disclosures. When I choose to disclose, I have control not only over what I disclose, but also over the context of the disclosure. This allows for a feeling of empowerment.

The decision to disclose to colleagues was fairly easy, but the decision to disclose to patients has always been much more difficult. When disclosing my illness to a colleague, they may judge me as a person, in which case I think that reflects poorly on their own attitudes. However, when I disclose my illness to a patient, I worry that other nurses will judge me as a nurse, and that is far more worrisome to me. In reality I have
faced very little negative feedback from fellow nurses regarding my decision to disclose to patients, but it is something that I continue to fear. Perhaps this is related to power differentials. When I disclose to fellow nurses, we are on an even playing field, but when I disclose to patients, there is often a significant power differential. Perhaps what I fear is that others will accuse me of exploiting this power differential to meet my own needs.

The amount of support I received from colleagues regarding my decision to disclose my illness is not necessarily consistent with the literature. I suspect that part of this may be that when I tell the truth, there is little to gossip about. The rumour that spread about the emergency mental health service going into my home was one of very few instances that I heard of gossip being spread pertaining to my illness. Other possible factors include some increased awareness in recent years that mental health clinicians can suffer from mental illness, and the fact that I suffer from depression, which may have less stigma associated with it than disorders that involve mania or psychosis.

**Reasons for disclosure.**

Disclosure of one’s depression is a “highly strategic, partial and selective social exchange, whereby people attempt to gain social support and understanding while ensuring their character and moral worth are preserved” (Davis & Manderson, 2014, p. 71). Brohan et al. (2012) identified a number of reasons for disclosure, including role modeling, obtaining support, being honest, explaining behaviour, and stressful experiences of concealment. Benefits of disclosure may include empowerment and a reduction in self-stigma (Corrigan, Kosyluk, & Rüsch, 2013). Disclosure may also be used for the purpose of advocacy, although Moll et al. (2013) found that this could be challenging, and something that individuals did not always feel up to taking on. I, on the
other hand, find disclosure for the purpose of advocacy to be empowering and energizing, although this may have a great deal to do with the positive responses I have received.

An individual included in Short, Grant, and Clark’s (2007) autoethnographic study cautioned that “I think one has to be careful about the motives for discussing one’s own mental health difficulties these days, as it seems sometimes to be somewhat fashionable, like it is a badge of honour and a validation of why one can legitimately support other people with mental health difficulties” (p. 776). It can be easy to think that as a nurse with a mental illness, one is in a better position than colleagues to understand. Yet I am only an expert in my own illness experience, not that of my patients.

I found disclosure for the purpose of advocacy to be empowering rather than challenging. By challenging stigma directly I regain a sense of control, which is something that my illness sometimes steals away from me. The words of warning in Short, Grant, and Clark’s (2007) work are a reminder of the importance of maintaining humility when disclosing mental illness for the purpose of advocacy; it is not for the purpose of elevating oneself, but rather an attempt to expand the awareness of others.

* * *

Disclosure to patients.

Even though I’d disclosed to many of my patients that I had a mental illness, I had always opted not to bring up my history of suicide attempts, out of concern that it may be inappropriate. Then I began working with Amanda, who was very depressed and thinking about suicide. Much of what she said resonated with my own past experience. I believed it would be helpful for me to share this with her, but I wasn’t sure if it would be a violation of nurse-patient boundaries. If I was to self-disclose to Amanda and she later
brought it up with one of my colleagues, would they negatively judge me?

After a number of meetings, though, it felt like it was in Amanda’s best interest for me to disclose, and she and I ended up being able to have a remarkably frank discussion about suicide, which in turn put me in a much better position to evaluate her level of risk. She asked a lot of questions about dealing with suicidal thoughts, which she had never done in our previous meetings. As our meeting drew to a close, I reflected that as a nurse, probably the best thing I had done for Amanda was to let her see my patient self. Yet I never did tell any of my colleagues about it.

* * *

Steven was a somewhat cantankerous patient with whom I’d developed quite a good relationship. When I returned to work after an extended period of sick leave, he asked where I’d been. When I told him I’d been in hospital for depression, he said “Oh. How are you doing now?”

“Really good.”

“You taking medication?”

“Yup. Actually, I’m taking the same medication that you are.”

The next time I saw him, we talked as usual about how things were going for him. Then as we were wrapping up he asked, “You doing ok?”

“Yes, I’m good.”

“You taking your pills?”

“Yup. Are you?”

“Yeah” he answered somewhat begrudgingly. Steven had a long history of stopping his meds, getting sick, getting back on meds, repeat cycle.
Much to my surprise, it became a regular occurrence that Steven would ask about my mental health and my medication compliance, taking on something of a caretaker role. At the same time, allowing myself to take on the patient role was probably the best nursing intervention I could have done to boost Steven’s own med compliance.

* * *

Sara expressed doubts about having to take lithium, a psychiatric medication, and wondered whether she should consider taking it long-term.

“Well, I take lithium, and will probably take it for the rest of my life,” I told her.

She looked surprised, and paused for a moment before saying, “Thanks for telling me that. I had never met anyone else before that took lithium, and that bothered me.”

With that simple admission I had helped to normalize what Sara was experiencing, and that desire to normalize pathology is probably the key driving factor in my decision to self-disclose to clients. I am a psych patient, I take meds, and I am “normal”. That can be so powerful.

* * *

Disclosing personal experience with mental health issues to patients may well be perceived as professionally unacceptable (Moll et al., 2013), a failure to maintain appropriate boundaries, and an admission of significant personal weakness which runs contrary to prevailing expectations of mental health professionals (Hinshaw, 2008). In Moll et al.’s (2013) study, a mental health professional reported having been fired from a position after disclosing to a patient that she had used psychiatric medication. Pirrie (2013) struggled with whether or not to disclose her mental illness to her clients; while she had observed that judicious self-disclosure by clinicians could benefit the therapeutic
relationship, she herself had not yet felt ready to take that step.

Yet when nurses self-disclose to patients, this can help patients to feel that they are being treated as individuals, enhance trust, and convey a sense of understanding (Gray Deering, 1999). Disclosure to patients may also help to break down the boundary between healer and ill person (Probst, 2014). Gray Deering (1999) cautioned that there should be a goal when nurses decide to self-disclose, such as education or normalization, and the disclosure should aim to meet the patient’s needs rather than the nurse’s. Kottsieper (2009) suggested that effective self-disclosure to patients requires ongoing self-reflection around one’s motivation, and recognition of potential pitfalls such as over-identifying with patients.

The story about Sara represents not just my interaction with Sara, but with many patients for whom I have been able to provide a sense of normalization by disclosing my own experience with mental illness. I think it is quite powerful that I can sit in front of a patient as a nurse, looking and feeling completely well, and tell the patient that I either am taking or have taken the new medication they are starting on. It helps to erase the “us and them” divide, and it allows me to demonstrate that psychiatric treatment doesn’t turn people into drugged up zombies; rather, it can make them well.

