

**Recovering Not Condemned: The Lived Experience of Baccalaureate Nursing
Students with Mental Health Concerns**

By

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ABSTRACT

Mental illness affects one in five Canadians and this number is higher among post-secondary students (Canadian Mental Health Association, 2012). Over the last three decades, studies have sought to determine how many students have mental health concerns in hope of substantiating the need for more support and funding for mental health services on campus. Knowledge gained from these studies is often seeped in a bio-medical perspective of mental health and illness, where the students' mental health concerns are problematized and the target of *psy* interventions. What is lacking is an understanding of the university students' lived experience, a person-centered understanding that sheds light on what supports or threatens students' mental well-being while illuminating the socio, political and economic realities that may be at play in the lived experience of students with mental health concerns. This research project has addressed this gap by using interpretative phenomenological analysis to explore the lived experience of baccalaureate nursing students in the university and critically appraise their understanding of their lived experience. This research concludes that the rising rates of mental health concerns are the distillate of the *psy* complex and the by-product of student stress within the university and not merely a problem inherent to a student as the *psy complex* purports. This new knowledge may serve as a foundation for, meaningful mental health services on campus and, the development of nursing curricula that is sensitive to the lived experience of nursing students with mental health concerns, one that fosters mental well-being and recovery.

Keywords: Corporatization, mental illness, mental health, nursing, *psy* complex, recovery, students.

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DEDICATION

To the nursing students I interviewed, for their honesty when talking with me and for their courage in overcoming adversity. To all who are striving to overcome the challenges they encounter while living with mental health concerns, may they find their path to recovery.

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CHAPTER ONE

RESEARCH PROBLEM

1.1 Introduction

“When a trout rising to a fly gets hooked on a line and finds himself unable to swim about freely, he begins a fight which results in struggles and splashes and sometimes an escape. Often, of course, the situation is too tough for him. In the same way, the human being struggles with his environment and with the hooks that catch him. Sometimes he masters his difficulties, sometimes they are too much for him. His struggles are all that the world sees and it usually misunderstands them. It is hard for a free fish to understand what is happening to a hooked one.”

Karl Menninger, 1930

Menninger’s analogy speaks to how easily the experience of another is misunderstood. A perspective that lacks examination of the contextual realities runs the risk of producing ill perceived and ineffectual interventions. The lived experience of post-secondary students is somewhat similar to the fish in Menninger’s analogy who swim in the ponds we call campuses. These campuses sustain and nurture student cognitive and mental well-being. However, current literature claims that more and more students are struggling with mental health problems, they behave as a hooked fish. The literature pleads for something to be done to address the crisis on our campuses (Canadian Association College and University Student Services, 2014; Canadian Mental Health Association, 2012; MacKean, 2011) however focuses primarily on the student as having the problem as opposed to an exploration of contextual issues and a holistic resolve. The literature seldom explores student mental health concerns as a function of the campus (pond) or other factors that extend beyond the campus; factors that can ensnare students and thereby threaten their mental health. This thesis addresses this paucity of research by exploring the lived experience of nursing students attending a university program who self-identify as having a mental health concern.

As a faculty member, I have seen the struggles faced by students with mental health concerns and I question where the struggle originates. Is it something innate to the student or rather a response to the problematic environment, be it academia or beyond? I have also questioned whether the number of students with mental health concerns is rising or if the student experience in modernity is an ever-increasing threat to students' mental well-being. Are students increasing mentally ill or is their 'thrashing', using Menninger's analogy, a response to a psychiatrized environment. A psychiatrized environment that sees mental health concerns as stemming from individual shortcomings. The toxicity of the environment is seldom considered. I have watched as misunderstood students with mental health concerns abandon their studies despite their proven capabilities and talents. Pitifully, their 'thrashing' is problematic and not recognized as a sign of burgeoning resilience, a skill all too few argue is required to maintain sanity in modernity. Within today's psychiatric complex Liegghio (2013) has argued that "under dominant 'psy' discourses and practices psychiatrized people are disadvantaged against constructions of "normal mental health" and experience their identities as pathologized and devalued and their humanity is denied" (p. 123). It is my hope that this research and future labour will give voice to the student with mental health concerns so that we can learn from their lived experience and create learning environments that foster mental well-being.

1.2 Background

Canadians value education and regard it as essential to obtain and maintain employment and necessary to sustain the comfortable standard of living that most Canadians enjoy. Canadians expect that universities and colleges will stimulate and prepare minds for the challenges of today and tomorrow. Canadians, according to their Constitution Acts, go so far as to view education as a right, whereby anyone regardless of gender, class, and ability can earn a spot in postsecondary

education (Department of Justice, 1982). As a result, Canada has the highest percentage of overall postsecondary educational attainment in the developed world, whereby almost half of the population aged 25-64 completed either college or university studies (Organisation of Economic Cooperation and Development, 2006). Despite this fact, the desire for postsecondary education seems insatiable in Canada. Statistics Canada (2011) reported sixty four percent of the population had completed college as well Picot and Hou (2012) using Canadian census data, noted that more recently 65% - 70% of Canadians age 23 are participating in postsecondary education. This rate of the population seeking higher education is unprecedented in Canadian history. Ontario alone anticipates 25,000 new university students over the next 25 years (Pinchin, 2009). Alarmingly, the Association of Universities and Colleges of Canada (AUCC), projects that national full-time enrolment will grow at a minimum of 9% nationally (AUCC, 2007, p. 29) and scholars are beginning to question how postsecondary institutions will be able to meet demand. In response to the enrolment torrent, several provincial reviews of postsecondary education in Canada have identified concerns regarding the quality of education, particularly the impact of enrolment growth on the degree and quality of student engagement and student-faculty interaction (Rae, 2005; Learning Alberta Steering Committee, 2006; McCall, W., 2007; Metcalfe, Mazawi, Rubenson, Fisher, MacIvor, 2007; Meredith, 2007). These reports confirm that enrolment grew three times faster than faculty employed at a given institution, over the period of 1987-2006 (AUCC, 2007, p.26). Although the student to faculty ratio is a crude measure of quality of education, particularly when comparing one institution to another, the ratio can be indicative of the likelihood of heightened distance between faculty and students. Poor student support and ultimately student outcomes is linked to distancing between faculty and students (Kuh, Kinzie, Schuh, Whitt, 2005, p.8). Students with disabilities, which include mental

illness, currently describe as the most common disability listed by students, may be particularly at risk (Zhang, Landmark, Reber, Hsu, Kwok, Benz, 2009, Macaskill, 2013). Little research has investigated whether or not these changes at universities and colleges are having an impact upon students with mental health concerns.

Central to nearly all Canadian university and college mission statements is the goal to pursue knowledge and a commitment to the intellectual growth and development of the students that come to their institutions. Moreover, universities and colleges benefit from the synergy of great minds and the resulting intellectual corpus is what distinguishes one post-secondary institution from another. Post-secondary institutions are in effect the sum total of the minds of those that are associated with the institution, faculty, administrators, community partners, and students. Young, healthy, engaged, sharp minds are an essential resource for post-secondary universities and colleges. Whatever threatens healthy minds in effect threatens the *raison-d'être* of the post-secondary institution.

Best practice in business models encourage those in positions of authority to examine their processes, the quality of the “product” they produce, as well as to take stock of the status of their valuable resources. Post-secondary institutions would be wise to the same. Studies and reports that scrutinize post-secondary education processes are available in the literature, reports that attempt to compare quality of postsecondary education also appears in the literature, however, studies of what nurtures, protects and or threatens the most valuable resource in the post-secondary institution, the healthy mind of the students, has not been a research priority. Many authors argue that these healthy minds are paramount to success in postsecondary education (CACUSS, 2014; CMHA, 2012; Silverman, Underhile and Keeling, 2008) and to future employment. To become a nurse and to practice nursing also requires a healthy mind.

1.3 Research Problem

As the number of students enrolling in postsecondary education rise providing a quality education experience becomes more of a challenge. Institutions of higher education are constantly demanding more resources to meet Canada's voracious appetite for education. If, to quote Silverman, Underhile and Keeling (2008), "minds are what higher education is about", then resources would wisely be allocated to promote and sustain healthy minds. The Canadian Mental Health Association (CMHA) reports that one in five Canadians is affected by mental illness; however, this number is higher among post-secondary students (CMHA, 2012) and this number is increasing (Ahern and Tuckett, 2010; (Brown, 2011; Lunau, 2012; MacKean, 2011; Madden 2012).

Most mental health concerns begin in young adults (Kessler et al. 2005) and in Canada more than half of this age group is attending post-secondary education (Organisation of Economic Cooperation and Development, 2006). For example, more than half of 3000 students surveyed at the University of Alberta experienced a sense of hopelessness while a shocking 87.5% of the students indicated that at times they felt overwhelmed with anxiety (Brown, 2011). Sean Madden, the president of the Ontario university student association (OUSA), writes in the OUSA blog (Madden, 2012) that a recent survey of Ontario University students reports that 29 percent of student unable to function because of depression, 9.4 per cent were immobilized by anxiety disorders and 6.1 per cent seriously contemplated suicide. Postsecondary institutions across Canada are asking why it is that these young individuals with the future before them feel fearful, hopeless, depressed, and suicidal (Lunau, 2012).

The increase in mental health concerns and mental illness is not unique to Canadian universities and colleges. Fratt (2008) shares that according to the American National Health

Assessment, depression made it difficult for nearly half of students to function in 2005. The article also noted that in other American student surveys, most campuses are identifying a slow and steady increase in the number of students who seek mental health services and the severity of the mental health needs among students who seek help is raising. Other international research projects have reported psychological distress as common in university students (Bayram & Bilgel, 2008; Burris, Brechting, Salman & Carlson, 2009; Field, Diega, Pelaez, Deeds & Delgado, 2008; Khawaja & Dempsey, 2007; Leahy, Peterson, Wilson, Newby, Tonkin, & Turnbull, 2010; Stallman, 2010; Wynaden, Wichmann & Murray, 2014; Yorgason, Linville and & Zitman) and on the rise (Hunt & Eisenberg, 2010). Universities market themselves as places that develop minds and human potential; however, nurturing mental *well-being* is not necessarily part of the equation. Studies substantiate that psychological distress is high among post-secondary student population, as students are exposed to a wide variety of mental stressors that trigger mental health concerns, not only in relation to the rigour of the academic program but also surrounding financial, relational, developmental, environmental, and social concerns (Ibrahim, Kelly, Adams, and Glazebrook, 2012; Macaskill, 2013).

For the last three decades studies of university students have focused on mental disorders, trying to determine the prevalence of disorders in the student population (Bayram & Bigel, 2008; Ibrahim, Kelly, Adams, and Glazebrook, 2012; Zivin, Eisenberg, Gollust and Golberstein, 2009). More recently inquiry has turned to identify barriers to, and strategies for, maintaining mental health and *well-being* of students in tertiary education settings in the hope of determining what services would best support the ever-increasing number of students dealing with mental health concerns (Cleary, Walter, Jackson, 2011; Gibbons, 2010; Flatt, 2013). What is lacking in the

literature is the perspective of the university student living with a mental health concern and an understanding of what helps and hinders their mental wellbeing.

Many scholars have been asking if the rising number of students experiencing mental health concerns is reflective of the increase in enrolment (Macaskill, 2013), or is it that students are more vulnerable mentally, or is some other factor at play. For example, Macaskill (2013) argues that the move to the corporate university model has meant a marked increase in enrolment, yet funding per student has been cut, which changes the student experience in ways she believes contribute to mental health problems in students. Healy (2012) argues that the rise in the number of students with mental health concerns is the consequence of over diagnosis fostered by the marketing practices of psychopharmacological industry which benefits when mental disorders are attributed to new markets namely children, youth and emerging adults (Healy, 2009, p. 314) and Frances concurs (2013, p. 83). A decade ago, Allan Schwartz (2006) questioned if College students were becoming more mentally disturbed and his research found that the indices of pathology remained unchanged over the ten-year study period; however, the use of medication had increased fivefold. Adlaf, Demers, and Gliksman, the editors of the Canadian Campus Survey (2004) also determined that the prevalence of mental illness reported among Canadian undergraduates, remained stable from 1998-2004. Two separate American studies, concluded that not only were numbers of cases of students with mental health concerns increasing but the severity of their experience (Hass, Hendin and Mann, 2003; Osberg, 2004). In the end, MacKean (2011) argues the research findings warrant attention, and that students are suffering, and finding ways to support them should be a priority in Canada.

Possible reasons why post-secondary students experience a higher rate of mental health problems and illnesses are; first episode onset of mental illness between ages 18-24, living away

from home, first experiences with alcohol/drugs, first serious romantic relationships, and the high demands of universities all add to student stress (Lanau, 2012). However, many of these factors are not new to young adults and therefore do not explain the increasing struggles with mental health problems currently experienced by postsecondary students. Some authors cite the cumulative reality of social and familial breakdown as causes for mental health challenges for example Levine and Cureton (1998) believe that post-secondary students are coming to school “overwhelmed and damaged more than in previous years” (p.95). Cheng and Robb (2013) two psychiatrists from the Children Hospital of Eastern Ontario claim that modern society disconnects family, namely parents from children. Strong attachments are necessary for mental health and modern society weakens attachments and therefore contributes to mental health problems. The President’s New Freedom Commission on Mental Health (2003) and Haynes (2002) assert that social and psychological stressors overwhelm students during their childhood and school period, leaving them vulnerable in face of the complexities of post-secondary education. Barry Schwartz (2004) in his book, “The Paradox of Choice” questions the role of culture, particularly the craze for greater personal autonomy and control as possibly contributing to the mental misery of so many youth. The author sites three UNICEF studies, 1970, 1980 and 1990 where it was found that the incidence of suicide tripled in France, more than doubled in Norway, doubled in Australia and increased by 50% or more in Canada, England and the United States in the three decades studied. Only in Japan and former West Germany did youth suicide go down. The author surmises that the last two countries, although similar in many aspects of modern life, do not permit as much freedom of choice to youth. Schwartz makes the novel assertion that perhaps “emphasis on freedom of choice, together with the proliferation of possibilities that modern life affords, has (...) contributed to unrealistic expectations” (p. 210).

On the other hand, others argue that success with life's challenges and the ability to overcome mental health problems make an individual more resilient, a character quality that serves as a benefit when undertaking post-secondary education (Benard, 1997).

Many authors have described obtaining an accurate picture of the need for mental health support in the post-secondary student population as no easy task. Proving that mental health needs have increased or decreased assumes that all those needing services are declaring their need and asking counselling and health services for support and these services in turn are effectively collecting data. This is clearly not true. The Canadian Mental Health Association maintains that 1 in 4 post-secondary students have mental health problems yet less than one fifth of these seek the help they need. Furthermore, and more alarmingly, of the one in five who seeks help, only one third will obtain service because the capacity, either at the school, community, or provincial level is not there (CMHA, 2012). Thus, collecting data on the mental health needs of post-secondary students is rife with challenges and likely, the numbers that do surface are but the tip of the iceberg and only paint an incomplete picture of the challenges faces by these students.

Another challenge to understanding the scope of how many students are affected by mental health problems is the student's reluctance to seek help and many are social, economic and structural in nature (Cranford, Eisenberg and Serras, 2009; Arria, Winnick, Garnier-Dyksta, Vincent, Caldereira, Wilcox and O'Grady, 2011). Furthermore, several authors investigated the reasons students did not use mental health services and found the following social and structural reasons. Self and other stigma, distrust/fear, concerns with confidentiality, cultural competency, denial, the need for self-control/perfection and the preference for informal help, lack of time, resources/knowledge as well as socio-economic and cultural background (Eisenberg, Golberstein and Gollust, 2007; Arria, 2011; Ting, 2011). An additional barrier to help seeking is that

symptoms of mental health problems themselves can interfere with help seeking behaviour. The authors stress the need for initiatives to improve access to mental health as well as to undertake research seeking to understand why postsecondary student's mental health needs continue to be unmet.

In the Canadian report entitled *Mental Health and Well-Being in Post-Secondary Education Settings: A Literature and Environmental Scan to Support Planning and Action in Canada*, MacKean (2011) states that more students with chronic mental illness, defined as having a mental disorder diagnoses and taking psychopharmacological interventions, are attending post-secondary institutions. MacKean relates that increasingly mental health problems identified by students can pose a major hindrance to their academic success (2011). No Canadian study spoke to how student mental health concerns contribute to academic outcomes in nursing education. However, three international studies explored mental health problems among nursing students. A Swedish nationwide study (Christensson, Vaez, Dickman, and Runeson, 2011) found 10.2% of nursing students reported depression. High workload, dissatisfaction with education, low self-efficacy, and conflicts between personal and college demands were associated with high prevalence of depression. The researchers concluded that, in order to protect student mental health, it was important to find ways to lessen nursing student stress (Christensson, Vaez, Dickman and Runeson, 2011). A Brazilian study (2009) found high rates of hopelessness and depression among nursing students and stressed the need for early identification of symptoms as crucial (Alexandrino-Silva, Pereira, Bustamante, Ferraz, Baldassin, Andrade, Alves, 2009). A Hungarian study (Piko and Piczil, 2004) found that students were vulnerable to mental health problems because of their duties and their inexperience, the authors argued that inexperienced

students had not yet developed effective ways of coping and problem solving leaving nursing students exposed to mental stress and illness.

Although nursing students in Canada are not speaking up about their mental health concerns other students are speaking up. According to an extensive literature and environmental scan conducted by Canadian Association of College and University Student Services (CACUSS) there is evidence that: many post-secondary students experience problems with mental health. The survey also shows that more students are coming forward to seek help for mental health problems; more students with chronic mental illness are attending college/university; and most importantly mental health is having an impact on student academic success (CACUSS, 2012). Furthermore, institutions of higher education do not have the resources nor the understanding of how mental health and illness affects students' success or failure in a given program, nor sadly do they comprehend what fosters recovery and well-being for student with mental health problems. According to the document *Mental Health Strategy for Canada, Changing Directions, Changing Lives* (2012) the mental health commission has set forth several priorities that speak to the mental health of student population. For example, Priority 1.2 emphasizes that the mental health, mental illness, recovery and well-being of youth who are primarily students, is crucial to Canada. Research to substantiate this priority is lacking thus little is available to inform post-secondary institutional policies and services. Other priorities support the need for more research and involvement of student stakeholders in said research. Priority 6.2 insists that we as Canadians must find ways to improve mental health data collection, research, and knowledge. Priority 2.2 emphasises that only by actively involving people living with mental health problems and illness in making decisions about service systems will Canadians be better served.

The proposed study will support the priorities set by CACUSS (2013) to give voice to postsecondary students with mental illness and concerns.

A theoretical perspective known to give voice to groups and individuals that are voiceless or marginalized is critical theory (Kellner, 2005). Although representing a sizable segment of the post-secondary student population, an estimated twenty percent, students with mental health concerns are marginalized (Megivern, Pellerito. Mowbray, 2003) or pitiably choose to self-silence and retreat in fear of discrimination (Mejo, 2010). Yet if we are to address the needs of students with mental health concerns we must begin by listening attentively to their stories, their experience in post-secondary institutions, their understanding of the challenges they face, their comprehension of supports and threats to their mental well-being. Importantly, a critical lens of inquiry does not simply count the prevalence of symptoms or diagnosis, or accept findings as status quo but questions what is *'normal'*.

In an attempt to comprehend the complexity of mental health concerns Foucault, Rose and Castel, introduced several significant terms into the research lexicon namely, *Power, regimes of truth, subjectification, governmentality, apparatus (diapositif), bio power, technology,* and the *psychological complex*. To Foucault power is not a property that someone possesses and uses over another, rather power is a relational conception, ubiquitous in nature, a network that fluctuates and permeates all social strata, producing and therefore constraining subjectivity (Gordon, 1999). Power pervades subjectivity, the lived experience of a person. Power infuses the lived experience through “*regimes of truth*” what Foucault describes as the background for discourses and practices that orient what is possible to speak of as being true or false.). *Subjectification* is how the force of power acts on persons. Foucault states “It is because the body has been ‘subjectified’ (...) that the subject-function has been fixed on it, because of all this

that something like the individual appeared, about which we can speak, hold discourse, and attempt to found science” (Foucault, 2006, p. 56). Subjectification is part of the students with mental health concerns experience. The subject-function is ‘fixed’ onto nursing students by virtue of what is expected to be ‘normal’. Power and its accompanying disciplinary practices embody what Foucault terms ‘bio power’. The purpose of bio power is to “manage and administer individuals and, by extension, communities and populations” (Perron, Fluet and Holmes, 2004). Developmental psychologists have attested that youth and young adults fear isolation (Erikson, 1979); marginalized students with mental health concerns crave belonging (Megivern, Pellerito, Mowbray, 2003); bio power can easily play to these vulnerabilities, while subtly driving its agenda. Bio power has disciplinary technologies or apparatuses that are found “right in the depths of society”; found within and between individuals, bodies, gestures, dispositions, and techniques (Foucault, 1977, p.27). Techniques of surveillance, documentation, organization, administration, and examination (comparison, measurement, differentiation, and classification) are a few of the disciplinary technologies that push humans towards increasing normalization and standardization. In opposition to this tendency is a societal movement towards being more accepting of individual differences that would appear to be an antidote. However, both forces have one thing in common: both emphasize an atomistic view of people as individuals and weaken social bonds and the sense of belonging that is so essential to mental well-being. In the book *Tribe: On Homecoming and Belonging*, Sebastian Junger (2016) describes his critical review on soldiers and Posttraumatic Stress Disorder (PTSD). The author makes a convincing claim that mental illness (PTSD, depression, anxiety), may be more about loneliness and not belonging to a ‘tribe’ than about neurochemical imbalances (p.19). Junger writes,

Cohesive and egalitarian tribal societies do a very good job to mitigating the effects of trauma, but by their very nature, many modern societies are exactly the opposite: hierarchical and alienating. America's great wealth, although a blessing in many ways, has allowed for the growth of an individualistic society that suffers high rates of depression and anxiety. P. 101

This tendency to order is an elusive force especially in modern day that drives human existence.

Foucault warned that this tendency to greater order is not without its dangers and that madness and distress is one expression of the 'technicalization' of our way of life (Bracken and Thomas 2010). As a researcher wanting to explore the complexity of the lived experience of a student with mental health concerns I question how nursing students understand this tendency to order, to drive normalization, standardization and technicalization and if this elusive power contributes the nursing students' understanding of their lived experience with mental health concerns.

Governmentality, according to Foucault's work, provides for a means to study the individual's capacity of self-control and *regimes of truth* (Lemke, 2000). According to Kiersay, Weidner, and Rosenow (2010) where there is conduct, inevitably there will be a governmentality conducting it. Institutions of higher learning exist because people congregate in a space for the purposes of learning. Institutions of higher learning have rules of conduct, policies describing how things are to be done, mission statements that drive agendas and ideologies that justify the status quo or movements to change. Institutional rules dictate university conduct and influence student mental well-being. Considering governmentality is thus important to this study as regimes of truth may affect how student come to understand their lived experience with mental health concerns.

The apparatus is yet another concept that can further our understanding of the lived experience of students with mental health concerns. Foucault defined the term apparatus as "the institutional, physical, and administrative mechanisms and knowledge structures that enhance and maintain the exercise of power within the social body" (O'Farrell, 2005, p. 129). Agamben (2005) writes that the apparatus is:

“Virtually everything... a strategic function ... and it includes the episteme... which allows in a certain society in a certain time to distinguish scientific and not scientific statements, what you can say, and what you cannot say”.

Building on Foucault’s seminal work, and particularly the concepts of apparatus and governmentality, Rose argues that the person is amenable to the *psy* culture of the time as it, like the apparatus, organizes everyday life (Rose 1996, 2003, 2007). Rose, like myself, was compelled to understand the human experience of mental illness and by his research he realized that such an exploration required examining “the ways in which the contemporary apparatus for “human being” has been put together: the technologies and techniques that hold personhood-identity, selfhood, autonomy and individuality in place” (Rose, 1998, p. 3). Rose conceptualized the *‘psychological complex, or psy complex as the apparatus from which the person knowingly or unknowingly came to be. Like Rose who believes that understanding the lived mental illness experience requires a thorough understanding of, or sensitivity to, the psy complex, I concur that an investigation of the experience of the student with mental health concerns requires such sensitivity to the psy complex in which students exist. This apparatus determines what students; institutions and society consider truth and falsehoods in relation to mental health and illness. The pharmaceutical industry is an integral part of the psy complex in that the industry actively constructs contemporary culture and as mental illness (Healy, 2009; Francis, 2013). Students are likely unaware that today they are arriving at university as consumers of the psy complex with diagnoses and prescriptions (Levinson and McKinney, 2013). Castel (1984), another critical theorist, sees the medicalization of youth as yet another tentacle of the psy complex whereas Levinson and McKinney, (2013) see the corporate university as an extension of the psy complex in that the corporation markets little more than psy complex infused services to parents and students. As early as 1982 Castel argued, “Moral deficiency became psychological maladjustment or emotional instability” (1982, p. 42) and the psy complex was favoured when*

psycho-medical techniques were applied to the treatment of moral deficiency. This became more apparent in the 1990's when large numbers of students began arriving in post-secondary institutions with psychiatric diagnosis who had been culturalized by the *psy complex* into believing that a normal 'almost worry free' life experience is possible with pharmacological modification (Caplan & Elliott, 2004; Hyman, 2006; Rose, 2003, 2007). Likewise, corporatization of postsecondary education has come to mean accommodating student needs as defined by the *psy complex* (Levinson and McKinney, 2013). Although the influence of the *psy complex* is difficult to identify directly, analysis of prescription trends internationally, the primary *psy complex* intervention, reports that North Americans, consume much higher amounts of psychotropic medication prescriptions than European Countries (Steinhausen, 2015). Castel further warns that ideologies can lead to flawed diagnosis and blaming the victim for their "maladjustment" (1982, p. 43). Rose and Castel demonstrated that inquiry into a lived experience of a person with mental illness must be sensitive to the influences of the *psy complex* if it is to have any significance and contribute to science. Levinson and McKinney (2013) argue that overlooking the influence of the *psy complex* puts the mental well-being of students at stake. Listening attentively to the student with mental health concerns as they tell their stories and then analyzing their experience through a critical lens that appreciates the influence of the *psy complex* is important to this study. Sadly, the *a priori* point of most studies is that the student has a mental and emotional problem. "Their problem" challenges their academic success and responsibility lies with the student to come forward and ask for help. Help within the post-secondary institution entails professional intervention whereby the student must obtain a diagnosis to access interventions; with a diagnosis, they are eligible for accommodations, medications, or therapy. To date no research that explores this issue, from the perspective of a

student, a sentient being who may be maladaptating to a sick situation constructed by both the governmentality of the University and the *psy complex*. Exploring what it is like “to be” a student with mental health concerns in a postsecondary institution, requires a lens of exploration that can address complexity. There is no clear boundary between student mental health or illness and the university. There is no point at which the value, beliefs and actions of one entity does not affect the other; the student, institution, and society are interlinked and interwoven.

Consequently, in order to undertake this research, I have chosen to situate the inquiry in a Heideggerian appreciation of human existence. This research will not use a dualist understanding of subject-object, but rather employ a holistic view where “truth” lies in an analysis of the lived experience. In the university, this perspective should allow for better insights into this lived experience of nursing students with mental health concerns. This experience of *being* a student with a mental health concern occurs within a dynamic environment; where emerging forces or “regimes of truth” contribute to how the lived experience manifests. Findings from this research project should not only benefit postsecondary nursing students but also academics, support personnel and administrators. It will contribute to the body of knowledge exploring mental health concerns of students whilst questioning the view that mental illness is on the rise. The following research objectives and questions guide this research.

1.4 Research Objectives

1. Explore the experience of nursing students with self-reported mental health concerns.
2. Explore how students understand their mental health concerns and critically appraise their understanding in relation to the psychiatric apparatus that surrounds them.
3. Critically analyse and quarry if the rising rates of mental illness diagnosis and mental health concerns among post-secondary students are the distillate of the psychiatric

- complex post-secondary students experience or a by-product of the stresses of student life.
4. Describe how nursing students understand how curricula and clinical experience enhance or threaten their mental health and wellbeing.
 5. Critically analyse the institutional perspective on student mental health and illness in light of the socio, economic and political realities at play in the post-secondary institution where they are studying
 6. Critically analyse the lived experience of the student nurse within the new corporate university model.

1.5 Research Questions

1. What is the experience of nursing students with mental health concerns?
2. How do nursing students with mental health concerns describe themselves?
3. How do nursing students with mental health concerns understand their experience?
4. How do nursing students with mental health concerns make sense of their experience in light of the psychiatric apparatus that permeates student life?
5. How do institutional policies, procedures, and technologies help and/or hinder nursing student mental wellbeing?

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This literature review will situate the proposed study; the lived experience of baccalaureate nursing students with mental health concerns, in the current body of knowledge. The review will describe, summarize, and evaluate the literature that speaks to the experience of students with mental health concerns. It will articulate what theories explain key relationships, what methodologies explore central concepts, and where gaps in literature persist.

2.2 The context

The literature speaks to the rise in the number of university students with mental health problems (MacKean, 2011; Hass, Hendin & Mann, 2003; Osberg, 2004). Some authors argue that the rise in numbers of young people with mental illness should be questioned as the increase may be the result of diagnostic inflation and a marketplace desire to “sell psychiatric ills” (Frances, 2013, p. 92; Healey, 2012; Schwartz, 2006). Despite opposing views regarding the accuracy of the number of cases, as well as the questionable acuity and qualitative character of the mental illness, students are struggling with mental and psychological distress. In an attempt to understand the nature of post-secondary student mental health concerns, Storrie, Ahern and Turkett (2010) conducted a systematic review. This review identified four issues that were key to research addressing the mental health concerns of post-secondary students: the emotional/mental health problems experienced by university students and their effects; how university staff deals with students suffering emotional/mental health problems; the barriers and strategies of seeking help; and epidemiological trends occurring in the university student population. This research project began with a similar search of Medline, Psych info, and Pub med databases and the

Cumulative Index to Nursing and Allied Health (CINAHL). The search criteria were research papers between 2009 -2016, student, social problems, emotional problems, psychiatric problems, mental problems, medical, health, university, college, post-secondary, university teacher lecturer. Limits imposed on the search options included English language, peer reviewed, and scholarly journal. The search identified 3126 articles where Storrie et al. identified 624 in 2009. Thus in 7 years the pool of literature addressing post-secondary students and mental health problems has increased by a factor of five, demonstrating that this area of concern is of increasing interest to academics, administrators and governmental bodies. From the 3126 articles retrieved, 296 articles directly related to the current study of which 45 articles were primary research. Remarkably primary research regarding mental illness and post –secondary education from 2010-2016 had increased eleven-fold since Storrie et al. was published. This literature review looked at key research identified by Storrie et al. (2009) and new research identified since 2009 as well as key areas relevant to this study, i.e. social political and economic realities that might also contribute to how students understand their lived experience. The following six categories describe the nature of the literature discovered and serve to organize this literature review.

Category 1: Epidemiological trends occurring in the university student population and critical reflection on the pervasiveness of psychiatric diagnoses among university students. Category 2: Experience of emotional/mental health problems among university students. Category 3: How university administration, staff, faculty members, and fellow students perceive and address the reality of student emotional/mental health problems. Category 4: Attitudes and stigma university administrators, faculty, peers hold and self-stigma that students with mental health concerns experience. Category 5: Strategies that support mental health, and, category 6: Barriers to mental health including institutional structures, technology, or social influences.

2.3 Epidemiological Trends in the University Student Population

Although tragic events related to mental health concerns, such as the suicide of a college student at Queens University or homicides and suicides at the Universite de Montreal Ecole Polytechnic capture popular attention, these are atypical cases within a much broader social and public health issue spectrum. However, these events justify the need to appraise the magnitude of mental health concerns amongst post-secondary students. Globally over the last three decades epidemiological studies have proliferated (Strangler and Printz. 1980; Rimmer, Halikas & Schukit, 1982, American College Health Association, 2008; Erickson-Cornish, Riva, Cox-Henderson, Kominars & McIntosh, 2000; Adlaf, Demers, Gliksman, 2004; Zivin, Eisenberg, Gollust and Golberstein, 2009; Stallman & Shochet, 2009; Stallman, 2010; Ibrahim, Kelly, Adams & Glazebrook, 2012; Macaskill, 2013; Rugira, Nienbar, & Wissig, 2013). Some studies purport that the number of students with mental health problems is increasing and is a crisis that requires immediate attention (Adlaf, Demers, Gliksman, 2004; American College Health Association, 2008; Gallagher, 2008). Others claim that the number of students with mental health concern is no different than that of non-students' counterparts in the general population, questioning that perhaps this is not unique to post –secondary institutions but inherent to the young adult life experience (Blanco, Okunda, Wright, Hasin, Grant, Liu and Olfson, 2008). Still other researchers claim that the number of students with mental health concerns has remained the same over time reflecting a constant level of 'dis-ease' in our modern society and this level of 'dis-ease' warrants addressing (Ibrahim, Kelly, Adams, and Glazebrook, 2012). Even if studies cannot agree if the number of students with mental health concerns is on the rise or stable all studies do agree that young adults are struggling with emotional and psychological ails and

research that aims to understand their experience and how to ameliorate their situation would benefit post-secondary students, post-secondary institutions and society at large.

The search strategy found forty-five articles, of which ten were epidemiological studies. This review also includes three classic studies from the 1980's that set the tone for later studies as well as highlights two studies that present Canadian epidemiological results (Adlaf, Demers, Gliksman, 2004; American College Health Association, 2008) that are considered national hallmarks. This analysis will begin with the classic epidemiological studies of the 1980's.

Epidemiological studies conducted in the eighties maintained that 5-12 % of the college population reported mental health concerns that warranted mental health services (Nagelberg & Shemberg 1980; Rimmer, Halikas & Schukit, 1982; Strangler & Printz, 1980). An oft-cited classic study is that of Strangler and Printz (1980). This review of 500 student files at a university psychiatric outpatient clinic examined psychiatric diagnosis using the DSM III criteria for the prevalence of disorders. The outcome of the study was a list of most common diagnosis in the college population (Adjustment disorder, Affective disorders, Anxiety disorders), and concluded that this population was vulnerable to mental health concerns and that further research was warranted. This study translated into subsequent studies that focused on the identified diagnoses (Megivern, Pellerito, Mowbray, 2003). Strangler and Printz's (1980) study prioritized care in the post-secondary student population for the next decade, although data from this study was collected at one university outpatient clinic and only on those client file's that represented students that came forward and sought help from this particular clinic. The study did not capture the experience of what we now understand to be the silent sufferers of mental health concerns. Furthermore, the criteria for diagnosis, was only the DSM –III, and no psychometrical assessment instruments were available to substantiate the diagnoses. As a result, the lists of key

diagnosis from this study served as the foundation for numerous subsequent studies albeit never being objectively verified.