Disclosure may also assist the nurse in establishing rapport with the patient. Goffman (1963) pointed out that when one member of a stigmatized group comes into contact with another, they modify their treatment of one another based on the belief that they are members of the same group. Thus, the patient may react to the nurse who discloses as someone who is a member of the in-group. This is important in mental health nursing, in which rapport is an important foundation for treatment.
Disclosure on the part of the nurse may also help the patient see the nurse as the nurse normally sees the patient. This is what seems to have happened in my story about Steven. In projecting the role of patient on to me, I believe he took on the role of caretaker for himself, which likely impacted his own approach to caring for his illness and improved his therapeutic outcomes.

With Amanda, I was in a much better position to assess her degree of risk to herself by establishing rapport through disclosing my own history of suicidality. Because of that rapport and shared experience, we engaged in a frank discussion that would likely not otherwise have been possible. I was thus better able to perform my nursing role by incorporating a patient role.

Acceptability of disclosure likely depends on what exactly is being disclosed. In my story about Amanda I struggled a great deal with deciding whether or not it was acceptable or appropriate to disclose that I had a history of suicidality. I felt almost certain that my colleagues would disapprove of the disclosure if they knew, and they would suggest that suicidality is something far too personal to disclose to a patient. In that story, I see a clear benefit to the patient involved, which is perhaps the most important deciding factor. Still, I have told very few colleagues that I’ve ever disclosed my history of suicide attempts to a patient.

Summary

As Kidd and Finlayson (2010) observed, nurses’ decisions around disclosure are complex. While there are certainly forces promoting silence, there are clear potential benefits stemming from disclosure. Yet it is not as simple a question as silence versus disclosure; there are also decisions around when to disclose, to whom, how much, and in
what context. My narratives show that while for the most part I was very open with others about my illness, I wanted to be in control of the context, and I was quite fearful of the possibility of those who had treated me when I was unwell seeing me in a fellow professional context. Decisions around disclosure to patients add yet another layer of complexity. This type of disclosure may be seen as inappropriate, but it can have therapeutic benefits. My narratives also show that the nature of the disclosure is relevant as well; I was far more judicious around decisions to disclose my history of suicidality. Clearly, there are no simple answers or guidelines that can be broadly applied to all nurses. Decisions around silence and disclosure are highly individual and highly personal. Yet as Hinshaw (2008) pointed out, disclosure on the part of those with mental illness can promote change and address stigma.
Chapter 5: Meanings and Identities

I’d been coming up with various excuses for what was wrong with me and why I didn’t feel like myself, but eventually I concluded, with careful clinical reflection, that I met the diagnostic criteria for major depressive disorder. If anything, I felt relieved that what was happening to me fit with a familiar label. Still, though, I opted not to seek help, thinking that because I was a mental health nurse, I should be able to take care of myself; if I couldn’t, that would mean I was a bad nurse. Acknowledging the need for outside help would be an admission of my own professional failure; nurses weren’t supposed to be psych patients. As a result, I didn’t seek help until after I had tried and failed to kill myself.

Throughout this process, I struggled to understand what was happening to me. My thoughts, my emotions, and even the way my body worked had become foreign to me. When I decided I did have major depressive disorder, part of that was coming to the conclusion that what I was experiencing was a biologically based illness. After that, I began to conceptualize two distinct notions of self: sick me and well me. This notion has been reinforced through subsequent episodes of depression. The biomedical view and my identity as a nurse have certainly shaped my treatment preferences, and have led me to favour pharmacotherapy over psychotherapy. Part of the appeal of the medical model is the lack of culpability it implies. As a person, but particularly as a nurse, I don’t want to believe that something I did or didn’t do triggered my episodes of illness, and the biomedical model offers an easy out from that line of thinking.

The biomedical model has also influenced the language that I use related to my depression. The adjective “depressed” gets tossed around a lot in common usage, and
feels inadequate to describe the depths of my illness, so instead I refer to periods “when I was sick”. In many ways I look back on the last few years and rather than seeing a continuous period of time, I see a life fractured into sick periods and well periods. I maintain a sense of chronology based on these disjunctures.

* * *

No story about depression would be complete without attempting to capture what depression feels like. For me, it felt like mental, emotional pain. I do not recall feeling a lot of sadness, but the inability to feel happiness, interest, or anything the least bit positive was absolutely crushing. I was indifferent to even my beloved pets. I felt like a shell of a person who couldn’t sleep or eat properly and moved with agonizing slowness. My brain didn’t seem to work; I couldn’t concentrate or remember. Living that way felt like torture, and I just wanted it to end.

For the most part, I have been aware of the illness process as it has happened, and because of my professional background I have, to some extent, been able to observe and identify depressive symptoms: that is “sick me”. Yet I then felt impotent when I was unable to intervene and alter the course of disease.

So much of my experience of depression, and what remains strong in my memory, has come not from biologically based symptoms but from the associated social experience. The aspects of my overall illness experience that still generate the most pain and anger are the way that others treated me because of my depression. Symptoms of disease are temporary, but the pain of what I perceive as mistreatment by others persists long after the symptoms resolve, and the associated coloring of anger has never gone away. I know that I am not my illness, but I’m not convinced that all of those around me
are aware of that.

* * *

I have always had a very clear separation in my mind between “sick me” and “well me”; they are different selves that think and feel differently, perceive the world differently, and relate to others differently. When I am sick, it feels like “well me” goes away, and I’m not sure if I’ll ever get her back. One psychiatrist commented that I must have low self-esteem given my recent suicide attempt, and I tried to explain to him that this was not the case; I felt very good about who “well me” was, but “sick me” was in so much pain that I didn’t think it would be possible to get “well me” back. Recovery has been accompanied by a huge sense of relief to discover that “well me” is still inside me and can emerge unscathed.

Even in full remission, though, my illness is part of who I am, and it influences how I look at the world. I surround myself with people I think are likely to support me should I lose “well me” to illness again at some point. This is true both personally and professionally, and along with it comes a wariness I wish I didn’t have to have.

* * *

Meaning

Human conduct depends on the creation and maintenance of meaning (Hewitt, 2007). Meaning shapes how individuals interpret and respond to events, others, and themselves (Lively & Smith, 2011). Meanings are not inherent in things, but instead are products of our responses to those things (Karp, 1996). Thus, meaning is not static, but changes with new understandings due to new events, self-reflection, or social interactions (Lively & Smith, 2011). Meanings related to mental illness are therefore not inherent in
the psychiatric condition itself, but rather are derived from cultural beliefs on a broader societal level as well as within social groups such as nursing. Associated meanings can shift through the course of illness (Charmaz, 1991) as those with mental illness seek to find both meaning and order in relation to their illnesses (Karp, 2006).

While participants in a study by Lewis (1995) described a range of reactions to receiving a diagnosis of depression, some found the diagnosis to be a relief, as it validated what they were experiencing and contributed to a sense of empowerment with regards to resolving it. This is consistent with the experience described in my own narratives. Lewis (1995) found that individuals described a need to explain their depression and find meaning within it. While individuals described both social and biological explanatory frameworks, feelings of powerlessness could be reinforced by either framework, and Lewis (1995) suggested that this sense of powerlessness could occur when a biological explanation translates to the individual himself being pathologized.