Two years later Rimmer, Halikas, & Schukit (1982) conducted a four-year longitudinal study of students entering college. The focus of the study was to investigate rates and changes in psychiatric functioning of students with specific diagnostic criteria, each year, over a four-year period. The study captured demographic data, drug usage, and psychiatric problems. The study revealed that the prevalence of psychiatric illness among the population studied was 39%; this translated to 61 symptoms clusters or diagnoses found in 158 students at some point in the four years of the study. Importantly the research also showed that the percentage of students reporting symptoms clusters had declined over the four years. It was found that during year one 5% of the students had psychiatric illness raising to 6% in year two and then dropping to 4% for the last two years. This would indicate that student's mental health improved. Interestingly the research summary did not mention the variants in mental health experienced over the years, the change in symptoms clusters, and the reduced perceived mental health concerns in later years. The researchers do write that 39% of the 158 students had or were experiencing the symptom clusters at the time of the interview at some point in the four years. This way of recording findings leads to inflated percentages and infers that a student remains a student with a psychiatric diagnosis. The study showed that a student's experience varied over the time and that students experience less mental health concerns later in their studies. The researchers claimed to identify depression as the most common illness among students representing 90% of the diagnoses. Current epidemiological studies would not substantiate such a finding (Ibrahim, Kelly, Adams, and Glazebrook (2012). Are other factors at play that lead to erroneous inflation of the depression diagnosis? For example, in the 1980's anti-depressants such as Prozac were flooding the markets

and the diagnosis of depression abounded across all populations. Simultaneously, anxiety as a diagnosis in the college population was minimal in the 1980s. This leads to other questions: did the type of mental health concerns affecting students change drastically in three decades? Have diagnostic methods and assessments become more refined, or are other factors at play such as the pharmaceutical industry driving diagnoses?

From the mid 1980's until 2000 no epidemiological studies were published. In 2000, Erickson-Cornish, Riva, Cox-Henderson, Kominars, & McIntosh (2000) explored the perceived distress in university students over a six-year time span. The study looked retrospectively at files of 982 students who sought counselling services applying the Global Severity Index and a demographic questionnaire to data in the files. At first researchers found a slight increase in the demand for mental health services. However, when they looked deeper into the data they saw that only a few students with extreme stress had sought more assistance and that in fact distress experienced by the majority of students had remained stable. A limitation of the study is that it took place at one counselling centre; students were mostly graduate students, and the study used only one self-reported measure of student distress. Erickson-Cornish et al. (2000), as with earlier studies, drew their conclusion without considering any other external factors that could be contributing to the students' experience. In this study, as in Rimmer et al, 1982, mental health concerns are inherent to the student.

Four years later, a Canadian epidemiological survey entitled *Canadian Campus Survey* was conducted (Adlaf, Demers, Gliksman, 2004). This study went beyond simply the number of students with certain diagnosis to an attempt at capturing the complex experience of post-secondary students. The key objective of this study was to assess campus-based ecological factors in 2004 and 1998. Although the focus of the survey was addiction, it also netted

information regarding other mental health concerns. The questionnaire had 251 unique items covering six broad domains; alcohol consumption and patterns, heavy episodic drinking, hazardous and harmful drinking, non –medical drug use, gambling problems and psychological distress measured by the 12-item General Health Questionnaire mental health screener. Adlaf, Demers, Gliksman, (2004) write that their study data was obtained by self-reporting and consequently required that students were in a ‘healthy- enough’ frame of mind to respond and there was a bias of under reporting of more undesirable behaviours. In both surveys, more women than men responded, 55% versus 45%. The strength of this study was that it looked beyond the diagnosis of a mental disorder. The results exposed that over the six-year period; drinking had increased, particularly with women; types of addictions had changed from alcohol to other mind-altering substances; and stress was a significant issue in the university student population. However, importantly the prevalence of elevated psychological distress remained stable in the period 1998-2004. In both surveys, one third of the undergraduates identifies themselves as psychological distress. The study also found that substance use increased substantially at certain times of the year, when for example beer companies held promotions and sponsored college bar happy hours. The study brought to light that a certain ‘kind of student’ could be more or less at risk: “A-oriented” students were at highest risk for the use of substances and for distress. Likewise, the role of social supports was illuminated and it was determined that living off campus with family corresponded to lower substance use and stress. The study found that women experienced stress that is more elevated whilst men suffered more substance abuse. Year of study had a significant influence on substance use and stress. Third year students were at highest risk of distress and substance use. The study also compared students attending post-secondary institutions to their non- attending counterparts and found university students were

more likely to report elevated stress and use hallucinogens during the past year, but less likely to use cocaine or ecstasy. Finally, a compelling public health concern surfaced from this study. One third of students reported elevated distress and this percentage remained constant. When compared to non- university young adults the rate of distress among university students was more than double that of non-university young adults. What also surfaced was a new area of concern requiring attention, anxiety as a student experience.

At the same time, American researchers were also interested in the health concerns of post –secondary students. Every year since 2000, the American College Health Association (ACHA) has used the National College Health Assessment (ACHA-NCHA) tool to help institutions collect data on students' health habits, behaviours and perceptions (ACHA, 2013). In 2008, the ACHA-NCHA II was revised to 66 items of which 11 deals directly with mental health concerns, symptoms of psychological ills, access to and willingness to access mental health services. The First version of the tool surveyed 552,192 students at 832 institutions of higher learning. The second version of the tool surveyed 534,661 students at 737 institutions. In 2013, for the first time, the institutions surveyed included six Canadian institutions, and a summary of the aggregate results of the Canadian institutions is available for review (2016 results were not available at the time of this writing). However, based on 2013 survey results the total number of Canadian student respondents thus far was 34, 039. The overall response rate was 20.4% (ACHA-NCHA Canadian Reference Group, 2013). Canadian students experienced the following during the last 12 months. Fifty-four percent felt hopeless, and three percent felt overwhelmed by all they had to do. Eighty-seven percent felt exhausted (not from physical activity) and sixty-four felt very lonely. Fifty-seven percent felt overwhelming anxiety. Sixty-nine percent felt very sad and thirty-eight felt so depressed it was difficult to function and nearly ten percent seriously

considered suicide; and one percent of the 534,661 students surveyed attempted suicide. The survey also captured that seven percent of the students were diagnosed and treated for anxiety and/ or diagnosed and treated for depression in the last year. The survey also asked if the students had experienced traumatic or very difficult challenges in relation to academics, career, family problems, relationships, health, sleep, personal appearance, and seventy-four percent responded affirmatively. Being that this report was from September 2013 and was the first to provide statistics on Canadian students, comparison between responses of Canadians between years is not possible at the time of this literature review, however the survey results did show that in 2013 Canadian post-secondary more students felt more anxious, overwhelmed, exhausted, lonely, angry, depressed than their American counterparts. More Canadians than Americans seriously thought of suicide, although less Canadians attempted suicide or intentionally cut, burned, bruised or otherwise injured themselves (ACHA-NCHA-II Reference group Executive Summary, 2013). Although the ACHA-NCHA-II epidemiological study provides some piquant information that can serve as a basis for future inquiry, the proportion of Canadian respondents is only 1/5 of the population. Canada in 2013 touted nearly 100 universities, thus the sampling of six institutions for the survey was not random and far from representative. However, the survey illuminated that perceived stress is high and an ardent, persistent threat to post-secondary students' mental well-being.

Another often-cited work by Zivin, Eisenberg, Gollust, and Golberstein (2009) describes how researchers conducted a baseline web-based survey of university students in the fall of 2005 and then a two-year follow up and compared results. The survey was an amalgam of several mental illness screening tools, The Patient Health Questionnaire –9, The PHQ anxiety module, the SCOFF screening instrument for eating disorder symptoms, suicidal ideations and a tool to

measure self-injury designed by the researchers for this study. The researchers also asked for prevalence of use of most common psychotropic medications and if they used mental health counselling services and at what frequency. In 2005, 57% of the student population, randomly selected, completed the baseline questionnaire, and 723 students responded. The study concluded that 33% of the student population had mental health problems and that 60% of the students who had a mental health problem in 2005 still had the problem in 2007. They also identified that certain mental health problems were more persistent than others, namely depression lessened over the years and eating disorders were more likely to persist. The researchers also found students perceived little need for help and willingness to use mental health services despite persistent mental health concerns. The limit of this study lies in the screening tools used, being nothing more than a long list of symptoms unverified by other assessments. A second limitation is that students self-selected therefore there is no way of knowing if this favoured students with mental health concerns. This would result in inflated rate of students with mental health concerns. Interestingly, the researchers comment in their discussion that:

“Our data reveal not only a large number of students with persistent untreated problems, but also a substantial number of service users without positive screens for mental health problems. College administrators and health providers, not to mention insurers, must wrestle with how to prioritize mental health” (Zivin et al., 2009)

The quote alludes to the belief that the mental health problems are to be treated and that others, not the person with the mental health concern must wrestle with how to solve the problems. Little is gained from this research in understanding what contributes positively to mental well-being or about the contextual factors that might have contributed to the mental health concerns experienced by the students surveyed.

The interest in post-secondary student mental health and well-being is not unique to North America, in September of 2012, Ann Macaskill, published her epidemiological study of

students at a large university in the UK (Macaskill, 2013). The goals of the study were twofold: firstly, to assess the levels of mental illness in undergraduate students. Secondly, to test the hypothesis of the UK Royal College of Psychiatrists purported that the rise in the level of post-secondary students with mental health concerns relates to the British government encouraging more students from a wider sector of society to attend university, increasing financial and social pressures on students. The author writes “UK students attending university [in the past] tended to be an academic elite, coming from economically privileged backgrounds with more assured levels of family support, all of which decrease their vulnerability to develop mental health problems. Widening participation in university education has changed this (Macaskill 2013, p.426). Using the Diathesis-stress model as her theoretical foundation, she surveyed students at a large university regarding their exposure to biological, psychological, financial, and social factors that increase stress and vulnerability to mental health problems. The study examined the incidence of psychiatric ‘caseness’ or what might be best understood in our context as psychiatric need, using the General Health Questionnaire (GHQ-28). Students from 11 disciplines were studied and represented either first, second or third year students. Macaskill, (2013) found that the overall incidence of psychiatric need in the sample population was 17.3%. This is strikingly similar to the estimated general population incidence in the UK of 17.6% (McManus, Meltzer, Brugha, Bebbington, and Jenkins, 2009). Mid-way through the study students reported significantly greater rates of psychological distress and, the rate of stress reported was higher than that of their non-student counterparts (23.1% versus 17.6%). According to the researcher, only 5.1% sought treatment for their psychological problems (Macaskill, 2013). The finding that so few students seek help, and thus do not show up to be counted by health services, put studies that use health and counselling service data into question. The

number of incidents reported from health and counselling centre are likely less and do not reflect the silent sufferers. Macaskill (2013) concludes that post-secondary education in the UK has moved to a corporate university model where student enrolment has increased, whilst funding per student cut. This is changing the student experience in ways that she believes contribute to the mental health problems students' face. Students are in larger groups, making it more difficult to have a sense of belonging. In the corporate university, demands more of faculty, which mean less time for student support. In an attempt to teach to large classes' faculty are encouraged to use technology, which has the potential to help or hinder relationships and little is know how technologies affect mental health concerns. The study shows that more students are seeking out mental health services and that counselling services have not had the funds to keep up with growth in student numbers. Macaskill (2013) surmises that, the root of the distress students are facing, lies in the corporate university agenda and not necessarily in the student themselves.

Two Australian epidemiological studies (Stallman & Shochet, 2009; Stallman, 2010) surfaced in the recent literature. These studies provided a snapshot of the number of students with mental health concerns and the magnitude of their concerns. The research used surveys based on the K10, a measure of non-specific psychological distress, used to screen for DSM-IV anxiety-mood disorders. Students at multiple universities who came to health services completed the survey. In 2009 over 1100 students from 3 universities, and in 2010 over 6,400 from 2 universities, completed the surveys. The majority of the respondents were female, full time students, domestic, undergraduates, who described themselves as having elevated distress, at a rate of 45.1% (Stallman & Shochet, 2009) to 84% (Stallman, 2010). Albeit the large difference in distress rated, nothing explains the substantial increase in one year, or why the level of distress in the student population is significantly greater than found in the general population, 29%

(Australian Bureau of Statistics, 2008). Both studies confer that the level of distress peaks mid-way through a program of university study. Limitations of this study lie with the tool used: The K-10 is a screening tool used to diagnose stress and mood disorders (Stallman, 2010). The high levels of distress may be the result of the tool bias. A vulnerable population like a student dealing with the natural tensions and complexities of student life may respond to the suggestions inherent in the tool. A second limitation is that this study, is that self-selected students that identify themselves as having a physical or emotional need were surveyed, not the general overall student population. The two Australian epidemiological studies findings confer with epidemiological studies in Canada, United States, and the United Kingdom.

The mental health concerns of post-secondary students appear to be global interest. A scan of the literature from 2009-2016 exposed an additional 6 epidemiological studies representing the following countries; Ethiopia, Trinidad, Greece, France, Egypt, and Malaysia (Ibrahim, Kelly & Glazebrook, 2013; Kounenou, Koutra, Katsiadrami & Diacogiannis, 2011; Shamsuddin, Fadzil, Wan Ismail, Shah, Omar, Muhammad, Jaffar, Ismail & Mahadevan, 2013; Verger, Gilbert, & Koess-Masfety, 2010;). Six of the studies surveyed students across different faculties and found increased rates of depression and anxiety (Kounenou et al., 2011; Verger et al., 2010; Ibrahim et al., 2013; Shamsuddin et al., 2013). All the studies used a cross sectional study design. The studies analyzed data from surveys that collected socio-demographic information and responses from one or more mental health screening tool: the SRQ-20; General Health Questionnaire (GHQ-28); Centre for Epidemiological Studies depression scale (CES-D); the SCL-90R – a psychological distress measure in adults and adolescents; the Composite International Diagnostic Interview-Short Form (CIDI-SF); or the Depression Anxiety Stress Scale (DASS-21). Each of these tools asks respondents to rate their level of symptoms as a

means to identify psychopathology based on the DSM IV. Correlations between mental distress symptoms and socio-demographics show similar findings across all six studies. Increased distress with economic instability; more anxiety among female respondents except in the Ethiopian study where no difference between gender was identified; living away from home contributed to elevated stress; supportive relations reduced mental tension; and in the Malaysian study levels of distress augmented with years of study (the other studies did not track this factor). Limitations of the survey results lie in the reliability of the tools especially when translated. Validity for most of the tools was fair to good; however, all of the tools focused on negative symptoms and therefore captured nothing about flourishing, resilience, and recovering.

A contrasting perspective on the issue of post-secondary student mental health issues comes from Tanzania (Rugira, Nienber Wissing, 2013). This study looked at flourishing students rather than distressed students. Using a cross-sectional survey design researchers surveyed a convenience sample of 279 undergraduate students. The mental health continuum-short measured well-being rather than symptoms of mental disorders. Students from three universities were polled and 73% described themselves as flourishing while 27% were languishing or struggling with mental health concerns. The researchers found languishing students at all three institutions but found that the smallest institution, had the highest well-being (flourishing) scores. Limitations in this study lie in the little understood tool about reliability and validity and the sample was small and not randomly selected. The study does concur with the body of epidemiology studies that show that more than one quarter of the post-secondary student population struggle with mental health concerns.

An important Ontarian study, found in the grey literature, is *The Impact of Mental Health Problems in the Community College Student Population* (Holmes, Silvestri, and Kostakos,

2011). Although the study focused on post-secondary student in the community colleges, the findings support and substantiate the need for services in universities. This descriptive analysis surveyed counsellors at 15 of the 24 community colleges in Ontario. The purpose of the study was to determine the frequency among students of mental illness, mental health problems, and academic challenges. In total 1,964 completed surveys were statistically analysed. The survey tool was based on the American College National College Health Assessment (ACHA, 2008) and the Boston University Centre for Psychiatric Rehabilitation, Student Self-Assessment of College Classroom Difficulties (2009). The survey had three parts: the first was composed of DSM diagnosis and treatments, the second listed mental illness/mental health problems, and the third listed academic challenges theorized as being associated with psychiatric diagnosis and mental health problems. The recruited counsellors completed the survey immediately after they saw a student in their college offices from October 2009-April 2010. Data revealed that counsellors concluded that sixty-one percent of the students reported having a diagnosis of one or more psychiatric labels. Mood and Anxiety disorders were the most prevalent. The frequency of visits to counselling services related to the number of psychiatric labels, most mental health problems were describe as being stress or interpersonal relationship in nature. Service providers reported that sixty-eight percent of the students encountered academic challenges; however, not objectively validated. From the findings of the study, the authors cry for an institutional response to the seemingly increased number of students with mental illness and psychiatric labels and associated problems. The authors claim the survey determined that psychopharmacological interventions are the primary treatment for the various *psy* disorders found among Ontario's college students. The researchers claim that sixty-eight percent of the students, they spoke with disclosed having academic difficulties, however the report does not comment on the challenges.

The authors do not disclose any study limitations. However, I question the quality of the data, as it was not a first-person account. The ACHA is a student survey tool yet in this study, the counsellor completed the survey on behalf of the student. As well, the focus on the *psy* perspective, the psychiatric labels, diagnosis, and assumed symptom clusters of the DSM biased the questions in the survey. The results therefore focus on the problems as seen by an observer, a *psy* expert, not as a person experiencing mental health concerns. The data does not reflect the person with the lived experience, nor does it seek to find what could help, its focus is on what hinders. The results justify the need for more financial support for counselling the “sick”, which would benefit the counsellors’ position on the issue of study. However, it does little to understand the mental well-*being* of students or what might contribute to recovering.

Overall, the epidemiological studies tell us that students are struggling with mental health concerns. Most studies report that students most often experienced anxiety and that this experience varies over the years of study. Current epidemiological studies reveal a sensitivity to contextual factors that contribute to the mental health experience such as age, years of study, economic status, and gender. Macaskill’s (2013) epidemiological research is the first to allude to the significance of socio-political and economic realities and the role of the corporate university in students’ mental health concern experiences.

2.4 Critical Reflections on Psychiatric Diagnoses among University Students

The work of Nicolas Rose is central to understanding the complexity of the mental health experience of students. The following paragraphs will expound on Rose’s key research findings that served to inform this research project. A seminal article in the literature that informed this research project is an earlier publication by Nicolas Rose (1979), *The Psychological Complex; Mental Measurement and Social Administration*”. This study used historical critical theory to

explore how 20th century psychology changed from an exploration of the internal experience to a means to measure and differentiate experiences as seen externally and how this came to constitute ‘regimes of truth’ in the *psy* disciplines. Rose’s exploration hoped to illuminate how “discourses may be opened up for interventions (...) that may give rise to transformation” (Rose, 1979, p. 11). Rose shows by means of critical history how politics and intelligence morphed together with Frances Galton’s work of IQ testing, and how norms derived came to control the population. Rose writes, “It is the norm which allows the ‘gripping’ of the population” and determines the relation between population, norm, individual and deviant (p. 19). The relationships Rose asserts serve as foundational for the *psy* disciplines and through the “apparatuses of administration, welfare and insurance of education and health, (...) over the last 100 years or so, have progressively installed themselves between law and the population” (p. 60). Knowledge of the ‘*psy apparatus*’ and how it controls people by exerting power, in the sense of how Foucault means it, by establishing norms, is crucial to an understanding of the mental health experience of students or otherwise. In a second publication, *Power and Subjectivity, Critical History and Psychology*, Rose analyzes how the *psy* disciplines have played a fundamental role in the creation in the mental health experience. He asserts that *psy* disciplines determine the kind of mental health experience that we in the west have come to judge as ‘normal’ (1996). People have come to understand themselves in terms of the norms, values, and techniques availed to them by the *psy* disciplines: “Psychology has participated in a transformation in the ways in which individuals have come to make their lives meaningful to themselves” (Rose, 1996b, p. 23). Likewise, Rose concludes his paper by saying that on a macro level, institutions also use these norms, values, and techniques to manage people. For Rose the lived experience of mental health concerns intertwines with the *psy complex* and therefore any

meaningful study of the experience of mental health concerns requires sensitivity to the multicorporeal socio, political and economic realities.

Rose also wrote *Inventing Ourselves, Psychology, Power, and Personhood* (1996a), in which he elaborates on his critical history research project. In this book, he argues that all the *psy* disciplines play a substantial role in how human beings understand themselves. Using Foucauldian critical theory conceptualizations, he explored the history of the *psy* disciplines for a period of 100 years, with the goal of gaining insight into the “conditions under which these horizons of experience have taken shape, to diagnose our contemporary condition of self” (Rose, 1996a, p. 2). Rose determined that the inner being, what he describes as the “internal universe of self, is central to the ways we think, how we determine the norms by which we judge abnormal from normal, and how we conduct ourselves” (p.4). He argues that the *psy* disciplines have profoundly influenced human beings at this internal universe of self by “‘making up’ the kinds of persons we take ourselves to be” (Rose, 1996a, p. 11). According to Rose, research that wishes to understand the internal psychological experience requires a critical appraisal of the influence of the *psy* disciplines on the human experience.

A search of the literature produced several studies that, for facilitating understanding of the literature, cluster into the following categories: *Psy* Diagnosis and Treatment, *Psy* Diagnosis in the Corporate Environment, Nursing Lacking a Critical *Psy* Perspective, and Critical Studies of Recovery.

2.4.1 *Psy* Diagnosis and Treatment

In the literature, several authors engage in critical discussion regarding the proliferation of diagnostic labels and the abuse of diagnoses as a mechanism to promote social, political, and economic interests. Some authors go so far as to term this as abuse and disease mongering

(Dear and Webb, 2007, Healy 2012; Moynihan et al. 2002; Moynihan and Cassels 2005; Moncrieff et al., 2005; Wolinsky 2005). Recently in *Saving Normal: An Insider's Revolt against Out of Control Psychiatric Diagnosis, DSM-5, Big Pharm, and the Medicalization of Ordinary Life*, Frances (2013) presents a critical review of psychiatric diagnosis and the DSM-5. Frances is forthcoming about the role of the pharmaceutical industry in wanting new diagnosis to market their products to new populations of children, youth, and young adults. He cites diagnosis of autism, attention deficit and childhood bipolar disorder as examples of diagnosis for new markets. He believes that there is no real rise in mental illness rates. He claims those who are responsible for the establishment of the DSM-5 may have been inexperienced and thus susceptible to social, political, and economic influences when they formulated diagnostic criteria. This is an interesting claim being that he was integral in the development of the DSM-IV diagnostic manual. Three chapters in his book discuss *psy* trends of the past, present and future in hope of situating his arguments in a historical context. He attempts to provide critical appraisal of the concept of 'normal' as it is understood in psychiatry, believing as Rose, that what is normal/mental health and what is abnormal/mental illness, arises from the dictates of the *psy complex*. This chapter does not offer more than a confirmation that the concept is difficult to comprehend.

In the same vein as Frances' critical review, Healy (2012) critically appraises the power of the pharmaceutical industry in controlling drug markets and purposes. This control makes for health care and in particular mental health care pharmaceuticalized. In his book *Pharmageddon*, Healy (2012) presents years of critical research of the pharmaceutical industry. He shows that the industry controls drug trials and thereby exaggerates the benefits and denies their dangers, thereby manipulating what physicians understand about the drugs, leading to over prescribing

and very little appraisal of pharmaceutical interventions. He concludes that our current ‘evidence-based’ medical system needs reform as more a product of economic and political factors than real objective science. Healy’s research is comprehensive in relation to the socio-political and economic forces that drive the pharmaceuticalization of medicine. Since the publication of his book, Healy has established Rxisk.org, a database populated by *psy* patients reporting their experience when taking medications in hope of counteracting the overwhelming pharma-industry, its biased research, and the worldview it indorses. Recovery literature, presented later in this chapter, stems from survivor and anti-psychiatry literature and provides some suggestion for alternatives.

Other critical perspectives on *psy* include Charles Rosenberg’s (2006) work entitled; *Contested boundaries: Psychiatry, Disease, and Diagnosis* which describes how in the past 50 years the pharmaceutical industry research and its marketing practices have shaped both medical and consumer notions of mental illness and its treatment. His critical history outlines how *psy* diagnosis have expanded exponentially since the latter half of the 19th century and how “emotional pain, idiosyncratic and culturally unsettling behaviours” have increasingly been categorized as disease. He comes to conclude: “diseases were deployed as rhetorical weapons in recurrent battles over cultural values and social practices” p. 423. Rosenberg also explains that he sees increasing dominance of the bio-medical reductionism model, where neurochemical and genetic models define mental illness. He shows how social and political influence shape *psy* diagnosis citing the 19th century dominant belief in determinism, made for the ‘sick- role’ as a personal responsibility. Rosenberg also cites government policies, health care reimbursements, and regulatory procedures, as having, in various ways, shaped disease definitions by validating certain interventions and thus influencing individual experience. He argues powerful

stakeholders are involved in decisions that relate to clinical practice. The result is a bias in what is legitimate mental health diagnosis and treatment. In the same light, this research study presumes that the lived experience of nursing students with mental health concerns is by the definitions of *psy* as defined by government policies, university policy, health care reimbursements, and regulatory procedures. Unfortunately, few articles spoke to this perspective; indicating that there is a dearth of research in this area. The literature did expose how women, as university students, might experience the *psy* diagnosis and *psy* treatments. These studies used feminist theory as the primary lens for critical analysis.

2.4.2 Psy Diagnosis and Female Students

Susan Van Den Tillaart, Donna Kurtz, and Penny Cash (2009) used a qualitative critical feministic approach, to explore how women with a mental health diagnosis experience access to comprehensive health care. They based their research on over 20 years of literature that speaks to how people with mental health concerns receive inadequate health assessment and treatment. As experienced nurses, they noted that many social, cultural, economic, and gender issues affected women's efforts for wellness. They interviewed seven members of peer outreach group. The researchers asked how did your mental health diagnostic label affected your life and well-being. What was your experience with health care services prior to diagnoses? Are there things that are there, things that need to change, so that your health and wellbeing concerns become recognized? The authors write that the voices of the participants made known that participants' experiences revealed hegemonic and reified understanding located in language, practices and social relationships of health care professionals and in institutions" (p. 157). They conclude that women experience unequal treatment and are marginalized, stigmatized, powerlessness, and silenced. The researchers found that personal and societal stigmatization related to mental health diagnosis

played a substantial role in the perceived isolation and unsatisfactory experiences. The study ends with the participants' ideas for change that could decrease institutional and interpersonal barriers. The researchers conclude that participant narratives can raise awareness and help practitioners gain a broader understanding of what contributes to sustained poor health outcomes. These narratives show stigmatization as embedded in cultural, political, practices, language and professional and social relationships. These embedded practices sustain the inequalities the women in this study experienced. The researchers challenge nurses and other health care professionals to listen to the voice of persons with mental health concerns; to act with an emancipatory intent to support the empowerment of clients with mental health concerns; and lobby for change in the health care system that currently puts those with mental health concerns at risk by marginalizing, disempowering and silencing. The strength of this research project is that it captured the voice of the participants with mental health concerns. The study appreciated the complexity of the lived experience. The study also viewed those with mental health concerns not as victims of illness but as survivors who can be empowered to transform their lived experience. A limitation of the study is that no recommendations for how nurses can move forward to transform the health care system policies and practices.

One year later Marilee Reimer and Melanie Ste. Marie (2010), two Canadian researchers, examined the lived experience with mental health concerns of six first generation (first to go to university in their families) female university students at two universities using institutional ethnography. The researchers focused on experiences with university support services. They were interested in the institutional processes that lead to their diagnosis and *psy* label. Along with interviewing the six participants, the researchers conducted in-depth interviews with Counselling Services and Student Health personnel. Reimer and Ste. Marie believed that as the

university underwent restructuring from a professional model to a business model (the corporate university) there was a drive towards an increasingly standardized approach to mental health services. The researchers state that their findings show that services offered and provided for women were the least costly meaning pharmaceuticals and not talk therapy. The women in the study did not consider the pharmaceutical interventions beneficial. Pharmaceuticals did not empower the women rather pharmaceuticals medicalized their experience. The researchers argue that helping students to discover the impact that their social context is having on their mental health is extremely important to improving their mental well-being. The researchers also found that students' mental health concerns were dominantly addressed using the bio-medical model and that this model dictated how services were organized and left them to believe they were responsible for their 'illnesses'. Their research findings also validated that medicalized support services within the corporate university desire efficiently (i.e. cheap) treatment for the highest volume of students. They conclude that services must move beyond the bio-medical model; however, this is likely impossible in the corporate university. A limitation of the study was that all students were liberal arts students.

An earlier Foucauldian critical review by Bondi and Burman (2001) found similar findings to Van Den Tillaart et al, (2009) and Reimer & Ste.Marie (2010). These researchers believe that with the emergence of individual psyche, subsumed with the *psy complex*, a person becomes responsible for their own mental health. The *psy complex* disavows feminine archetype characteristics such as empathy, sensitivity, compassion, tolerance, nurturance, and sacrifice while masculine archetype traits such as ambition, independence, assertiveness, and emotional control are 'normal' mental well-being at universities. In addition, the conceptualization and defining of normal or healthy mental health is ambiguous and typically defined by the

characteristics of normal healthy men; whereas abnormal mental health experience was more likely related to stereotypical women characteristics. Treatment is by far mostly pharmaceutical with the goal to suppress symptoms, rather than using talk therapy that attempts to address the distress and its causes. The authors refer to British National Health Services to show that white, middle-class women who have access to counselling and psychotherapy choose talk therapy over medication. Others on a fixed income, dependent on national health services, cannot access such therapies, as National Health Services policies do not allow for the reimbursement for talk therapy. Unfortunately, this article does not present the details of how the authors came to make these critical commentaries.

Being that nursing students are more likely to be female, an exploration of the experience of mental health concerns in nursing student requires an appreciation of the female perspective of how *psy* diagnosis and treatment is experienced. The aforementioned critical research studies provided a basic understanding of the critical feminine perspective and once again demonstrated that the lived experience can be sensitive to socio-cultural, political, and economic realities. This review will now move to focus on recent research that has critically questioned the role of the corporate university in how the students experience mental health concerns.

2.4.3 Psy, the Student, and the Corporate University

Two researchers, Levinson and McKinney (2013), used critical theory to examine *psy* on a Canadian university campus. They examined the history of college health services, interviewed providers (N=5), faculty (N=10) and students (N=22) of health services at a university. They critically appraised historical, social and media accounts of student mental health and pharmaceutical drug use (both prescription and non-prescription drugs), on campuses in the US and Canada. They believed there is an “elective affinity” between *psy* and the management

strategies of the corporate university. In their critical historical review, they note that since the 80's there has been a substantial increase in the number of psychiatric medications prescriptions to children and youth. The 1990s mark the first time that many universities saw students who were consumers of *psy* diagnoses and prescriptions. These students came with "assumptions about how routine experience is ever amenable to pharmacological modification" (p. 157) and thus came to university believing and asking for such interventions. The researchers found that half of their students describe themselves as high academic achievers, and describe the university as academically demanding, requiring them to use their medication to help them function. They also noticed that the media has promoted the idea that post-secondary education has become a high stake, high-pressure experience and consequently mental health services are in high demand. Levinson and McKinney (2013) then underwent a critical historical review of university health services since the 1980's, and concluded that services reinforced the expansion of *psy* by medicalizing ordinary difficulties into matters of mental health claiming that academic stress requires intervention. They substantiate their findings by listing the proliferation of public campaigns on campus addressing student *psy* concerns education that could include pharmaceutical treatments. The authors claim that their historical critic of corporatization in Canadian Universities parallels the diffusion of the *psy* on campuses and that they both hold a natural affinity towards each other. Firstly, *psy* and corporation both place emphasis on the individual responsibility and accountability. Secondly, the *psy* campus has become a marketing strategy for the corporate university, where mental health services are marketed as value added when choosing a particular university. Levinson and McKinney (2013) found that the corporatization of higher education, emphasizes efficiency and outcomes as well as services over teaching, and this reality promotes a *psy* culture on campus. In addition, the authors bring to light

the fact that government mandates over the last few decades have required universities to have *psy* services claiming this promotes student success. While well meaning, all these supports only further emphasize that students have mental health concerns, without ever hinting at the possibility that university culture may be making the students ‘sick’. The authors claim, the *psy* culture has successfully diverted attention away from the significant source of student mental health concerns: the values and worldview of the corporate university that turn students into businesses and profit centres and supports into marketing tools. Levinson and McKinney’s (2013) critical research captured several perspectives: that of the student, faculty, administrators, and service providers. The perspective of students is ample (N= 22 students). The perspectives of the others especially the health professionals (*psy* experts) are less substantial and limit this study. The historical critical analysis of student health services at one university is weak and another limitation. The strength of the study lies in the appreciation of the context in which students with mental health concerns find themselves and especially the implications of post – secondary corporatization on student mental well-being. No other critical research spoke to *psy* diagnoses and the student experience indicating there is a lack of research that explores the interplay of *psy* experience and the university, especially in its corporatized form. However, the literature revealed critical research that spoke to corporatization and how it affects post – secondary education and nursing practice. The following section of this literature review speaks to this research.

2.4.4 Corporatization of the University

In 2004, Florence Myrick, a professor in the faculty of nursing at the University of Alberta, published, her critical review where she explored the notion of globalization and its hegemonic influence on the university agenda and how corporatism is usurping the

teaching/learning process. She used nursing baccalaureate education as an exemplar. She makes the claim, that corporatization is transforming pedagogy by subliminally infiltrating corporate thinking into the university ethos. It is a hegemonic process that has insinuated itself upon what is taught and researched. Universities are becoming businesses that focus on efficiency and assisting students to adapt to the dominant corporate culture, where education is about students successfully identifying with, rather than critiquing, current social and cultural authorities. In particular, the author cites how education has moved towards professionalism and specialization that Myrick sees as spreading the corporate agenda. She suggests that “teaching is in jeopardy of becoming a form of procedural manipulation in which teachers require no authentic encounter with the student or with the curriculum” p. 27. The corporate university does not motivate teacher to become the best educator but rather to become the best researcher (i.e. fundraiser) who brings grants and recognition which in turn will serve to market the university; an important aspect of the corporate agenda. Myrick demonstrates that corporate ideologies and those of the nursing discipline can be at odds, making for a troubling educational experience. She also describes how western countries have seen the erosion of safety nets to favour corporate agendas, as seen when patients wait longer for care, and less resources are available for nursing care. The researcher argues that the hegemonic influences, inherent in the corporate agenda challenge nursing teaching and practice. This critical review is the first to address the corporate university agenda and its impact on nursing education. Other authors stress that nursing practice requires critical reflection (Stickley & Timmons, 2006; McAllister, 2008), however none offers a means by which nursing can stand up to the corporate university agenda.

The literature revealed a critical appraisal of corporatization of the university and nursing education by Gary Rolfe’s (2013). This article traces the development of the modern University

over the past 200 years and contrasts what it has become as a corporate identity. Rolfe then focuses his critical eye on nursing education since the 1990's. In juxtaposing the two critical reviews, he attempts to examine the tensions encountered at the interface between a professional practice and an academic discipline, and highlights that recent trend to corporatize the university influence nursing education and ultimately the nursing profession. Building extensively on Bill Reading's (1996) critical review of the corporatization of the university, *The University in Ruins*, Rolfe states the new corporate university has changed the ethos of the University from cooperative and collaborative to competitive, marketing itself as a centre of excellence. Rolfe uses the oft-cited claim that "excellence in research" only means excellence as defined by the corporate agenda, which has nothing to do with the best outcomes for nursing. The corporate agenda, does not consider a patient's outcomes but rather the value of a grant, and especially grants that contribute economically to the corporate agenda. Rolfe claims the current corporate agenda, where teaching is now competencies-based, high tech, high volume, high throughput with less and less direct contact with students, is challenging, and perhaps even dictating how to teach the discipline of nursing. As in Myrick's review, Rolfe argues that the corporate university ideologies are at odds with the ideologies of the nursing discipline. He concludes his critical review by paraphrasing Heidegger: "philosophy must be our way of dwelling in the ruined University". Rolfe's critical review is comprehensive and relevant to this study as nursing students with mental health concerns find themselves in the corporate university and a recipient of nursing education imbued with corporate ideologies. The tension between the corporate and nursing profession ideologies will colour their educational experience and the tension that faculty experience can contribute to a toxic learning environment that does little for mental well-being.