Major depressive disorder was a familiar label to which I already attached meaning: it was a biological condition that I not only knew was treatable, and I also knew how to treat it. In the midst of an experience of disease that was far outside my own realm of experience within myself, it was almost comforting to be able to attach that experience to what I already understood depression to be. This meant that rather than being baffled by the completely foreign way in which I was thinking and feeling, I felt like I understood what it was and what it meant, and felt empowered to approach the illness the same way I had successfully done with my own patients.

Language is an important part of creating frameworks of meaning (Burr, 2003).
Consistent with the meanings I attached to my illness, I have opted to use biomedical language in describing it. I refer to discrete units of time when I was “sick”, “in partial remission”, or “in full remission”. In using this language, I want others to understand my depression the way that I do, and take it as seriously as one would a physical illness. Jago (2002) reported that she frequently heard people speak offhandedly of being depressed, adding that the term “depression” has been turned “into a catchall for everything from sadness and melancholy to a full mental meltdown into madness” (p. 752). Using the language of medicine and pathology is perhaps an attempt to legitimize one’s illness to others. This suggests some of the same fear of stigma that arose in my stories in the chapter on stigma.

**Illness vs. disease.**

Illness refers to an ascribed meaning based on social and cultural systems, whereas disease refers solely to the biological process (Conrad & Barker, 2010). Knowledge of a pathological disease process gives little information about the subjective experience of illness (Karp, 1996). Instead, illness can only be understood within its social context (Karp, 1996), and concepts of illness vary depending on the norms and values of particular social groups (Burr, 2003). Illness also involves a judgment based on cultural prescriptions and norms regarding the ability to carry out various activities (Burr, 2003).

Considering my depression in this way, it becomes quite apparent that the illness and the disease were two very different experiences. While the disease process significantly impaired my functioning during acute phases, the illness experience in many ways had a greater impact on my recovery process, and it was certainly a much more enduring experience. Years later, I still feel wounded by the way some people treated me
in response to my illness. I don’t think those wounds will ever heal, and I will never fully understand why my disease condition impacted others’ behaviour the way it did.

**Mental illness.**

Karp (2001) found that the dominant view of family caregivers of those with depression was that mental illness was biologically based. He suggested that this could act as insulation from blame or guilt, feelings that arise in a social context based on the expected evaluations of the self by others (Karp, 2001). Such feelings have been described as role-taking emotions (Thoits, 1989). The creation of a dichotomy between person and biological illness can be a useful tool in the emotion work associated with emotions considered to be illegitimate (Karp, 2001), and a view that one is the victim of a biological condition can absolve the self of responsibility (Karp, 1994).

Karp’s (2001) comments regarding the attitudes of family members of individuals with depression are likely equally applicable to those suffering from mental illness themselves. A biologically based conception of illness carries with it a sense of lack of culpability, and absolved me of concerns that I did something wrong that caused my depression. It also offered a convenient way of compartmentalizing the illness as separate from the rest of the self in order to find hope for recovery. Underlying this was the sense of familiarity of the medical model from my training and work as a nurse.

Karp (2006) viewed taking medications as a social act, as the meanings people attach to taking medications are closely tied in with societal views of mental illness. He suggested that the decision to take psychiatric medication must be considered in the context of adopting a biomedical view of reality, and therefore it is a process that challenges one’s very identity and involves a transformation of the self (Karp, 2006,
1996. Similarly, Hewitt, Fraser, and Berger (2000) suggested that Prozac, an antidepressant well known in popular culture, “fosters a medicalized self” (p. 180) and supports the social construction of depression as an illness that can be treated. Pirrie (2013), on the other hand, viewed taking medication as part of a “whatever works” approach to her mental illness.

I didn’t experience the sense of transformation of self that Karp described. However, in many ways the biomedical view of reality was already my reality as a nurse. In my professional role I regularly administer medication and teach people about why they should continue taking their medication. As a result, once I accepted the idea of taking on a patient role, taking medication was very compatible with that. I also understand what the medications are and how they do what they do. I’m not taking something with the nebulous idea that somehow it is supposed to make me feel better; I’m taking a pharmacological agent that I know acts in predictable ways at particular binding sites to cause predictable therapeutic and adverse effects. This understanding helps me to view medication as a tool rather than something that defines me.

Identity Theory

Identity refers to one’s location in the world, and can only be understood along with that world (Berger & Luckmann, 1966). It is formed by social processes and maintained and altered by social relations (Berger & Luckmann, 1966). Thus identities are not fixed, but rather are “dynamically constructed in the moment” (Leary & Tangney, 2012, p. 70). Berger and Luckmann (1966) described identity as a “phenomenon that emerges from the dialectic between individual and society” (p. 174). Identity standards guide individual behaviour in various situations (Burke & Stets, 2009), and identity provides a sense of
location in relation to the broader social world (Hewitt, Fraser, & Berger, 2000).

There are different types of identities that individuals may have, including social identities based on membership in certain groups; person identities, which differentiate the individual from others; and role identities (Burke & Stets, 2009). A role refers to the set of both general and specific behavioural expectations tied to a social position (Burke & Stets, 2009). Individuals normally occupy many roles, each with associated behavioural expectations (Corrigan, 2005). Role identities derive from the meanings people attribute to themselves while in various roles; these are learned through social interactions (Burke & Stets, 2009). Individuals may have role identities for each role they play (Turner & Stets, 2006). These role identities provide a source of meaning in life, guidelines around normative behaviours, and a sense of great self-control (Thoits, 2011).

Being a nurse is a key role identity for me; I consider it a fundamental part of who I am. As a nurse, I have certain expectations about my ability to carry out various role functions. Yet sometimes those nursing role expectations have transferred over to my identity as a patient, leading to a sense of failure when I was, for example, unsuccessful at the patient task I set myself of overdosing on medications in a suicide attempt. Shortly before I was first diagnosed, I struggled with the idea that I, as a nurse, should be able to take care of myself. If I could take care of my patients, why wouldn’t I be able to take care of myself? But at the same time, my nurse self and patient self, while I may conceptualize them as two separate identities, still reside within the same person. According to Thoits (1985), having multiple identity enactments can contribute to conflict between the roles, which in turn can negatively affect emotional experience.
Illness and identity.

Illness identity encompasses the set of roles and attitudes related to one’s mental illness, as well as the associated meanings (Yanos, Roe, & Lysaker, 2010). It involves not just how the illness is conceptualized, but what that means about the person with the illness (Yanos, Roe, & Lysaker, 2010). “Mentally ill” is only one of the roles that individuals may occupy, but one’s status as a patient may come to override other status characteristics (Corrigan, 2005). Being identified as mentally ill involves a process of social transformation, as one’s identity comes to include an attribute that is regarded as socially undesirable (Aneshensel, Phelan, & Bierman, 2013). However, individuals are able to actively engage in identity reconstruction to lessen the erosion of self by illness (Conrad & Barker, 2010). Wargo (2006) stated that “I have learned that I am much more than my illness” and Richards (2008) pointed out that her illness is not the only thing that defines her, and the medical narrative is only part of her. This is consistent with my own conceptualization of well self as being separate from ill self.