2.4.5 Nursing Practice in the Corporate Psy Institution

The literature search revealed one American critical reflection on corporatization of psychiatric hospitals. Wanda Mohr (1995) sought to explore how psychiatric nursing care ideologies conflict with corporate America, looking particularly at the privatization of psychiatric hospitals since 1991. The researcher posed the questions: “Can good nursing and corporatization co-exist?” Mohr sought to discover how the larger social, economic, and political influences within a hospital affects the psychiatric nurse-client therapeutic relationship. In this study, Mohr unpacks the emergence of the corporate for profit mental health hospital since 1980. The author investigates the ideologies of the corporation and then compares them to ideologies that are typically inherent in the nursing profession. The author argues that caring, holism, and advocacy, typical nursing ideologies do not easily fit with the dominant ideologies of the corporate culture. It is important to note that Mohr does not claim that the ideologies are incompatible; however, she does affirm that it is paramount that nurses become aware of potential ideological conflicts. A significant limitation is that the publication makes no mention regarding; methodology used in this project, what resources were tapped into or, who served as experts on the topic under study. It is the only article to address the impact of corporatization on nursing practice in the psychiatric setting. This once again substantiates the lack of critical reflection in nursing education and in nursing mental health practice (Stickley, and Timmons, 2006; McAllister, 2008; Rolfe, 2013).

2.4.6 Lack of Critical Perspective in Nursing Mental Health Teaching

In Stickley & Timmon’s (2006) research article the authors argue that nursing students need to be challenged to consider alternative approaches to understanding mental health and illness. The authors believe that those entering into nursing school come to school with their lay

models of belief about mental illness infused in the tenants of the bio-medical model that are also informed by media accounts of people with mental illness who are violent, disabled, deficient or incapable. The authors challenge educators to provide nursing students with alternatives to this bio-medical and lay model. Sociological models such as Parsons 'sick role', Doyal's thinking that capitalistic thinking categorized what is 'disease', or Foucault's work on madness showing that mental illness is not an eternal biological phenomenon but rather a sociological construct, are vital in allowing students to gain alternative views of so called mental illnesses. Stickley and Timmons (2006) stress that Goffman's work is also vital as it shows that the mental health institution is a 'total institution' that controls every aspect of the person and that this control stigmatises the mentally ill. Stigma forces a 'sick' label onto those that are mental ill and causes more problems than the original mental health concern. The over representation of certain cultures and women in psychiatric care is also questioned with a critical lens of theory. The authors stress that such philosophical perspectives are invaluable for students to understand the complexity of mental health and the nurse-person therapeutic relationship. The authors conclude that it is easier to treat brain chemistry with chemicals than wrestle with the complexities of abstract ideas about society and culture that may imply moral responsibility. This critical appraisal surmises that university baccalaureate programs lack this critical educational perspective and therefore ill prepare students for practice. With, at best, one theory course and practicum on mental health, most nursing students at the undergraduate level expose students to little more than the bio- medical model. This poorly prepares nurses and leaves them as foot soldiers to the *psy* complex and bio-medical view of mental illness.

McAllister, M. (2008), also argues that nursing education has to change to move beyond a bio-medical content focus to one that promotes attitudinal change, which can be fostered with

critical literacy. In this study the researcher, evaluated the attitudinal changes of students exposed in a nursing course to media representations of mental health issues as well as critical theory perspectives. The author writes that although the response rate was only 30% she concludes that students claimed that critical literacy skills enhanced their clinical role, and that students felt engaged and enlightened by the experience and that their attitude towards caring for those with mental health concerns improved.

2.4.7 Critical Lens on Recovery

One critical appraisal on recovery was found in the literature (Barker and Buchanan-Barker, 2011). The authors maintain that the concept of recovery first appeared in the 1980's and is now commonplace in the *psy* fields, however definitions may still be unclear argue the authors. In the US, the concept emerged from the civil rights movement of the 60's and 70's when the belief in self-determination was of central value. However, in New Zealand recovery developed in a socio-cultural context that favoured cross-cultural dialogue, social support and pro-cultural factors (Schinkel and Dorrer, 2007). Although on a global stage, most government health care policies pertaining to mental health now require a 'recovery focus' it remains unclear what this means and in particular what values are associated with the conceptualization. The authors say that nurses need to claim and develop the concept of recovery as their own and be critical of how governments and others with political authority's come to refer to recovery and what a nurses' role in a person's recovery might be. This unfortunately is as far as the article goes to contribute to a critical appraisal of recovery. There is clearly a lack of literature.

2.5 The Mental Health Concerns Experienced by University Students

In 2013, Salzer (2013) conducted a comparative study of campus experiences of college students with mental illnesses and the general college student population. The aim of the study

was to examine campus experiences and relationships of college students, and to contrast findings between students with or without mental health concerns. Five hundred and twenty surveys were submitted representing participants from 357 different post-secondary institutions. Statistical analysis of four hundred and fifty respondents revealed that most, were female (79%), white (89%) and disclosed they were diagnoses with one of the following disorders; bipolar (37%); major depression (26%); and schizophrenia (42%). Most respondents had medication prescribed for their lived experience (73%) and received outpatient treatment (89%). The majority of the respondents were former college students (N=278) where the range of time since departing from school was from 0 to 40 years, with more than 50% having left school within 10 years of completing the survey. Multivariate analyses (MANOVAs) determined that students with mental illnesses face the same barriers as other students: financial stress, poor pre-existing academic skills, and lack of confidence. Weak campus engagement and relationships with others are associated with poor academic performance for both groups yet students with mental health problems experience greater problems because of the symptoms of their illness and perceived discrimination, which contributes to heightened distress and a greater risk for abandoning their studies (Salzer, 2013).

Although Salzer's study attempted to discover what difference exists in the university student experience between those with or without mental health concerns, the study design is fraught with problems that put the result validity, reliability, and generalizability in question. Limitations include that anonymous responses are unverifiable. Likewise, being that most of the respondents completed the survey years after their post-secondary experience responses time and experience can distort findings. Findings compared to norms based on four years of data that reflects cultures, values, and expectations of education and society from over a decade ago, from

a limited pool of post-secondary institutions can be misleading. I question the validity of comparing results without understanding the implications of social and cultural influences on the mental health experience. As well, most of the respondents reflect a narrow perspective on the issue that of Caucasian women diagnosed mental health problems, missing the experience of diverse students and silent sufferers that would be less likely to step forward. However, this last fact begs the question, why were most respondents white and female? Did they suffer more from mental health challenges? Alternatively, do they care more about the issue; do they feel safer discussing mental health concerns and therefore come forward?

Markoulakis and Kirsh (2013) published a critical interpretative synthesis of 10 articles pertaining to difficulties experienced by students with mental health concerns. The researchers teased out three constructs that captured the nature of the difficulties university students experienced: first, internal difficulties that were categorized as physical, psychological and social; second, external difficulties that resulted from structural forces such as university policy or funding and stigma; third, academic outcomes arising from academic impairment or fear of failure if mental health problems were disclosed. Although this article does not reflect primary research the insight into how to explore the complexities of the lived experience of students with mental health concerns as an internal, external or outcomes challenges can be useful as a means to comprehend the entangled nature of the lived experience of a student with mental health concerns.

A number of primary research articles published since 2009 attempted to capture the prevalence of mental health concerns by reaching out to students beyond those that came forward to the health or counselling services. These studies approached students in non-clinical settings, such as classrooms or student commons. These studies did not only track numbers but explored

how students experienced symptoms of mental health concerns as categorized by the DSM IV (Russell & Shaw, 2009; Eisenberg, Nicklett, Roeder and Kirz, 2011; Farabaugh, Bitran, Nyer, Holt, Pedrelli, Shyu, Hollen, Zisook, Baer, Busse, Petersen, Pender, Tucker, and Fava, 2012;). These studies invited students at their place of study to complete health screening questionnaires used to diagnose disorders; Beck's depression inventory (BDI); SCOFF designed to identify eating disorders; Leibowitz social anxiety scale and correlated responses on the screening tool with demographic information also collected. Researchers found 13% of students in three US universities, scored in a range that suggested symptoms of depression and 10% had suicidal ideations. Ten percent of the students studying at a large university across seven faculties in the UK reported marked to severe social anxiety (Russell & Shaw, 2009) and 13.5% of undergraduate females and 3.6% undergraduate males in a large American college (N=2,822) screened positively for eating disorders. Findings would suggest that in the post-secondary setting a considerable proportion of students would be afflicted with a wide array of mental disorders. However, all three studies claim that there are limitations to their result and that the screening tools used could be responsible for score inflation or incorrect scoring. For example, the SCOFF is a screening tool yet many students with positive screens would not necessarily qualify for clinical diagnosis (Eisenberg, Nicklett, Roeder, and Kirz, 2011). The BDI has a problem with construct validity regarding suicidal ideation (Farabaugh et al, 2010). Furthermore, all but one study were single site surveys or used opportunistic sampling (Eisenberg, Nicklett, Roeder, and Kirz, 2011), thus findings may be biased, and generalization is not possible. Eisenberg, Nicklett, Roeder and Kirz, (2011) warn that their study did not explore, the role of setting on the mental health experience, the availability of health services and qualities inherent

in the student character (academic competitiveness) which could contribute substantially to student's mental health experience.

Three years following Farabaugh et al, (2012) Ibrahim, Kelly, Adams, and Glazebrook (2013) published a synopsis of current research on depression in the university student population. The authors completed a systematic review of 24 primary studies published between 1990 and 2010 in hope of: identifying studies reporting on rates of depression among university students; examining the hypothesis that there is an increase in the rates of depression among undergraduate students; and attempting to score the quality of the research. Only one study used a semi-structured interview, the Mini International Neuropsychiatric Interview, allowing students to describe their experience beyond a standardized tool. The systematic review reported a prevalence of depression in university students that ranged from 10% to 85%. The extreme variation highlighted the difficulty of understanding the prevalence of mental health concerns. Problems with findings can be the result of many factors: methods of assessment (Weismann et al., 1996), geographic location (Steptoe et al. 2007) and demographic factors (Kaplan et al. 2008) to name a few. The extreme range in the data puts to questions quality of research on student depression (Ibrahim, Kelly, Adams and Glazebrook, 2013). The researchers write that the tools used screened for psychological distress rather than clinical depression thus inflate scores as well as missed atypical presentation which is more common in the young adult population. Furthermore, relying on self-report of symptoms, which 23 of 24 articles did, is likely to impact on the sensitivity and specificity of the classification of depression. It would seem, that very few students who did not have a mental health challenge would self-report, so not only are the high rates understandable but may also indicate poor sampling technique. Ibrahim et.al, (2013) conclude their systematic review stating that current tools are insufficient for the research task.

Despite tool shortcomings and an extreme range of prevalence, the study did reveal that the lowest level of depression found in the student population is higher than the general population rate in the US (9%) (Gonzalez et al, 2010), ergo continued scholarly inquiry to understand depression in the student population is warranted.

Other findings from Ibrahim et al. (2013) systematic review were that gender difference existed as 15 articles found a higher prevalence among female students. In regard to year of study higher prevalence of depression were found in earlier years, as Zivin et al., (2009) had found, but contrasted the findings of Adlaf et al., (2004) who found the highest level of mental health concerns in third year. Financial stability contributed to lower depression rates or better mental health. This parallels the findings of Timmins, Corroon, Byrne and Mooney (2011) and Macaskill (2013). Another important finding was that the researchers did not detect an increase overtime, of depression rates, in undergraduate students that confers with Ziven et al, (2009), and negates claims that post-secondary students are experiencing more mental health problems today than yesteryear. Ibrahim, et al, (2013) conclude their systematic review stating that there is evidence that depression represents a significant health concern in the university population and is a common internal experience of university students that is subject to external factors (economic pressures, living arrangements). However, the authors question if the high levels of depression reflect a normal experience as the majority of students are emerging from adolescence with its emotional and hormonal instability. They concur with the National Institute of Mental Health (2009) that high depression rates may be a result of stressing about their future and employment (Ibrahim, et al., 2013). In other words, many students are 'growing up' in University and it may be temporary, in effect, their 'anxiety' and 'depression' can be a normal phase in a process of maturing, of transitioning from one developmental stage to the next.

Wynaden, Wichmann and Murrays (2013) research also attempted to gain an understanding of mental health concerns as experienced by university students. The goal of this exploratory work was to explore students' mental health experience at one point in time at a university to enable strategic planning regarding university support services. The open-ended survey sought information about barriers and supports for mental health concerns. The study revealed that 87% of the students did not consult health professionals, largely because they did not know if their concern warranted help from a professional. They were afraid, embarrassed, or ashamed to access such help, and a significant number of respondents (22%) did not have time or could not pay for treatment (12.3%). In the discussion, the researchers conclude that a significant number of university students do suffer with mental health concerns that affect their academic performance and stigma continues to be a major factor in accessing support. Limits of the study were the use of an online survey; such a tool does not allow for clarification and may lead to misunderstanding of the written word. The survey captured far more female student responses and only a portion of the student population. However, findings did parallel other studies and contributed to the literature that enforces the need for enhanced education of staff and students regarding mental health concerns and reducing stigma.

2.5.1 Mental Health Concerns as Experienced by Nursing Students

A review of the literature confirms that many post-secondary students face challenges to their mental health. Programs that require simultaneous academic and clinical components, such as nursing, have the potential to pose a greater threat to student mental well-being (Nolan & Ryan, 2008). Timmins, Corroon, Byrne, and Mooney (2011), using Lazarus' Stress Theory set out to identify student stressors associated with a nursing program and examine the impact of this stress on the student behaviours. Nursing students completed a survey based on the College

Lifestyle and Attitudinal National survey (N-246) in a university in Ireland. Only currently enrolled nursing students participate thus this study did not capture the view of students who may have left the program because of mental health concerns. The majority of students considered their mental health as good or very good (69%) the remaining (31%) did not. Fourth year students were the least likely to report they had good mental health. Significant factors that elevated student stress were examinations, assignments, financial situation, needing a job to support studies, relationship with clinical staff and clinical assessment of competence. These stressors are not in themselves unusual for any post-secondary student, save for stress resulting from conflict with clinical staff, which has been identified as problematic in other studies (Gibbons, Dempster and Moutray, 2008). What was noted in the study was the compounding of more than one stressor as the typical lived experience of nursing student. The researchers also found, although some students talk to peers or family as a means to reduce stress, most nursing students prefer to remain silent and “to go it alone” (Timmins, et.al, 2011). Oddly, while nurses and nursing programs teach others how to deal constructively with stress nursing students in this study did not practice or role model this behaviour. Further research that explores the relationship between stress, mental health concerns, and nursing is encouraged for the mental well-being and sustainability of future practitioners.

Gibbons et al. (2008) published their qualitative study that identified experiences that led to both distress and eustress (good stress) in nursing students. The researchers conducted focus groups with 16 final year nursing students, as they would have the most experience with potential stressors. During the hour-long focus groups, the students commented on what they found to be sources of eustress and distress. Four themes surfaced from the data: clinical experience; level and sources of support; learning and teaching experience and; course structure.

Clinical experience was distressing when students noted a difference between theoretical teaching and what they saw on the units, and when units were understaffed. Eustress came when students had their practice validated and positively evaluated by other nurses on the unit. The 'perceptions of the ward team' were critical in determining stress levels. Students also shared that they experienced varying levels of faculty support (or from tutors) during their clinical experience. This support did not equate with more time but rather the quality of the feedback given to students. Focused attention seemed to favour eustress whereas being criticized added to stress. For many of the students the most valuable source of support was in fellow nursing students. Learning and teaching experience provided several avenues to raise levels of distress. Firstly, students experienced significant distress when they perceived themselves disadvantaged because one tutor (clinical faculty) provided more support and guidance than another did. Secondly, students were distressed when they felt their tutor or the tutorial system (laboratory) did not equip them with the skills expected for examinations. Thirdly, students also felt distress with delays getting feedback. The way a course was structured was a major source of distress as well. Class organization and key information presentation could be distressing. Most students needed to work part time to support their studies and this added to their time pressures and therefore added significantly to the distress they perceived. Many of the students in the study stated that the demands of the course were too high. The study had several limitations. It was a convenience sample therefore was not representative of the student population (all were female). The authors caution that students feared their responses could affect their progression in the program resulting in a positive bias. The authors suggest an anonymous questionnaire as an alternative method to assure less biased responses, however a questionnaire would drive responses and not leave room for open-ended reflections. The researchers could have considered

having the focus groups led by non-partial facilitators, who were not involved in any way with the nursing program.

2.5.2 Mental Health Concerns and Years of Study

Several studies indicate that there might be a difference in perceived mental health problems depending upon the students' year of study. Some researchers found that earlier years are more stressful (Bewick, Koutsopoulou, Miles, Slaa and Barkam, 2010; Ibrahim et al, 2012; Zivin et.al, 2009) and others claim that mid-way through a program of study higher levels of stress are found (Adlaf et al, 2004; Timmins et al, 2011). Four researchers were interested in seeing if the students' experience of mental health problems changed over their time in the university. Zivin et.al, (2009), as mentioned earlier, conducted a longitudinal study at one university in the US. They examined: i) the persistence and change in students' mental health status over a two year period as measured by tools that screened for several mental health problems common in post-secondary student population (anxiety, depression, eating disorders, self-injury and suicidal ideations) and; ii) the persistence and change in student's help-seeking behaviour over the same period. The researchers found that of the students who had mental health problems in 2005, 60% of the students continued to have mental health problems in 2007 although the degree of persistence varied substantially by type of problem. Depression, anxiety, self-injurious symptoms and suicidal thoughts were less persistent, meaning that fewer students reported negative symptoms on the screening tools whereas more students reported disordered eating symptoms over the two-year period. This demonstrates that most mental health problems lessened over the study period despite elevated stress levels. Adlaf, Demers, Gliksman, (2004) and Macaskill, (2013) found higher stress mid-way through post-secondary programs. These contradictory results tell us that researchers are having a very difficult time getting a firm handle

on this 'slippery' problem and that other methodologies may be required to attain meaningful insights.

Bewick et.al., (2010) explored changes in undergraduate students' psychological well-being as they progress through university. They surveyed students at the time of pre-registration and during each semester of every year of a three-year program at one university using the General Population Clinical Outcome in Routine Evaluation tool. Their findings show that students perceive the greatest strain on their well-being in semester one of each year and the lowest at pre-registration. They looked at anxiety scores and depression scores and found similar results for both mental health concern and no difference between genders. They also noted significant reduction in levels of distress as the student moved through the program. They concluded that there is heightened distress in university and that in particular students needed psychological support when transitioning to university. What needs further exploration is an attempt to understand if this distress is pathological or a normal manifestation and simply as part of this transition experience.

2.6. University Staff Members and Student's Attitudes

As the attitudes towards nursing students with mental health may play a key role in how a student nurse might experience mental health concerns and recovery, research that examined the attitudes and stigma was also included in this literature review. A study by Hansson, Jormfeldt, Svedberg, and Svensson (2011) of mental health professionals' attitude towards people with mental disorders found that negative attitudes were prevalent among staff in mental health care. This cross-sectional study investigated mental health staff attitudes towards people with mental illness and compared these attitudes with patients in contact with mental health services. Interestingly, most of the staff surveyed were nurses or assistant nurses (82%) and worked

predominately with people diagnosed with non-psychiatric conditions. The data showed that negative attitudes towards people with mental illness are prevalent among mental health care staff and that their attitudes are similar to the public that accessed the health care services. Younger staff had attitudes that are more negative. While the research reveals that negative attitudes exist among nurses in the workplace towards others with mental health concerns, little exists pertaining to attitudes of university/ post-secondary staff towards nursing students. One study by McAllister, Wynaden, Walters, Flynn, Duggan, Byrne, and Happell, (2014), details research on the experiences of university staff working with students who are managing a mental health problem. The aim of the study was to explore the nature, extent, and impacts of interaction between academic and professional staff and university students who disclose they are experiencing mental health challenges. Mental health problems included either a labelled diagnosis, an emerging disorder, or the presence of high stress that was leading the student to believe that their mental health was at risk. The researchers interviewed 26 university staff, 22 academics, and 4 professional staff from 2 Australian Universities. Data that pertained to how staff perceived students with mental health concerns showed that students had difficulty meeting deadlines; suffered increased stress and anxiety that impacted student performance; students had a range of difficulties navigating boundaries of social, professional and academic relationships; and students were more likely to not accept behavioural consequences. The study also illuminated that the majority of staff reported moderate or frequent contact with students with mental health concerns; either face to face, phone or email. Contact lasted anywhere from one term to the duration of the program. The study also brought to light that students initiated the contact by self-disclosing. All staff shared the perception that stigma associated with mental illness was not as prevalent as it was at a time earlier in their careers and that as a result more

students were self-disclosing. Being on campus, rather than in a virtual world, also seemed to promote student and staff rapport and thus an opportunity to discuss mental health concerns. The study found barriers to the initiation of staff support, including: students' unwillingness to disclose; distance learning; casual employment contracts (part time contract); unsuccessful outcomes with past student encounters; and staff lack of mental health knowledge. Factors that positively influence staff attitude and promoted staff engagement in student support were staff having prior mental health experience with either with a student, personal or family experience and staff being knowledgeable about side effects of medication. Staff also articulated organisational challenges that hindered their ability to provide support to students with mental health concerns. This happened when staff needed to report and tap into in-house counselling services, managers or the Employee Assistance Program. Overall participants perceived that their university lacked structured support systems for staff who wished to work with students with mental health concerns. This lack of institutional support became a deterrent to reaching out to students. The researchers concluded that staff were left feeling confused as to what was expected of them by the university; was it to educate or provide support? To help students with mental health concerns staff needed to strong emotional self-awareness and strategies to replenish their reserves of compassion and empathy. Unfortunately, the staff do not feel the university supports the important work of supporting students with mental health concerns. Staff involved in preparing students in professional program, like nursing, was particularly uncomfortable and morally stressed because of inherent risks for both the graduate and the clients. Staff expressed confusion as to how "academic staff work to protect the ideals of their profession, while fostering the personal goals and potentials of a student who is potentially unsuitable to practice, or for whom work in the field may be potentially damaging?" (p.40). This

finding pertains directly to nursing student and faculty and may be a factor in this current study exploring the lived experience of nursing students with mental health concerns. The researchers conclude their study with a striking observation that none of the staff participants mentioned strengths of student with mental health concerns; they only focused on disordered behaviours and potential negative effects. This in itself speaks volumes to the overarching attitude of staff towards student with mental health concerns. The authors end their study with the recommendations for a systematic review of university policy, strategy and services and the development of guidelines on how to support student with mental health concern. Staff are asking that their role is explicitly acknowledge and that staff are provided with the training and support they are requesting to support students with mental health concerns (McAllister, et al.,2014).

Another study examined how Universities are coping with students with mental health challenges, this time in the USA. Brockelman, Chadsey, and Loeb (2006) assessed the relationship between information sources and university faculty perceptions when working with students who have psychiatric disabilities. Participants were randomly selected faculty at a large American university from a variety of colleges; however, the university did not have a school of nursing. Faculty selected (N=561) were mailed a survey with return envelope and postage. The response rate was 20%. Nearly two-thirds of the respondents were male, and taught in graduate and undergraduate program. Data was analysed statistically and more than half of the participants had experience with friends, students, or family having a psychiatric disability. It also revealed that 22 of the 106 respondents had personal experience with a psychiatric disability and 11 were currently living with a psychiatric disability. Overall faculties viewed students with psychiatric disabilities in a positive manner, and expressed being comfortable with having

‘these’ students on campus. A large number of staff did not feel adequately trained to work with students with psychiatric disabilities and would like resources to help them help these students. A significant finding from this study that could relate to this PhD study was that faculty self-experience with a psychiatric disability related to faculty positive perceptions of students with psychiatric disabilities, as did having experience with others with psychiatric disabilities. Limitations of this study included confusion that arose around the terminology ‘psychiatry disability’. The researchers claim using the term ‘psychiatric disorder’ should have facilitated understanding, however, this proved not the case.

The literature review revealed one phenomenological study exploring nurses’ attitudes towards mental illness, conducted by Michelle Gerrety, in 2013, entitled *Exploring Nurse Educators’ Experiences, and Attitudes towards Mental Illness*. This research contributed to gaining an understanding of nursing educator’s attitudes about clients with mental illness and explored nursing faculty’s perceptions of how their attitudes affect nursing students’ attitudes. Three rounds of semi structured interviews with six purposefully selected nurse educators, all of whom were non-psychiatric nurse educators served as the bases for data collection. The researcher reported that nurses held attitudes toward mental illness that were both favourable and unfavourable, where unfavourable was described as avoiding those with mental illness, avoiding talking about mental illness and perceptions of avoidance by association to have a friend with mental illness, meant being stigmatized by association. The data also revealed that past-experience with mental illness made for positive attitude changes in nurses, and that nurse educators believed that their attitudes transferred to their students. The researcher used the data to substantiate the importance of educating nurse educators about mental illness and assuring clinical experience in mental health for all nursing students and nurses.

Harms (2010) also published a Doctorate Dissertation exploring the perceptions, attitudes, and beliefs of 18 non-psychiatric nurse educators regarding patients with mental health concerns using a phenomenological study design. In an attempt to have participants share their perceptions, and attitudes, the researcher asked the participants to imagine working with someone with mental illness and then to describe images, thoughts or feelings that they experienced. Findings show that images centred on problematic actions observed in mentally ill individuals, the images engendered uncomfortable memories and treatments were most often the use of restraints. Consequently, perceptions of those who were mental ill were often negative. Faculty perceived themselves as lacking skills in mental health nursing. Attitudes were on a continuum and often influenced by past-experience; faculty who had known someone with a mental illness or familiarity and experience to offer had the most positive perceptions. Nurses believe others influenced their attitudes. They also believed that it was possible to teach empathy and compassion. They also felt that they needed to engender positive attitudes towards those with mental health concerns in student nurses. The study found that nurses, regardless of attitude, sought to prepare themselves and their students to work with patients with mental illness. Once again, the research points to the need to research more about how Faculty are being educated and developing positive experiences with students with mental health challenges and further that a phenomenological approach can be useful.

Bjorkman, Angelman, and Jonsson (2008) compared attitudes of psychiatric nursing staff and medical nursing staff towards patients with mental health concerns using the Level of Familiarity Questionnaire to measure attitudes towards certain psychiatric diagnoses. Data collected for three weeks, from 120 of the 150 registered nurses and nursing assistants at a Swedish university hospital, showed that sixty-six percent of the respondents had experience

with a patient with a mental health concern and twenty-five percent had a friend or family with a mental health concern. Positive attitudes, towards persons with mental illness were more common in mental health nursing staff as compared to medical-surgical staff. Likewise, staff were less likely to stigmatize those with mental health concerns if they work in a place where they come in contact with people in recovery, not only people in crisis (outpatient clinics as opposed to inpatient acute setting), and if nursing staff have, or have had, a close friend with mental health problems.

Happell and Gough (2007), two nurse scholars in Australia wishing to study why nursing students do not readily enter into careers in psychiatric mental health nursing, conducted a study where they surveyed 605 nursing students before their clinical placement in mental health. The instrument used was a modified Psychiatric/Mental Health Clinical Placement Survey for First day of Placement. The data was analysed using SPSS 12.0. The findings revealed that an overwhelming number of respondents did not consider mental illness to be the fault of, or a sign of weakness in the person experience a mental health concern. However, students did perceive themselves to be ill prepared for the practice setting and this added to their anxiety regarding their mental health placement. Attitudes to mental illness and mental health nursing correlated to preparedness, or theoretical knowledge. This research points to the need to dig deeper into understanding the role of the education of all nursing students in understanding mental health challenges of not only their patients, but also of their fellow students.

Building on Happell and Gough's (2007) work, the authors Poreddi, Thimmaiah, Chandra, and BadaMath, (2015) examined Indian nursing students' attitude towards people with mental illness and career choices in psychiatric nursing. They conducted a cross sectional descriptive study with 116 nursing students using the same tool that Happell and Gough had used

8 years earlier. They found that the majority of students held the attitude that people with mental illness are unpredictable, cannot handle responsibility, were more likely to commit offences or crimes and were more likely to be violent. Bennett and Stennet (2015) also explored nursing students' attitudes towards mental illness, this time with 143 Jamaican third year nursing students; however using a different tool, the Attitudes towards Acute Mental Health Scale. Their findings indicated that nearly half of the nursing students surveyed held negative attitudes towards mental illness and a perception that mentally ill people were dangerous. These findings support previous studies, stressing that negative attitudes persist in nursing student populations, especially among those from Third World nation. This may be a factor to consider as Canada has many internationally educated nurses and educates many international students.

In conclusion, the extent to which the literature describes studies that have explored the phenomenon of attitudes of administrators, staff, and faculty towards people with mental illness shows that this phenomenon is significant to fostering or hindering the mental well-being of people with mental health concerns. When nursing students with mental health concerns encounter negative attitudes from faculty or peers they will not disclose their lived experience and be more likely to hide symptoms. Likewise, attitudes held by administrators, faculty and peers could be stigmatizing. The literature will now turn to an investigate studies that have explored stigma as it relates to nursing students and their lived experience with mental health concerns.

2.6.1 Stigma

In searching, the literature for research that addresses the stigma associated with mental illness in nursing two systematic reviews surfaced. Ross and Goldner (2009) completed a systematic review of the literature that explored stigma, negative attitudes, and discrimination

towards mental illness within the nursing profession. Their research identified three positions that mental health services providers may assume in relation to stigma and mental illness: stigmatizers (those that stigmatize others), stigmatized (having experienced stigma) and de-stigmatizes. Nurses as 'stigmatizers' held negative attitudes, which was also substantiated by others (Haddad et al 2007, Thornicroft 2007, Bjorkman et al 2008). Nurses as 'stigmatizers' had fear of the mentally ill, often similar to those stereotypes found in the general public, that people with mental illness are violent and can easily lose control of themselves and nurses fear they might inadvertently provoke an explosion of uncontrollable behaviour through something they say or do (Hardcastle & Hardcastle, 2003, Santorius & Schultz, 2005 and Thornicroft, 2007). The researchers found that nurses feel they lack the knowledge and skills to be competent and confident working with people with mental illness. They recommend additional education regarding mental illness and mental health for nurses to deal with this knowledge and skill gap, as do others (Bailey 1994; Hardcastle & Hardcastle 2003; Lethoba et al. 2006 Mavundla 2000; Reed & Fitzgerald 2005). Ross and Goldner (2009) also found Nurses as 'stigmatizers' blame and shame those with mental health concerns, citing, Thornicroft, 2007, and Halter, 2007 and several studies show that nurses could perceive people with these diagnose as 'bad' or 'difficult' (Deans & Meocevic 2006, Thornicroft 2007). However, Ross and Goldner (2009) make an astute commentary that perhaps some of what is perceived as negative behaviour might result from what is considered the best model of practice at this point in time, for example; being emotive when working with a person who has Borderline Personality Disorder. Nurse as 'stigmatizers' is also reflected in the articles that speak to the pessimistic attitude nurses hold regarding prognosis outcomes (Munro & Baker 2007, Thornicroft 2007). Ross and Goldner (2009) systematic review goes on to demonstrate that nurses are also

stigmatized, specifically those nurses who have mental health concerns or by choosing to be a psychiatric nurse, thereby associating with persons with mental health concerns. Nursing student submersed in the culture of the nursing profession; may in some way experience stigmatization when in clinical that can interfere with their own mental health care. What is of central interest of Ross and Goldner's (2009) literature review are the findings that nurses who have mental health concerns are 'stigmatized' by their profession. Two study that surfaced in Ross and Goldner's (2009) review exposed that nurses who struggled with mental health concerns were targets for 'horizontal violence' with shunning reactions from nurse colleagues and nurse managers (Farrell, 2001, Thornicroft, 2007). Clearly, the consequences of stigmatization are far-reaching and dangerous. Later in this chapter when the focus of the review turns to stigma towards nurses with mental health concerns more elaboration on the consequences of stigma will occur.

An interesting study by Jennifer Charles (2013) used ethnographic content analysis of client and family member authored literature around the concept of provider stigma to develop a conceptual model of the lived experience of provider stigma and served to inform this research project. She is a social worker who identified important themes related to the experience of mental health service clients' and their families in a search for client and family-authored books over the last 20 years. The research used Altheide's (1987) method for data collection and analysis for ethnographic content analysis. The following five themes were identified as relating to client and family member's experience of provider stigma: (1) Blame and Shame; (2) Disinterest, annoyance and or irritation; (3) Degradation and dehumanization; (4) Poor prognosis/fostering dependence and; (5) Coercion and lack of "real" choice. The first theme, Blame and Shame, emerged as significantly salient and spoke to how clients felt their mental

health providers blamed them for the difficulties they were incurring, and for the less-than expected progress in their treatment. Supporting her findings with Hinshaw's (2007) work, where a crucial attribute of stigmatization of mental illness is controllability, which leads to the perceiver's blame of the person with mental illness (p. 32). Shame, Charles concludes, "Implies an inherent imperfection in the person with mental illness" (Charles, 2013, p. 33). Charles explains, "The provider's influence on the client extends beyond just the use of persuasion or threats, but also includes the use of their socially ascribed power and influence" (p. 33). The mental health client senses they lack choice and have no alternative but to take the medication, follow the rules. This lack of any 'real' options conflicts with the conceptualization of recovery where "a recovery orientation includes emphasis on choice", (Jacobson and Curtis, 2000, P. 3). The model of provider stigma that emerged from this study can serve yet another lens to gain understanding of the lived experience that nursing students with mental health concerns who may experience provider stigma. Provider stigma may come from multiple service providers in the case of the nursing student namely health care providers, and educational care providers (faculty, administrator). Limitations of the study are that the data from which the model arose are narratives from people who do not necessarily represent the general population. Someone who writes a memoir is likely representative of higher educational status and more likely to be an advocate for their cause. This study does not represent health care clients and family that do not publish their experience or the vast majority that likely have not recognized the influence of provider stigma in their lived experience with a mental health concern.