Internalization of stigma can alter the way in which illness is constructed (Yanos, Roe, & Lysaker, 2010). There are several elements that pose an identity threat to those with mental illness: stereotypes, negative beliefs about a group; prejudice, the emotional evaluations based on stereotypes; and discrimination, the resulting behavioural responses (Corrigan, Kosyluk, & Rüsch, 2013). An individual’s sense of identity is challenged less by identification with mental illness than by perceived legitimacy of stigma associated with mental illness (Corrigan, Kosyluk, & Rüsch, 2013). As a nurse, I took pride in the fact that I was helping to challenge the stigma against mental illness, as I knew from professional experience that many of the negative stereotypes either simply weren’t true
or were broad overgeneralizations. This attitude that the associated stigma was not legitimate likely served to buffer my own sense of identity when I became ill and as a result became exposed to stigmatizing attitudes.

Wisdom et al. (2008) examined a number of published narrative accounts of mental illness to study the effects of illness on identity. They found that individuals described a sense of loss of self that often occurred with the onset of mental illness (Wisdom et al., 2008). Similarly, Jago (2002) described a “shifting, groundless identity” (p. 745) that accompanied her depression. Some narrative accounts analyzed described a sense of the self being replaced by an unknown self constructed from illness experiences (Wisdom et al., 2008). Individuals also described a duality of real, authentic selves and ill selves, with the authentic identities contributing to a sense of hope for recovery (Wisdom et al., 2008); this is consistent with the duality of selves described in my narratives.

Mood impacts identity, or individuals’ sense of social situatedness, because it affects how they imagine the social world and their participation in it (Hewitt, Fraser, & Berger, 2000). This is another area where conceptualizing separate identities as well and ill selves has likely served me well. When my mood was low, it certainly impacted how I situated myself in the social world, but that influenced only my ill identity, leaving my well identity intact somewhere far off in the distance. As a result, once I was doing better with regards to my disease symptoms, my well self was able to emerge more or less unscathed.

Karp (1994) likened depression to a career with multiple stages that involve a redefinition of one’s self-identity. The first stage was a period of inchoate feelings,
during which individuals do not have the vocabulary to define the nature of their experiences (Karp, 1994). Eventually individuals are diagnosed, and then struggle to come to grips with their illness identities and the role these will play in their lives (Karp, 1994). Describing the process of diagnosis, Karp (1994) stated:

Knowing that one has something that doctors see as a specific illness imposes definitional boundaries onto an array of behaviours and feelings that previously had no name… To be diagnosed suggests the possibility that the condition can be treated and one’s suffering can be diminished. (p. 20)

For me, the stage of inchoate feelings did not last long, because nursing culture had already supplied me with the vocabulary to describe my experiences. Much in the same way that Karp expressed, knowing a diagnosis offered a sense of both understanding and hope.

Thoits (1985) suggested that one can “reflexively assess the meaning of one’s actual or contemplated behaviours”. Since this is not dependent upon assessment of others’ reactions, it can lead to a private self-labeling of a deviant identity of one’s own (Thoits, 1985). An identity as patient is one of many that an individual may hold (Thoits, 1985), and Thoits (2011) suggested that the greater the number of role-identities, the lower the mentally ill identity should rank on an individual’s hierarchy of identities, making the individual better able to resist discrimination in social encounters. As individuals have multiple social identities, there can be conflict between roles, leading to emotional experiences that deviate from expected norms (Thoits, 1985).

* * *
Identities as nurse and patient.

I was eating lunch in the dining area of the psychiatric ward where I was an inpatient. Across from me sat a woman looking blankly across the room; she was very skinny, and to my professional eye she looked depressed. A nurse stood beside her, encouraging her to drink the liquid meal replacement on her tray. When it became clear that this was having no effect, the nurse in me took over and I spoke up, telling the co-patient about when I had needed to drink liquid meal replacements in the past due to my depression, and how important it had been to do so. She briefly made eye contact with me, and then wordlessly drank the supplement. I hadn’t thought twice about intervening to help this woman; that’s simply what I was used to.

This was not the only time the nurse in me made an appearance while I was ill. As I listened to my hospital roommate speak, I recognized that she was manic and agitated, and validated her concerns while gently redirecting her to another topic. I realized that I was unintentionally evaluating her mental status and responding the way I would as a nurse trying to defuse a situation. I noticed myself doing the same thing later on in the dining area when another patient started voicing persecutory ideas. I had years of experience responding to acutely mentally ill people in a certain way, and that endured even when I was acting as a nurse.

* * *

I had met Justin when we were both patients on a psychiatric unit. We had a romantic relationship at first, but when that ended we remained friends. At many points in time I knew his community treatment providers on a fellow professional basis. This became problematic when Justin was not doing well psychiatrically. Should I call his
treatment team and ask them to intervene? Would they think that was a violation of boundaries? Or should I call the mental health crisis line, which would also involve speaking to people I knew professionally? I knew what I would do as a mental health professional, and I knew what I would do as a fellow psychiatric patient, but straddling the fence between the two, I had no idea what the right answer was. Did one identity conflict with the other? Was it even possible to separate the two?

* * *

In a study of nurses with mental illness, nurses described losing control when unwell; this was seen as the antithesis of being a nurse, and led to a sense of the self crossing a boundary and shifting from nurse to patient (Joyce, Hazelton, & McMillan, 2007). Olson (2002) described a sense of shame at making this transition, and Pirrie (2013) stated that “in some ways, my transition from nurse to patient was as difficult as my experience of the illness itself” (p. 11). Weiss (2001) spoke of “straddling the fence” between two groups of colleagues: mental health professionals and patients. Similarly, Burnard (2007) described being both an insider, as a healthcare professional, and an outsider, as a patient and a member of a stigmatized group. Kemble (2014) expressed frustration with the separation between “us” and “them” and the “mad” and the “non-mad”, and the silence, isolation, and othering that goes along with it. Several nurses in Kidd’s (2008) study expressed the belief that one was not permitted to have identities as both nurse and person with mental illness.

When I was hospitalized due to my depression, my nurse self was impaired just as my patient self was, but she was still there. Two key role functions I have as a nurse are to help settle patients who are agitated and to prompt patients to attend to self-care
activities. Even though during my hospitalizations I was in a patient role, when faced with familiar nursing situations, I didn’t even think before responding as I would have in a nurse role.

I struggled a great deal with the situation with Justin, my mentally ill friend. I knew that it was not socially acceptable within the health professional community for me to have a friend with a mental illness, even though I had a mental illness. I had previously been told by a manager of mine not to have any further contact with Justin, as I described in a story in another chapter. When Justin became quite ill, I was confident that he needed to be hospitalized involuntarily. Even though he was my friend, I still assessed him as if he were a patient. Then came the decision of who to call. I had previously worked with both his nurse and psychiatrist. I dealt regularly with the emergency mental health service, so I knew them too. Should I call them to share my assessment of Justin’s instability, even though that would mean crossing into territory that was not considered acceptable for a nurse? Yet as a nurse and as a person how could I live with myself if I didn’t try to get Justin get the help he so urgently needed? When Justin later ended up in hospital for assaulting someone while psychotic, I blamed myself for letting my own fear of stigma get in the way of protecting society from someone who I knew was extremely unwell.