2.7 What Supports and Hinders Mental Health

2.7.1 Technology (Medication)

Kranke, Jackson, Floersch, & Townsend, (2013) explored the lived experience of college students with mental health concerns, with a particular focus on treatment perspectives and how treatment and recovery impacted students' school experience. This qualitative study was part of a large mixed method research project. The participants were 18-21 years of age and mostly women (76%). The researchers gathered data using a modified interview tool. Themes emerged from the data using "substantive significance" which the authors claimed increased knowledge by attaching code names to any of the students' words that referenced perceptions of (1). Their need for treatment; (2). Their needs for psychiatric medications; (3). How others perceived their need for medications and: (4). Participant utilization of disability services, and mental health services. The authors claim that participants reported a sense of empowerment from using medication and mental health services. They also reported that the seventeen participants felt minimally stigmatized by mental health treatment. The participants felt; positive family influence; improved functioning; low shame associated with mental illness or taking medication; managing medications and mental health visits independently; and willingness to disclose reflected their lived experience. In the discussion, the authors write that "many of these college students were thriving academically because of the treatment that allowed them to focus on their school work and minimized problematic symptoms that were distracting" (p.225), yet they do not explain how they assessed for 'thriving'. The authors report "Treatment [medication] put these students on the same playing field as peers (...) likely promoted their integration into the community and the transition to college" (p. 225), but offer no measure of integration into the community and more importantly to this study no measure of

transition to college. The authors allege that their research showed that environmental factors may have contributed to positive mental health experience, describe as a ‘sense of empowerment’; these environmental factors were familial openness to mental illness which mitigated stigma, and a families’ ability to normalize the utilization of treatment by comparing their own experiences. This meant family members shared their own mental health experiences with each other. Another environmental factor was if the university community was open to participants’ mental illness; meaning that the student could speak about their diagnosis and treatment to others, although others was not clearly defined. To clarity, the researchers came to understand that this experience of surprising others with their ability to function well, despite a diagnostic label, equates with promoting self-esteem. The researchers do situate their research in the larger context of the western educational system and argue that this system promotes individual, goal oriented, exploration of diverse array of philosophies and appreciation for diverse perspectives and therefore may create a context for the acceptance of individual differences. The authors continue to argue this may favour a sense of belonging, alluding to students with mental health concerns on medication as being something other than a typical student, requiring special acceptance, being on the outside and needing acceptance by others. The authors also argue that the university offers students with mental health concerns, who might have experienced social isolation in high school because of their mental health concern, an “opportunity to improve a tarnished self-image in their new relationships in university” (p. 226). How the researchers could draw this conclusion based on the data collected is far from clear in the publication. The authors also stress that being self-driven and management of treatment [medication] affords this new beginning, a chance to correct a ‘tarnished self- image’. This conclusion seems to be simplistic as there can be other important factors at play. The

researchers do not entertain alternatives to *psy* medication. The authors conclude that encouraging students with mental health concerns to make ‘good’ decisions regarding to whom they disclose, is a form of taking control as is, gaining mastery of their treatment [medication] both of which could influence their university and future. These are bold claims yet not grounded in the research data presented. The article entitled “*I Feel like It Improves Everything*’: *Empowering Experiences of College Students Utilizing Psychiatric Treatment* by Kranke et al., (2013), does purport that psychiatric medication fosters student empowerment; however the data presented does not clearly substantiate the claims. The tool focused on medication as an intervention yet the authors go beyond medications to discuss environmental factors that were uncovered as also being influential in the lived empowering experience. Without articulating what empowerment meant to the participants who experienced mental health concerns, or its measurement, it is hard to see the connection between medication and empowerment claimed to be central to the study.

2.7.2 Institutional Structure

Health Canada reports that most mental illness occurs during adolescence and young adulthood. Colleges and university play a key role in creating inclusive communities, identifying mental health issues early and providing effective resources and supports for all students (Government of Ontario, 2011). In scanning the grey literature of the past ten years, publications addressing public policies addressing mental health have proliferated in Canada. In the following pages key polices and strategies will be presented, that pertain to students with mental health concerns and higher.

In 2006, the Standing Committee on Social Affairs, Science and technology, published *Out of the Shadows at Last: Transforming Mental Health, Mental Illness, and Addiction Services*

in Canada. This document was the first national study of mental health, mental illness indications in Canada. Over a period of one year, the Senate Committee received over two thousand submissions from people directly involved in mental health care from across Canada. The study used first person accounts to highlight the challenges surrounding mental health, mental illness, and addictions. The report revealed that Canadians: were confused and frustrated around the type of mental health services available; felt that healthcare providers lacked of knowledge and compassion and; had innumerable examples of stigma and discrimination that they had encountered from health care professionals, employers and the public. In response to the Senate Committee developed recommendations intended to inform institutions, service organization, and groups working to improve the lives of Canadians with mental health concerns. Recovery defined as follows,

“Recovery is not the same thing as being cured. For many individuals, it is a way of living a satisfying, hopeful, and productive life even with limitations caused by the illness; for others, recovery means the reduction or complete remission of symptoms related to mental illness” (Standing Committee on Social Affairs, 2006, p. 42).

The report stressed the need for recovery-oriented system where Canadians with mental health concerns would be involved in decision making, have choices around the types of services and their delivery. Services and supports reflect a personal unique path to recovery and offered at the community level. One of the key recommendations from the Senate Committees was the establishment of the Mental Health Commission of Canada (MHCC), funded by the federal government for 10 years (2007-2017), with the purpose of developing Canada’s first mental health strategy.

Towards Recovery and Well Being: A Framework for Mental Health Strategy for Canada by MHCC (2009) is a second publication that has implications for this study. This framework

has five goals that could have impact on nursing students within the context of the university.

Goal One: People of all ages living with mental health problems and illnesses are to be actively engaged in their care and journey of recovery and well-being. Goal Two: Mental health is to be promoted, and mental health problems and illnesses prevented wherever possible. Goal 3: People have equitable and timely access to appropriate and effective programs, treatments, services.

Goal Four: The best evidence, based on multiple sources of knowledge, informs Actions, outcomes are measured, and research is advanced. Goal Five: People living with mental health problems and illnesses are fully included as valued members of Canadian society. This study may illuminate how his framework plays out in post secondary institutions and in the lived experience of nursing students with mental health concerns. Three years later, MHCC published *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, (2012). These strategies would affect the mental health of university students, as the required policies would relate to education and health governmental domains under the jurisdiction of the provincial government. As mentioned in the first chapter of this thesis Priority 1.2 stresses that the mental health, mental illness, recovery and well-being of youth who are primarily students, is crucial to Canada and research in this area is warranted to inform policies and services. Priority 6.2 insists that we as Canadians must find ways to improve mental health data collection, research, and knowledge. Priority 2.2 emphasises that only by actively involving people living with mental health problems and illness in making decisions about service systems will Canadians be better served. This study will contribute to these priorities. This literature review will now leave the national perspective to turn to the provincial strategies and policies related to students with mental health concerns that published in the last 10 years.

In 2009, The Minister of Health and Long-Term Care of Ontario published this province's mental health strategy *Every Door is the Right Door: Towards a 10 Year Mental Health and Addictions Strategy*. The report began by stating that mental health care in Ontario is fragmented and people with mental health concerns are suffering unduly. The report proposed seven directions to ensure 'Every door is the right door' for actionable items: (1) Act early; (2) Meet people on their terms; (3) Transform the system; (4) Strengthen the mental health and addictions workforce; (5) Stop stigma; (6) Create healthy communities and; (7) Build community resilience. These goals trickle down through multiple levels of government to end at the door of the health service departments at the university. Funding for services are dependent on the institution demonstrating that it is implementing these strategies. The lived experience of nursing students with mental health concerns in a baccalaureate who attempt to access services on campus should access services based on these strategies. The Council of Universities (COU) responded to the Ministry of Health and Long Term with *A Response to Every Door is the Right Door* (COU, 2010). What is of interest in the document is the interpretation of the COU of the seven directions and the underlying assumptions of their recommendations. For example, the recommendation for Act Early, was that the COU would set up "crisis teams" or "student at risk committees" to promote campus safety "to intervene if students are suicidal; if they engages in threats or disruptive behaviour, or drastic changes in mood or behaviour" (p.11). This interpretation of 'Act Early' and the response appears steeped in stereotypical judgements about mental health concerns, namely that persons with mental health concerns are violent to themselves or others. Furthermore, it has little in common with 'Act Early' as understood in the recovery-oriented model, which was the original intent of the Standing Committee on Mental Health. If a person with a mental health concern reaches a point in which they are in need of a

“crisis team” as described by the COU, this person would have been in need for an extended period and that likely no agency/institution had acted early, or pre-emptively. This illustrates how the intention of the strategy can be misunderstood at the institutional level and thus at the procedural and intervention level. As the representatives of the policy makers at the university level, COU did not understand ‘Act Early’ as intended by the framework; subsequent policies ran the risk of being ill perceived and stigmatizing to students with mental health concerns. To the second strategic direction: ‘meet people on their terms’, the COU responded: “There are no universal guidelines that indicate what accommodations are best suited to assist students with mental illness” (p.12). COU suggests rigorous evidence-based understanding of what accommodation works best. Once again, the tone of this response puts into question what understanding of recovery does the COU have? Who is to establish the guidelines they are requesting and what is evidence for this evidenced based guideline? In order to transform the system, the COU is suggesting that the Ministry of Health and Long-Term Care secure more resources to help Ontario universities move to a ‘case management’ approach for students with mental health concerns. It is unclear what role the student with mental health concern will play on this case team and if the principles of recovery are central to this ‘case management’ model. Case management models typically infer that the person is sick and needs to management. This is very different from the expected recovery-oriented model of support. ‘To Stop Stigma’, the COU suggests targeted health promotion campaigns, but makes no suggestion regarding how to stop stigma. Although campaigns bring stigma to light, they do not necessarily mitigate the sting of stigma most students experience. To create healthy communities, the COU recommends awareness campaigns to ensure that faculty, staff, and students are aware of mental health services on campus. Awareness can assist to promote a culture of acknowledgement and trust,

which the COU believes will encourage more students, faculty, and staff to seek treatment. However, research presented in this literature review shows that those with mental health concerns do not feel part of a community (Levinson and McKinney, 2013). Awareness is helpful but how is the community encouraged to be more inclusive of those with mental health concerns? How are communities where students with mental health concerns thrive and belong promoted? The suggestion to provide awareness is a start but left at that it runs the risk of separating the community into those that need service and those that do not. It does little to foster an understanding of people being on a recovery continuum. The COU response demonstrates no understanding of recovery and therefore is ill prepared to develop university policy that embraces recovery. Curiously, COU does not comment on the seventh strategy, 'Build Community Resilience'. Does the COU not see a role for the universities to build resilient communities? This may play out in the lived experience of students with mental health concerns and may prove central in this proposed study in understanding the lived experience of students with mental health concerns on university campuses.

In 2011 the Canadian Association of College and University Student Services (CACUSS) organized a conference *Student Mental Health: A Call to Action* and in preparation for the conference, Dr. Gail MacKean (2011) published *Mental Health and Well-being in Post-Secondary Education Settings: A Literature and Environmental Scan to Support Planning and Action in Canada*. The literature scan revealed an increasing attention to post-secondary student mental health by researchers, educators, and policy makers. McKean's research asked the following questions: is the prevalence of mental health problems increasing in post-secondary institutions and if so why?; and are there other options to the current model that primarily focuses on 'treating' students with mental health concerns which "is neither the most effective

way to go nor is it sustainable” (p.7). The scan then listed four models of care used in student mental health at the time of the scan. All targeted multiple levels of intervention and used a systemic approach to address student mental health. Kean articulates five tensions in post-secondary student mental health. They are as follows: 1). Post-secondary institutions values and roles (educating workers vs. developing citizens): 2). Resource allocation to student mental health (mental health promotion vs. mental health services): 3). Student population of focus (student with psychosocial disabilities vs. entire student: 4). Orientation of mental health services (traditional service provision vs. recovery): 5). Models of health (Bio-medical vs. Ecological). All of these tensions will likely contribute to the lived experience of students with mental health concerns within the context of the university.

In 2013, the Canadian Association of College and University Student Services (CACUSS) and the Canadian Mental Health Association (CMHA) prepared and published the report *Post-Secondary Student Mental Health: Guide to a Systemic Approach*. This document presents a framework for providing student mental health services on campuses and it focuses on environmental factors that lead or aggravate mental health issues. This framework also makes promoting health and wellness on campuses a priority to reduce the risks of mental health concerns. The framework suggests that if the goal is to transform mental health services on post-secondary campuses then actions must occur at different levels. These levels include: 1). Institutional structure (organization, planning, and policy): 2). Supportive, inclusive campus climate and environment, 3). Mental health awareness, 4). Community capacity to respond to early indicators of student concern, 5). Self-management competencies and coping skills, 6). Accessible health services: and finally 7). Crisis management. The framework also suggests that actions at levels 1-3 apply to all university students. Actions at levels 4-5 apply to students with

concerns who can cope and actions at level 6-7 apply to students struggling with mental health concerns. The framework clearly inverts the priority in the COU responses and suggests that post-secondary institutions put interventions in place before the ‘crisis’ point. However, critics of the framework fear that such a hierarchical framework will leave students, who are by nature reluctant to seek service, confused as to where they fit in the framework or give them the impression that services are only for certain students (Starkman, 2015). This levelling of interventions may be detrimental to fostering belonging to the overall community, as students are likely to identify with the cohort of people that represent their lived experience.

The Centre for Innovation on Campus Mental Health (a partnership project involving Colleges Ontario Council of Ontario Universities, Undergraduate Student Alliance, College Student Alliance and the Canadian Mental Health Association, Ontario Division), published the report *Environmental Scan of Promising Practices and Indicators Relevant to Campus Mental Health* (2015). The document identified at a provincial, national, and international level mental health programs and practices that would be useful for colleges and universities. The collaborative project proposed a framework to gather and compile data on student mental health services. The report admits that to date there are a number of promising practices that have been proposed in the grey literature, but few have been evaluated. The CACUSS framework presented earlier is an example of proposed model with little evaluation to date. The authors propose indicators for evaluation: retention rate for students with mental health issues; implementation of communication campaigns related to a mental health strategy; implementation of a screening process for early detection of mental health issues; number of training sessions for faculty/staff; implementation of student-led supports; wait time to access campus-based services, and suicide rate. In order to implement such a minimal of frameworks the authors argue that the campus

authorities need to; Build momentum and infrastructure; engage in a strategic planning process and; establish policies. The author surveyed current policies related to mental health on campuses and concluded that they are likely to relate to determinants of health; occupational health and safety; sexual assault, or be policies related to student housing, academic policies (grading, course and exam scheduling), or student code of conduct. Students who are experiencing mental health difficulties may also encounter policies relating to accommodation confidentiality and privacy. Students in distress will encounter policies that address disruptive at-risk behaviour, voluntary and involuntary leave policy. No policy that spoke to a recovery oriented model or how the post-secondary institution will understand mental health and well-being surfaced in the environment scan. The authors did look internationally and suggest that Canada might benefit from looking at the UK where a greater commitment exists to promoting mental health and supporting student experiencing mental health concerns and recovery. The environmental scan of promising practices also spoke to the importance of creating supportive, inclusive campus environments. The literature speaks to an increasing realization that the focus on treatment may not be the most beneficial for post-secondary students (MacKean, 2011). Rather more universities must focus their energy on a campus environment that is nurturing, supportive and promotes student mental health; increases mental health awareness builds community capacity to respond to early indicators of student concerns; teaches and models self-management competencies and coping skills; facilitates access to mental health services and lastly; has crisis management resources. What is missing from this nurturing supportive campus is an understanding of what recovery to a post-secondary student. This researcher believes that a recovery-oriented understanding would give students, faculty, and

administrators the perspective on mental health and well-being that would shift thinking and set the foundation for meaningful mental health services on campus.

2.7.3 Social Influences: Recovery

An important systematic review entitled *Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis*, surfaced in the literature (Lemay, Bird, Le Boutillier, Williams and Slade, 2011). This review synthesized published descriptions and models of personal recovery into an empirically based conceptual framework. From 366 reviewed articles, 97 met the researchers' criteria for inclusion: a conceptualization of personal recovery; an original model; based on primary or secondary research and was in English. The researchers developed a list of characteristics of the recovery journey. They also developed categories that typically described the recovery process. Connectedness (relationships, being part of a community), Hope and optimism about the future (motivation to change, belief in possibility of recovery), Identity (rebuilding a positive sense of identity, overcoming stigma), Meaning in life (meaning of mental illness experience, meaningful life and social roles, quality of life) and Empowerment (personal responsibility, control of life, focusing upon strengths) are key to recovery. This framework, argues the researchers, provides structure for research and clinical practice, and contribute to the development of measures for personal recovery. The researchers stress that the model is not rigid because recovery is individual, idiosyncratic, and complex. It serves as a guide for research. Bird et al., (2014) tested the validity and relevance of the Conceptual Framework of Personal Recovery concluding that the Conceptual Framework for Personal Recovery is robust and provides a defensible theoretical base for research however there is a need for an understanding personal recovery in the context of unique populations.

In summary literature that addressed the lived experience of post-secondary students, in particular nursing students with mental health concerns surfaced, and the studies were mostly epidemiological. Studies determined the frequency levels of *psy* labels (ACHA, 2008; Adlaf et al., 2004; Erickson-Cornish et al., 2000; Holmes et al., 2011; Ibrahim et al., 2012; Macaskill, 2013; Rimmer et al., 1982; Stranger and Printz, 1980; Stallman and Shochet, 2009; Stallman 2010; Zivin et al., 2009;). Only one study by Rugira, Nieber, and Wissing (2013) looked at student mental health and well-being (flourishing). A few studies found increasing ‘psy’ diagnosis in the student population (ACHA, 2008; Adlaf, et al., 2004, Erickson-Cornish, et al., 2000; Holmes, et al., 2011; Rimmer et al., 1982; Stallman and Shochet, 2009; Stallman 2010; Stranger and Printz, 1980). Others found rates decreasing (Zivin et al., 2009) or as the systematic review of all epidemiological studies from 1990-2010 concludes the numbers of students with mental health concerns has remained stable (Ibrahim et al., 2012) and is in fact no different from the general population Macaskill, 2013. A few studies used critical theory to examine frequencies of *psy* labels. In particular, the political, economic and social realities innate to these *psy* labels (Bondi and Burman, 2001; Frances, 2013; Healy, 2012; Levinson and McKinney, 2013; Reimer and Ste. Marie, 2010; Rose, 1979, 1996a, 1996b; Rosenberg, 2006; Tillaart and Kurtz, 2009). Other critical studies looked at the changing environment, particularly the corporate university and it’s contributed to the student and professor experience (Mohr, 1995; Myrick, 2004; Rolfe, 2013) and in particularly the student with a mental health concern (Levinson and McKinney, 2013; McAllister, 2008; Stickley and Timmons, 2006). One study found in the literature that critically appraised the concept of recovery concluded that although the word recovery appears in the literature it is poorly understood (Barker and Buchanan-Barker, 2011).