If the creation and maintenance of meaning is a social process, then the meanings that nurses ascribe to their own mental illness are likely to be influenced by their cultural identity as nurses. My narratives show that I quickly gravitated toward a biomedical model of illness, which in many ways is unsurprising given my professional familiarity with that model. The biomedical model of treatable sickness strongly influenced that
impact of my depression on my sense of identity, leading to a conceptualization of a well self and an ill self. This biomedically-driven view served to buffer my core sense of self during the acute disease process, which helped to prevent the erosion of self that can occur with chronic illness, as described by Charmaz (1991). While this acted as a protective factor, it was still a challenge to manage dual identities as nurse and patient. This challenge was less of an identity struggle within myself and more a struggle over how others would respond, as indicated in the story about Justin. Yet it is unlikely I would have been able to undertake this autoethnography had I not somehow managed to incorporate multiple identities as sick person, well person, patient, and nurse into a cohesive sense of self.

**Summary**

Individuals with mental illness ascribe meanings to their illnesses based on social interactions and cultural beliefs. For nurses, a biomedical model of illness is culturally familiar, and for me, it had a significant impact on the way that I came to understand my depression. However, my acceptance of a disease model of depression does not detract from the significant social impacts associated as part of the illness experience.

As with meaning, identity is not fixed, nor is it singular. Throughout my illness experience, I maintained my identity as a nurse. Yet there was also a new identity as a patient that I had to come to understand and navigate, and this illness identity was closely linked to the meanings I associated with the illness. My ill self became a dichotomous identity that shared space with my identity as a well self, and existed alongside the dichotomy between nurse and patient. The latter is documented by a number of others in the nursing literature.
Meanings and identities are in a continuous process of shifting as nurses with mental illness establish who they are and what their illness is, and reflexively examine those same meanings and identities. Establishing a related body of literature may assist nurses with mental illness as they move through this dynamic, reflexive process.
Chapter 6: Return to Work

When I am well, I’m a bright, cheerful person. A few years ago, as I got progressively more ill, it was simply not possible to recreate this internally, but I tried very hard to create an external façade in order to look the part of my normal cheerful self. This took a tremendous amount of effort, and the more ill I become, the more selective I had to be about how to allocate dwindling internal resources. I chose to focus that energy toward my patients. I felt some guilt that I couldn’t be the person that colleagues expected me to be, but also a sense of relief when colleagues kept their distance.

Later on, as I was trying to arrange a return to work after a stay in hospital, my manager expressed, in writing, concerns that prior to going off on sick leave I had not been interacting normally with colleagues at work, and seemed withdrawn. I knew that putting on a happy social face was expected, but I hadn’t realized just how formally it was expected. Yet here I was being questioned on my readiness to return to work, not because of anything to do with my work with patients, but because I hadn’t put on the expected happy face before going off on sick leave.

* * *

“She was catatonic.” “You were too flat.” These are psychiatric terms, and I was used to them being applied to patients, but now it was managers applying them to me, albeit in a seemingly inaccurate fashion, in an apparent attempt to keep me out of the workplace. Was I the employee or the patient? The meanings attached to these words are evaluations of psychiatric symptoms; by the use of these words with these meanings, were the managers behaving as thought I was a patient rather than a nurse? While I am
generally quite willing to take ownership of my illness, it felt like a huge violation to have my managers refer to me as they would a patient. If they see me as a patient rather than a nurse, what would that look like for my life at work?

* * *

When I initially agreed to preceptor Mark, a nursing student, I was not well, but I was getting by. However, by the time Mark actually started his preceptorship, I was really struggling. It felt like such a huge weight – Mark was always around, and so I felt like I constantly needed to put in a significant amount of effort to fill that attentive, positive, encouraging role of preceptor. As I got sicker, I was less able to do that, and as a result I felt less able to tolerate Mark’s presence. I took three weeks off for a brief stay in hospital, but when I returned to work, I could not even pretend to be “normal”, and instead became irritable and withdrawn. I felt a great deal of guilt over this, and found myself counting down the days until his preceptorship was over and I would no longer have to struggle to put on as much of an act every work day, and feel like a failure as a result.

* * *

**Emotion Cultures**

Like any other culture, nursing culture includes feeling rules, which refer to the social guidelines as to how group members should want to feel (Hochschild, 1979). Norms within both nursing culture and the particular workplace culture influence the emotions that nurses perceive they should display on the job (Rafaeli & Sutton, 1989). These norms are learned through the process of socialization (Rafaeli & Sutton, 1989). A study by Diefendorff, Erickson, Grandey, and Dahling (2011) revealed shared emotional
display norms at the nursing unit level that influenced affect regulation at the individual level. Bolton (2001) identified three key faces that nurses learn to display: the detached professional face, the “smiley face”, and the “humourous face” which is used to connect with other nurses.

In order to adhere to the feeling rules set out by nursing culture, individuals engage in emotion work in order to align their own subjectively experienced feelings and emotional displays with what they believe is socially expected (Hewitt, 2007; Holstein & Gubrium, 2008). Emotion work can be practiced upon the self or upon others (Hochschild, 1979), so that the nurse with mental illness may be the target of emotion work by others to attempt to bring his or her feelings in line with social expectations. In the case of mental illness, stigma is often used to enforce social norms and feeling rules (Aneshensel, Phelan, & Bierman, 2013; Goffman, 1963).

Karp (1996) described the need for individuals with depression to engage in impression management (Goffman, 1959) in order to meet the social expectation to “put on a happy face” (Karp, 1996, p. 43). Cultural expectations that individuals should be in a positive mood may be impossible to meet for those with depression (Hewitt, Fraser, & Berger, 2000). Karp stated that “despite the popularity of biological explanations for mental illness, as a society we expect people to manage their emotions, and we have very little tolerance for those who cannot” (Karp, 2006, p. 104). As a nurse preceptor, I had little tolerance for my own inability to engage in effective impression management.

In the stories above, evocation, or attempts to generate a desired feeling that is absent (Hochschild, 1979), was unsuccessful. Instead, my efforts focused on expressive emotion work, which involves attempting to alter expressive displays (Hochschild, 1979);
Grandey (2000) referred to this as surface acting. Grandey (2000) pointed out that emotional labour, which is emotion work done specifically for the work role, may have detrimental effects on an employee’s health, and even when emotional expression is suppressed, physiological emotional responses may persist.

“You were too flat” was the explanation I received for why I wasn’t hired for a job. “Flat affect” is a psychiatric term used to refer to lack of visual expression of feeling on a person’s face. Regardless of how reactive my affect may or may not have been during the interview, when I was told I wasn’t hired because I was too “flat”, I suspected I was being seen as a patient, a role that is often associated with expectations of a lack of emotional display. Using a psychiatric term like “flat” didn’t seem an appropriate choice of word to refer to a role-taking failure as a nurse with regards to expressive display norms. However, if I was expected to be a patient, perhaps my behaviour may be interpreted as reinforcing social expectations around patient-hood. Jewell (1952) demonstrated the significant role that cultural expectations can play in evaluation of the behaviour of another individual. Jewell (1952) examined the case of a Navaho male who was hospitalized and diagnosed with schizophrenia because certain behaviours were interpreted as being reflective of psychosis. However, upon closer consideration of cultural factors and the effect of these factors on the behaviour of this non-English-speaking male, Jewell (1952) did not find evidence to support the diagnosis of schizophrenia. Instead, a lack of understanding of sociocultural factors led to an erroneous reconciliation between overt behaviour and covert psychological dynamics. In my case, if a manager viewed me as being a member of the patient group rather than the nurse group, my behaviour may have been interpreted in ways that were consistent with
the associated meanings of behaviours within the patient group.

I felt a great deal of pressure to meet display norms. Yet one of the symptoms of depression that I experience is a significantly decreased ability to create expression on my face. Since I only had the capacity to do so much impression management, I needed to focus my efforts. The more ill I became, the less capacity I had for this, so my time with my patients became the focus of that emotion work. I was upset when my manager later questioned my readiness to return to work based on my unsuccessful impression management prior to going off on sick leave, as my ability to carry out impression management with colleagues seemed to me an unreasonable grounds for judging both myself and my ability to do my work as a nurse.

I felt a lot of guilt over my inability to conduct effective emotion work when dealing with Mark, the nursing preceptorship student. Supervising Mark was something I had agreed to do months before, when I wasn’t feeling as unwell, and I was concerned it would demonstrate lack of integrity to back out at the last minute. Given that I was directly supervising and teaching Mark, I had to be with him for much of each workday, and this demanded almost constant emotion work. This placed a much greater demand on my internal resources than my brief interactions with colleagues or even my interactions with patients. I felt like I needed to put on the expected happy face all day long with Mark, and it was absolutely exhausting. As a student, I had already experienced the dour, critical nurse whose negativity led to crying sessions following most clinical days. I didn’t want to be that nurse; I wished I could be the opposite of that nurse. As I got more and more unwell, had a short stay in hospital, and then returned to work, the only solution that I could come up with was to sit Mark down in an empty office and
physically get away from him. I then felt guilty for both my poor impression management and my role-taking failure as a nurse preceptor.

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**Perception of Risk**

“We have serious concerns about Ashley’s decision-making ability” read an email from human resources to my union steward. The email indicated that these concerns had been reported to the college that regulates nursing licensure. Additionally, I would not be allowed back to work until I provided my employer with whatever medical information they requested, and underwent an independent medical examination. Yet neither my manager nor human resources said any of this directly to me, as if I didn’t matter enough to warrant that amount of decency; I had to hear about it indirectly through third parties. Even my union only selectively disclosed some of this information to me; the remainder I learned when my disability case manager forwarded to me a copy of HR’s email. I was outraged, and absolutely certain I would not have faced the same challenges if I had a physical illness. Yet at the same time I felt hurt – why didn’t they want me back at work? Why was any of this happening, and why was nobody telling me the reason for it? What was wrong with the opinion of my regular psychiatrist who knew me well? After the union took a stand against the demand for an independent medical exam, my employer instead drafted a letter to my psychiatrist asking him to explain my behavior before I went off on sick leave. This letter described me as “catatonic” and having problems with attendance at meetings, yet my symptoms had not been consistent with the psychiatric definition of catatonia, and I had not missed or even been late for a single meeting at work. I could not grasp how the manager could possibly see this to be
true. I felt so powerless, and I couldn’t understand why this was happening. Why was the manager making things up? Why the focus on the past rather than the present? Why did they trust neither my psychiatrist who knew me well nor the College of Nurses that had returned my practicing nursing license to me? I knew that I was a good nurse and I was completely well, so why was I not being allowed back at work?

As this was going on, I was moved from unpaid leave to paid leave after my regulatory college finished the paperwork to clear me to return to work. There was no explanation given for the shift to paid leave, but was it a tacit admission that they were holding up my return to work? It certainly seemed like a strange contradiction.

Perhaps it comes down to this – for the manager, I am a potential liability, and a liability is not wanted. And that hurts so much. I know that I’m very good at what I do, but apparently what defines me is not my ability but my periods of disability. I can’t wrap my head around why that would be, and I am left feeling hurt and angry.

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Hewitt (2007) suggested that the label of mental illness derives from an inability to understand a person’s behaviour, seen as role-taking failure; this label comes to be applied to the whole persona and not just the behaviour. As a result, negative stereotypes attached to mental illness become attached to the person (Hewitt, 2007). The linking of label to undesirable attribute becomes a rationale for viewing the labeled individual as fundamentally different from others, and hence as someone to be devalued or rejected (Link & Phelan, 2001). The deviance can become a controlling identity that tends to subsume the presence of any other identities in the minds of others (Hewitt, 2007). This perception of deviance depends not on individual behaviour but rather on collective value
systems and rules for appropriate and inappropriate behaviours (Aneshensel, Phelan, & Bierman, 2013). Definitions of what constitutes deviant behaviour are often imposed by more powerful social groups in ways that preserve the powerful group’s interests (Corrigan, 2005). My nursing employer certainly seemed to view me as deviant; was the imposition of this label part of an attempt to preserve the employer’s interests?

The “mental patient” label is often linked to stereotyped beliefs about dangerousness (Link & Phelan, 2001). Corrigan (2005) identified multiple factors that contribute to overestimation of the frequency such social phenomena as the threat of dangerousness from people with mental illness. The availability heuristic applies when related associations or events are easily brought to mind (Corrigan, 2005). Perception of out-group homogeneity is a cognitive bias that contributes to the idea that negative stereotypes are generalizable to all members of the group (Corrigan, 2005). While I certainly could pose a risk to myself when I was ill, I fail to see how I ever might have posed a risk to others; if my employer perceived that there was such a risk, could that be more related to beliefs around mental patients in general, and my membership in that group, rather than beliefs about me as an individual with depression?

Hewitt (2007) stated that:

The way we deal with the mentally ill… so closely resembles the way we treat other forms of deviance precisely because mental illness seems to elicit both a perception of threat to social order and the attribution of negative essence… Despite the redefinition of insanity as illness… the mentally ill are often perceived as a danger and an inconvenience. Perhaps this is because their definition as ill does not substantially alter the negative quality of the essences imputed to them
Even when the presence of illness is acknowledged, it may not be accepted as a justification for not fulfilling obligations, leading to suggestions that the ill person is not trying hard enough or is using the illness as an excuse (Charmaz, 1983). That is, others blame those who cannot meet their “obligations” as a result of their illness, and as a result view them in negative terms (Charmaz, 1983). For me, the inability to engage in effective impression management made it very clear to my colleagues that I was ill, and as a result, I believe that the issues that Charmaz raised generally did not pertain to me.

Newman (1975) suggested that the outcome of the organizational process of social definition “is not only that a person is labeled deviant, but that he is removed from his interactional partners” (p. 203). This removal tends to be physical as well as social, and its extent mirrors the extent of the deviance (Newman, 1975). The extent of removal of those with mental illness is strongly influenced by the prevailing attitudes of the professionals responsible for removal (Newman, 1975). By delaying my return to work, my employer effectively maintained that physical removal as much as possible.

In a study using discourse analysis to examine the workplace experience of nurses with a mental illness, Joyce, McMillan, and Hazelton (2009) identified a prevailing discourse that nurses with a mental illness pose a risk to themselves, to other nurses, and to patients. They found that a boundary separated healthy and unhealthy nurses, where unhealthy nurses were associated with badness, unpredictability, lack of control, and unreliability (Joyce et al., 2009). Thus, these characteristics of badness, unpredictability, lack of control, and unreliability were imputed to me by virtue of falling on the wrong side of the boundary between healthy and unhealthy nurses.
When my employer sent a letter to my union expressing concerns about my decision-making ability and stating the conditions that must be met before I would be allowed back to work, this likely had a great deal to do with concerns about deviancy and perceived dangerousness. That would likely account for the fact that none of these concerns were expressed to me directly. I felt very hurt and confused, because I didn’t understand why my deviant identity would subsume everything else, particularly as I was actually doing well by that time. I felt powerless, because it seemed that there was nothing that well me could do to convince them that this well self was my dominant identity. This powerlessness comes back to the idea of stigma and the need for a power differential for stigma to actually have an effect.

One might think that the mental health professional community may have greater understanding of what mental illness is and therefore fewer negative stereotypes about potential risk. However, that is not what appears in my stories. As Link and Phelan (2001) suggested, once the “mental patient” label is applied, the link is made to stereotypes beliefs about dangerousness. The deviant identity may become the only identity that others see (Hewitt, 2007).

**Information Flows**

Lemert (1962) pointed out that “while the paranoid person reacts differentially to his social environment, it is also true that ‘others’ react different to him and this reaction commonly if not typically involves covertly organized action and conspiratorial behavior in a very real sense” (p. 3). Because the paranoid individual appears to demonstrate disregard for the values, norms, and implicit structure of the group, he or she is considered by others to be “dangerous”, “unreliable”, and “untrustworthy” (Lemert,
This imputed dangerousness stems from fear of the “organizational threat he presents and the need to justify collective action against him” (Lemert, 1962, p. 13).

From the point of view of the paranoid individual, the behaviour of others has a spurious quality, and he perceives the overt avoidance and exclusion of himself by others (Lemert, 1962).

Although I did not experience paranoid delusions in a strictly psychiatric sense, my stories show a similar concern for conspiratorial behaviour. Lemert’s ideas regarding consideration of the individual as dangerous, as well as the perceived spuriousness of the other’s behaviour on the part of the individual are very apparent in my stories. Based on Lemert’s viewpoint, the nurse manager and the associated organization perceived me as a threat to that same organization, and thus collective action against me was seen as necessary.

Interaction between this individual and the group then becomes “spurious, distinguished by patronizing, evasion, ‘humoring’, guiding conversation onto selected topics, and silence, all calculated either to prevent intense interaction or to protect individual and group values by restricting access to them” (Lemert, 1962, p. 8). This results in a stoppage in the flow of information and the creation of a discrepancy between expressed ideas and affect (Lemert, 1962). “This kind of spurious interaction is one of the most difficult for an adult in our society to cope with because it complicates or makes decisions impossible for him and also because it is morally invidious” (Lemert, 1962, p. 9).

The exclusionists’ perception of the paranoid individual as dangerous also becomes a rationale for official action, leading to “gross misstatements, most frequently
called ‘pretexts’ [that] become justifiable ways of getting his cooperation” (Lemert, 1962, p. 14). Individuals may be “denied or removed from access to power or the available means to promote their deviant goals and values. One of the most readily effective ways of doing this is to interrupt, delay, or stop the flow of information” (Lemert, 1962, p. 18).

This stoppage of information flow was actually quite devastating, and contributed to a sense of a spurious nature of interaction, as Lemert described, between me and my employer. I could not effectively make decisions about how to respond to the nurse manager when I knew neither what she was doing or why she was doing it. Above all, I felt a strong sense that an injustice was being done to me, as if my validity as a person and as a nurse was being denied. Being uninformed reinforced the idea that I was seen as a patient by management. In the patient role, I tend to be given information when, where, and how my treatment team decides to give it to me. This serves to reinforce the power differential between me, as a patient, and the treatment team. In my professional life, though, I am assertive and expect to be an active participant in all aspects of my work. When management hinders my access to information, I am no longer able to be that active participant; power is stripped away from me, and I am left feeling vulnerable, much in the same way I am vulnerable in a patient role.

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Nurses’ Experiences

After several months off due to my illness, I was well and ready to return to work. Before this could happen, I needed a formal return to work meeting. This took a while to actually happen, and the disability advisor told me this was because the manager didn’t have time available. Finally the meeting happened, but the manager said that my return
to work couldn’t happen right away because she needed to make arrangements for the educator to re-orientate me. This didn’t make sense of to me. I’d been off for less time than someone who went on maternity leave, yet a nurse returning from mat leave wouldn’t be asked to go through reorientation.

However, it turned out not to be just a matter of reorientation. For my entire four-week graduated return to work, everything I did was closely scrutinized. Almost daily I had to meet with the manager and the educator, and these meetings seemed to focus exclusively on what wasn’t going well. Colleagues constantly asked me when my “probation” was going to end, and expressed how punitive they thought it was. It wasn’t supposed to be a probationary period, but that’s sure what it looked like to everyone else. Every day was exhausting and I would get home and just want to cry. It felt like my competence was in question and I was expected to fail, and I had no idea why. What had I done wrong?

Once I commented to a coworker that the continuous scrutiny of my graduated return to work was driving me crazy, and added offhandedly that I wanted to shoot myself in the head. I saw a flicker of concern in his eyes. He knew about my suicide attempt, and a remark that may otherwise be considered socially acceptable was no longer okay coming from me.

Even when my graduated return to work period ended, the manager found subtle ways that seemed to show that I was not trusted, such as not assigning me responsibilities that normally rotated among staff, and asking me to sit out of clinical meetings. Clearly I was not to be trusted.

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Nurses found some management and colleagues could be “deliberately destructive” (Joyce, McMillan, & Hazelton, 2009, p. 394) to nurses’ well-being, and some management approaches were seen as disciplinary rather than supportive (Joyce et al., 2012). McNeil (2008) found that his nurse manager had an “entirely unsympathetic attitude” (p. 37). Some nurses in Kidd’s (2008) study identified being bullied by managers and employers. Fellow nurses may use gossip is a strategy to try to enforce expected standards of nurse conduct (Joyce, Hazelton, & McMillan, 2007).

Joyce et al. (2012) identified that there was little support for nurses returning to work after time off related to mental illness. Managers may struggle between giving nurses with mental illness equal opportunities to other nurses, while at the same time ensuring the safety of patients and other staff by protecting them from the “activities of unsafe employees” (Carlowe, 1997, p. 33). Hamill (2014) described being called in to meet with her supervisor and manager only a few days after going off on sick leave related to depression. The manager accused Hamill of abandoning her clients, and insisted that she sign a release allowing her employer to access her medical records (Hamill, 2014). Hamill (2014) suspected that she was confronted in this way because she had a mental illness rather than a physical illness, and thus the veracity of her illness was in question. When Anonymous (1993) was ready to return to work following a hospitalization for mental illness, the medical director at her workplace told her that her judgment was impaired because she was on antidepressants.

Deliberately destructive, disciplinary rather than supportive, entirely unsympathetic, judgment was impaired; these words resonate deeply when I reflect on my own experiences with nurse managers. Like Anonymous, I also felt my manager was
trying to keep me out of the workplace. Like Hamill, I was expected to grant my employer access to whatever medical information they wanted.

I found it hurtful that in all this, what seemed to get lost was the fact that I am a very good nurse. I am very skilled at what I do, and both my patients and my colleagues know it. Yet that seemed to be rejected along with the rest of me. It didn’t matter how good a nurse I was; I was also a patient, and therefore who or what I was as a nurse didn’t seem to matter. As a result, I was expected to fail.

The lack of communication was hurtful. When my employer wrote to my union without also contacting me, when managers tried to slow down my return to work, when I was essentially put on probation after returning to work… none of this was acknowledged, much less discussed. It seemed to be brushed under the rug in an attempt to brush my illness itself under the metaphorical rug.

Summary

The experience of returning to work as a nurse after an absence due to mental illness is complex, and my difficult experiences returning to work are echoed by the existing nursing literature. There are several areas of theory that pertain to this experience. Feeling rules guide how members of a social group such as nursing should feel, and nurses engage in emotion work to bring their experiences and displays of emotion in line with what is expected. For a nurse with a mood disorder, this can be challenging, exhausting, and at times impossible. When I was denied a job because supposedly I was too “flat”, this was not only an accusation of role-taking failure in impression management, but it also muddied the separation between being a nurse and being a patient. I also experienced internal guilt over my inability to present a happy
front while in a role as nurse preceptor; I felt like this failure at impression management equated with overall role-taking failure.

Further complicating the experience of returning to work was the perception of risk and deviance that is associated with having a mental illness. This perception of deviance is socially constructed, and depends not on a behaviour or condition itself, but on the cultural value systems and behavioural rules. While it seemed that managers’ attempts to keep me out of the nursing workplace stemmed in many ways from concern that I was a risk to others, this was quite different from my own perception that I posed a risk to no one but myself. Lemert (1962) offered interesting insights into the stoppage of information flow in response to a deviant individual; experiencing this myself was devastating.
Chapter 7: Conclusion

With this research, I have attempted to bring you, as reader, along on my messy, and perhaps at times ugly, journey through my inner thoughts, feelings, and memories. While I cannot claim that this autoethnographic venture is more authentic than other ethnographic research, there is far more of me suffused into this research than I would expect to be able to obtain from interviews with another nurse with a mental illness. While this research represents my experience alone, and cannot be considered generalizable, I have attempted to broaden my lens to include elements that are likely to be common across multiple nurses’ experiences. I have learned a great deal about myself through this journey, but as each reader will bring his or her own context to interpreting this work, it is my expectation that each reader will take something different. I expect to be judged, and while that’s not likely to always be a good thing, I am proud to be able to add to the small but growing body of work on the subject of nurses with mental illness.

Stigma has been explored, beginning with Goffman’s (1963) pioneering work on stigma and incorporating Link and Phelan’s (2001) process of stigma, which is heavily influenced by culture and in which a power differential is necessary. This is highly relevant to the “us vs. them” differential that can exist between mental health professionals and those with mental illness, which, for mental health nurses, means a sense of being caught in between two worlds. Stigma also leads to labeling of deviance, something that can become a controlling identity and thus strongly influences the reactions of others; this was a theme that came out clearly in the narratives.

Disclosure has been another key theme in this research, and is impacted by a culture of silence around health professionals with mental illness (Hinshaw, 2008;
Kemble, 2014; Moll, 2013). Decisions to disclose are also influenced by questions of clinical competence (Kidd & Finlayson, 2010; Kottsieper, 2009). While my decision to disclose to colleagues was easy, it was much more challenging when it came to disclosure to patients. Also, while there seem to be clear therapeutic benefits to disclosure, there is a fear of judgment from colleagues for failure to maintain appropriate boundaries (Hinshaw, 2008).

Like anyone with mental illness, I have sought to find meaning in my illness (Karp, 2006). As the biomedical model has been an important part of my nursing training and career, the meanings I attached to my illness were closely tied to that model. These meanings covered far more than the physiological disease process, though; rather, they incorporated broader social and cultural understandings and expectations. As I began to incorporate this recurrent illness into my identity, it became clear that my understanding was of multiple identities rather than one single identity: role identities as nurse and as patent, and person identities as sick person and well person. Yet these selves are inextricably intertwined, and as illustrated in my story of acting in a nurse role while I was a patient.

Finally, I examined the process of returning to work. This included navigating the emotion culture of the nursing workplace, with its feeling rules and expectations of emotion work, including impression management. It also involved coming to terms with my inability to meet those expectations prior to going off on sick leave. A major challenge was facing others’ apparent perception that I posed a risk to others, related to negative stereotypes and labels of deviance attached to mental illness. This was made more difficult by stoppages in information flows, as it felt like I didn’t even know what I
was struggling against. Similar to what is documented in the nursing literature, returning to work after an episode of illness was a difficult, draining, hurtful process, and it was frustrating that this occurred despite the fact that I was and am a very good nurse.

In the end, I am left in many ways with more questions than answers, as well as the hope that this research has also provoked questions among readers.

**Limitations**

Autoethnographies represent an attempt to extrapolate the cultural from the personal, but these stories do represent my experience alone. While there are certainly benefits to being able to achieve the depth of understanding of being both researcher and researched, any research where N=1 is unlikely to be generalizable in any way.

Given that this is thesis research, I have opted to present it in a more analytical format more closely resembling traditional academic expectations rather than focusing on evocativeness and encouraging the reader to draw their own conclusions from the stories. Thus, while this analytical element is gained, something of evocation is lost.

The subjective is very present in this research, and while that is a key feature of autoethnography, it does not conform to traditional objective expectations of academic research. This likely represents both a strength and a limitation.

**Recommendations for Future Study**

There was much that was left unexplored in this study for the sake of relative brevity. The literature hints at the experiences nurses have of psychiatric treatment, and there are indications that past experience of mental health problems can benefit a nurse’s professional practice; these are two major areas that would warrant future exploration.
Additionally, doing more collective autoethnographic work along the lines of Kidd and Finlayson (2010) would offer an opportunity to bring more nurses’ voices into the mix, thus offering the potential to broaden the reader’s understanding.

Lastly, in whatever form they may take, it is important for stories to be told of nurses’ experiences with mental illness. The culture of silence should be challenged, and in presenting my own story, I hope to encourage other nurses to speak up. In the words of Sara Bareilles (2013):

> And since your history of silence
> Won’t do you any good,
> Did you think it would?
> Let your words be anything but empty
> Why don’t you tell them the truth?
> Say what you wanna say
> And let the words fall out
> Honestly, I wanna see you be brave.
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