Methodologies used to study the lived experience of students and persons with mental health concerns included quantitative studies that implemented descriptive and correlation designs mostly using variety of survey tools. The number of qualitative research is increasing to the point that nearly all of the most recent work being qualitative in design using primarily ethnography, phenomenology, and grounded theory. Theoretical models that served to guide most studies were rooted in bio-stress theory, social theory exploring attitudes and critical theory. There is an appreciation in the literature that exploring mental health concerns required an understanding of the complexity of the experience of being a person with a mental health concern. Research that focuses simply on internal factors, meaning that the mental health concern arises from a flaw or problem inherent to the person, runs the risk of labelling persons, stigmatizing and squelching recovery that in itself has shown to foster mental health concerns. Social and critical models have provided a rich addition to the understanding of mental health concerns, where an understanding of mental health concerns takes more of an external focus meaning that mental health concerns arise out of contextual influences. As with any theoretical model, there is always a possible unintentional consequence of limiting a perspective to one lens and thus limiting understanding. With models that see mental health concerns as simply an external reality there is, a risk that the person will be understood more of a victim of context or victim of circumstance. Although this can foster activism, which is necessary to address the many inequalities and misunderstandings associated with the lived experience of mental health concerns. It may not necessarily help to gain an understanding of what makes for mental well-being or personal recovery.

After an extensive review of the literature, I chose to situate my research within the phenomenological perspective where I hoped to explore the interplay between these internal and

external realities. More precisely this study focused on how a student's experiences living with mental health concern, where living is often at the interface between internal, and the external realities, or what Heidegger described as *Dasein*.

CHAPTER THREE

THEORETICAL CONSIDERATIONS

3.1 Introduction

Phenomenology and Critical theory together serve as the theoretical framework to delineate the problem central in this study. As this study seeks to understand, the lived experience of undergraduate nursing students who have mental health concerns the chosen framework must allow for expression and exploration of personal internal experiences. Phenomenology is well suited for a study wishing to explore the lived experience. This framework allows for the voice of those directly involved with the phenomenon of study to speak. The researcher learns from the person who has experience with the phenomenon and captures the essence of the experience to understand the phenomenon. Although a lived experience lends itself to phenomenological lens, a study of mental health concerns may be more complex in nature and require a theoretical perspective that is sensitive to social, economic, and political realities. Forces external to the person may influence what reveals itself as a personal experience of living with a mental health concern; Forces inherent to the person's context, such as, stigma, health care system rules, or organizational structures. Critical theory as a theoretical framework allows for exploration of external influences that may be part of the reality experienced by the nursing student with a mental health concern.

Phenomenology uncovers phenomena in context and in this study; the context is the present-day University. The university is a business organization with systems, processes, and structures that create the environment in which a student learns works and lives. The university imbued with praxes that emerge out of current educational, social, and psychological can influence how relationships between the student and institution transpire. The praxes manifest in

university rules and regulations, policies and procedures. Thus, research wishing to understand the lived experience of the nursing student with mental health concerns requires a theoretical framework that not only allows for exploration of an experience, but also a framework that is sensitive to the structure of the university, as this context has influence on a student's state of being, *Dasein*. Critical theory and phenomenology together allow for an exploration of the internal or lived experience of a student with mental health concern whilst being sensitive to influences external to the student; influences that are part of the psychological reality of today and contribute to what becomes 'the lived experience'. The pairing of phenomenological and critical theoretical framework will allow for a deeper understanding of the complexity of modern student life and the mental health concern experience. The blending of these two theoretical perspectives is possible using Interpretative Phenomenological Analysis (IPA).

3.2 Interpretative Phenomenological Analysis

A research project exploring the lived experience of individuals lends itself well to phenomenological inquiry (Smith, 2004; Smith, Larkin and Flowers, 2009). Phenomenological inquiry is both a philosophy and a research method and recently IPA developed from phenomenological theory. IPA seeks to gain understanding by analysing the lived experience with phenomenology, but also permits the use of other theoretical lenses that serve to explain the complexities of the lived experience (Smith, Flowers, & Larkin, 2009, p. 164). Some proponents of IPA argue that to understand the lived experience within a complex context the researcher can blend IPA and critical theory (Smith, Flowers and Larkin, 2009). The same authors write, "while IPA provides a detailed experiential account of the person's involvement in a given context, Foucauldian discourse analysis might offer a critical analysis of the structure of the context itself and thus touches on the resources available to the individual in making sense of their experience"

(p. 204). The nature of *being* a nursing student with a mental health concern is complex; often the nursing student, professors, and university administrators are unaware of all the subtleties at play in the lived experience of *being* a student with a mental health concern. This research will bring to light the internal experience while being sensitive to the external influences that may impose certain understanding of *being*. Findings from this proposed study will then enhance findings from other qualitative and quantitative research that have explored the experience of student with mental illness, fill gaps identified, as well as serve to re-evaluate existing theory related to phenomenology and critical theory.

A theoretical framework that blends phenomenology and critical theory is not without controversy (Guba and Lincoln, 2005, p. 193; Shriner, 2002; Rayner, 2001). However, other researchers have come to see the richness of analysis when these two perspectives are blended (Dreyfus and Rainbow, 1983, Smith, Flowers, Larkin, 2009). Phenomenology and Critical Theory are compatible theoretical frameworks, not the opposite as some authors argue (Guba and Lincoln, 2005, p. 193; Rayner, 2001). These two theoretical lenses permit exploration of the complexity of modernity, sensitive to the imperceptible influences that are at play in this research, namely the mental health and illness experience. To satisfy academia and to dispel the fear that the theoretical perspective of phenomenology and critical theory are divergent and thus incommensurable, this researcher has undergone an extensive exploration of key conceptual underpinnings of phenomenology and critical theory to argue that the two theories can be blended when exploring the lived experience of nursing students with mental health concerns. The following pages will present the history, philosophical assumptions of phenomenology and critical theory, controversies between the two theoretical views and similarities. The descriptive/transcendental and hermeneutic/existential phases of phenomenology will be unravelled and key

Heideggerian concepts will be expounded upon; Dasein, Lichtung, Technology (Technicity), Total Mobilization and Enflaming. Parallels with the terms and concepts central to critical theory, regimes of truth, subjectification, governmentality, apparatus, diapositive, normalization, bio power, technology and the psychological complex will be explained to justify theoretical congruence.

3.3 Phenomenology

Ontologically phenomenology is a method that seeks to discover what is ‘real’ in the human experience, or that is truth at a certain time and place (Guba and Lincoln, 2005, p.193). Phenomenologists consider human beings as relational, historical *beings* whose fundamental nature is not given, but constituted by everyday life. ‘Life’ means the culture, idiosyncratic history, relationships past and present and social influences upon a person or group. The discovering of the reality of the living of everyday life is synonymous with Heidegger’s ‘*being-in-the-world*’ (Heidegger, 1927/1962, p.78). Epistemologically this study assumes a transactional/subjectivist stance: meaning that humans cannot separate themselves from what they know, and who they are, and how they understand the world is central to how they understand themselves, others, and the world. It is from the human and contextual interplay or relationship that understanding and meaning is derived (Parse, 1995).

A phenomenologist believes that knowledge stems from how we subjectively experience the world, and how we come to understand a given situation (Smith, 2004). Phenomenology is described as the philosophical study of ‘*being*’ (Larkin, 2013). Such a philosophical inquiry is concerned with the subjective experience and attends to the experiential underpinnings of knowledge (Holstein & Gubrium, 2005). Central to the nature of knowledge is “the nature of the subjective experience from the perspective of the research participant” (Harper, 2012, p. 27; Smith, J.et al., 2009). The method gives voices to the participant, and makes cognisant (or

“known”) their experience and thus contributes to the advancement of knowledge. Furthermore, according to Vander Zalm and Bergum (2000), knowledge gleaned from this particular experience can be beneficial in gaining an overall understanding of the issue. “Phenomenological inquiry yields empirical knowledge in the form of descriptive and explanatory theory, and understanding, which leads to practically relevant knowledge, and it also contributes to ethical, aesthetic, personal and socio-political ways of knowing” (Vander Zalm and Bergum, 2000, p. 217). Thus, this theoretical view aligns with the research question and method proposed.

Unlike other research, methods that attempt to test a predetermined hypothesis, the aim of phenomenology, and in particular IPA, is to explore in detail an area of concern (Smith et al. 2009, p. 53). Epistemologically, it holds an implicit assumption that the data will tell us something about “people’s involvement in and towards the world or/about how they make sense of this” (Smith et al. 2009, p. 55). Epistemologically, it relates to a postpositive paradigm (Clark 1998) and operates in-between relativism and social constructivism (Larkin, 2013). Moran and Mooney (2002) believe phenomenology is not always easy to describe but clarity comes when it is a way of seeing and a movement. The following paragraphs will describe how philosophers ‘see’ phenomenological inquiry and the subsequent ‘*movement*’ that transforms the philosophy into a methodology. To begin this discussion, it is important to understand that phenomenology has two significant philosophical phases: The descriptive–transcendental and the hermeneutic–existential phase.

Descriptive–Transcendental Phenomenology. Where today Phenomenology is as a research methodology, in the early 1920’s it was a philosophical movement, founded by Edmund Husserl (1859-1938) as a critique of psychologism and naturalism. Husserl argued that the study of consciousness could not use the same methodology as the study of nature, namely the

scientific method of induction (Larkin, Watts, Clifton, 2006). Consequently, Husserl (1952/1980) criticized how psychology was applying natural science methods to human issues. He argued that psychology deals with living subjects who do not simply automatically react to external stimuli, but rather are human beings reacting to their perception of what these stimuli mean to them. Husserl believed that this erroneous application of empirical reasoning ignored the importance of context and thus created a highly artificial situation (Jones, 1975). Husserl argued that matters of consciousness require inquiry that is sensitive to the unique individual perspective and therefore care to eschew researcher's presuppositions is required. Husserl actively sought to find a method by which someone might accurately know his or her own experience of a given phenomenon. Knowledge gained would contribute to understanding a phenomenon rather than test the hypothesis of a researcher as to what the phenomenon might be. The *'life world'*, is central to human science and it is understood by Husserl to be what a person's experiences pre-reflectively, without resorting to categorization or conceptualization (Husserl, 1970). For Husserl there could be no mind-body dualism, he viewed consciousness as a co-constructed dialogue between a person and the world (Valle, King and Halling, 1989).

Hermeneutic Phenomenology. Martin Heidegger (1889-1976), a student of Husserl, further advanced phenomenology as a philosophy by shifting the focus from human consciousness, psychology, to human existence, ontology (Paley, 2014). Unlike Husserl, who conceived of humans as constituted by state of consciousness (mind) in a body, Heidegger argued that consciousness is peripheral to one's existence (Paley, 2014). Heidegger focused on *'the mode of being'* or the situated meaning of a human in the world, which he conceptualized as *Dasein*. Heidegger argued that the question what it is 'to be' was conducted from the position of a *being*, being in time, rather than asking about being itself. Heidegger claimed that the meaning-

giving, knowing subject must be exchanged by a meaning giving, doing subject (Dreyfus, 1993). Like Husserl, the human experience was central to Heidegger's understanding however, for him that experience included the world and man '*being-in-the-world*', and consequently he gives priority to the temporality of existence. Thus, the focus of phenomenological inquiry is always affected by the world (Gendlin, 1967). In Heideggerian Phenomenology, experience or consciousness is always consciousness of something. Seeing is seeing something. Remembering is remembering something and this something, the object of which we are conscious, arises from a perception of a 'real' object in the world or through an act of memory or imagination. There is an intentional relationship between the object and the person's awareness of it (Lavery, 2003). To gain understanding of a phenomenon requires appreciation of this relationship or intentionality. In expanding on his thinking regarding intentionality, Heidegger also coined the term *comportment*, translated from the German term *verhalten*, to refer to directed activity. This directed activity was the structure of intentionality and helped to explain the way that human beings normally cope (Dreyfus, 1993). For Heidegger comportment represents not only conscious actions, but also non-conscious activity. Therefore, intentionality is not ascribed to consciousness, but to *Dasein*. To clarify, Heidegger strays from Husserl's thinking by referring to humans not in terms of a *being* (*sein*), a self-enclosed mind or bounded material body, but as '*Dasein*', a unique self-interpreting, self-understanding, way of being in the world (Aho, 2005). To Heidegger human beings are a *Dasein*- a *being* in the world. "Self and world are not two entities, like subject and object (...) but self and world are the basic determination of *Dasein* itself in the unity of the structure of being in the world" (Heidegger, 1982, p. 297). Previously Husserl conceived human beings primarily as knowers, Heidegger, in contrast, with his conceptualization of *Dasein*, began to view humans as being primarily concerned creatures, with

an emphasis on their fate in an alien world (Jones, 1975). This substantial philosophical shift moves human understanding away from a way we know; to the way, we are (Polkinghorne, 1983). To explore the way we are, Heidegger stressed the need to understand one's background or situatedness in the world. Dreyfus (1996) explains that Heidegger uses *lichtung*, a clearing, as a way to discuss situatedness, the things that make up our truths. Heidegger explains, "Only this clearing grants and guarantees passage to those beings that we ourselves are not, and access to the being that we ourselves are" (Heidegger, 1971, p. 53). To understand this conceptualization of situatedness, Munhall (1989) emphasises that to Heidegger people and the world are inseparable from cultural, social, and historical contexts. This is a significant development, central to this proposed study of the lived experience of students with mental health concerns. The study must explore more than how a student knows phenomena, namely their experience with mental illness, but also delve into the nature of being this student as well as their situatedness.

Dasein is further explained by Sheehan (2001) as to be there, in the midst of entities making sense a certain way (2001). Haugeland (2005) elaborates that *Dasein* is a way of life shared by members of some community. In Heidegger's book, *Being and Time*, he writes,

"That wherein *Dasein* already understands itself (...) is always something with which it is primordially familiar. This familiarity with the world, (...), goes to make up *Dasein* understanding of being" (Heidegger, 1962, p. 119).

Consequently, for Heidegger, human beings are always engaged, with the world and with other people. A human experience therefore cannot be studied separate from the time and place in which they are situated. Thereby *Dasein* helps us to gain insight into how we communally behave and why.

Enframing. Heidegger also speaks of another influence on *Dasein*, that of technology. Heidegger (1977) writes that technology is not the mere means, but rather a way of revealing (p.12), it is what orders, calculates, pursues, transforms, challenges and entraps nature (p.14-16), where nature refers to the nature of *being*. Heidegger uses the term '*Gestell*', translated as '*enframing*', to describe a destining character of technology where this '*enframing*' pushes *Being/ Dasein*, in a certain direction (Sawicki, 2003, p. 59). We cannot avoid its influence; rather it is a matter of how we respond to it (Godzinski, 2005). In an attempt to clarify what Heidegger meant of technology, Dreyfus (2003, p.40) coined the word *technicity* to describe the "way of revealing" or essence of technology whereas the tool remains "technology". The importance of this distinction is that Heidegger believed that the essence of technology (technicity) not technology is what causes human distress. Heidegger gives warning that technicity could entrap humans and distort *being*. Humans could use technology, but needed to free themselves from technicity. Heidegger claims "We can use technical devices as they ought to be used (...) and also deny them the right to dominate us, and so wrap, confuse, and lay waste the nature (as disclosers and preservers of worlds)" Heidegger (1959/1966, p. 54). Enframing as it relates to this research speaks to the influences that may order, transform, challenge, or entrap the experience of being a nursing student with a mental health concern.

Total mobilization. During the period of 1939-1940 Heidegger taught at the University of Freiburg and based much of his lecturing on the works of Ernst Junger *Total Mobilisation* and *Der Arbeiter* (The Worker). In these works, Junger spoke to the time of the Great War (WWI) and the period of upheaval that followed where there was an increasing mobilisation of human energy towards political causes and a severing of society from all its traditional moorings. Junger wrote that "the process by which the growing conversion of life into energy, the increasing

fleeting content of all binding ties (...) gives ever-more radical character to the act of mobilisation” (Junger, in *The Heidegger Controversy: A Critical reader*, 1998, p. 126). The same author emphasized that in modernity this is an ever-increasing movement towards total mobilisation “expresses the secret and inexorable claim to which our life in the age of masses and machines subjects us” (Junger, 1998, p. 128). Like Heidegger and Foucault, as will be explained later, Junger, saw the risk of technology, and how it, subjectifies the individual. Nursing students with mental health concerns may experience this tendency towards ordering in technicity or total mobilization or normalization according to Foucault, which will be elaborated on later in this chapter.

In addition, Heidegger believes that, phenomenologically, the human body is not a bounded corporeally, but rather it stretches beyond its own skin, actively directed towards and interwoven with the world (Aho, 2005). Being in the world entails an implicit connection to other human beings. A philosopher/researcher, cannot step into an objective realm, ‘outside’ of the world of the person; rather person and world are mutually –constitutive, a *mitsein*, translated as, *being with*, and cannot be separated. The two explored as one. Koch (1995) writing on Heidegger’s concept of co-construction believes humans are constructed by the world in which they live and at the same time are constructing this world from their own experience. Thus to a Heideggerian phenomenologist the ontological task of interpreting ‘*Being*’ becomes “working through the apparent self-evidence (i.e. historicity) of narrow, traditional points of view to the temporality of *Being* itself” (Racher and Robinson, 2002, p. 473). Any type of action we take is a way of constituting who we are in relation to others, self, and world. Hence, by engaging in practices we constitute ourselves as certain kinds of people in relation to others.

Phenomenology is explicitly a hermeneutic or interpretative activity. However, to Heidegger hermeneutics was not merely a matter of interpreting and thus understanding language nor was it a methodology for human sciences, rather it was ontology and this thinking revolutionized hermeneutics (MacCann, 1993). Heidegger believed that ‘things themselves’ are revealed (1962). To Heidegger, our access to *Dasein* is always through interpretation. However, understanding of *Dasein* was also gained from that which was not said or uttered, in the facticity, that which “refuses, resists, reverses interpretation and meaning” (Nelson, 2001). This hermeneutics of facticity, as Heidegger coined it, is also at the core of phenomenological philosophy. “Phenomenology is concerned both with examining the manifest and examining the disguised or latent meaning because they are integrally connected” (Smith, Larkin, and Flowers, 2009, p.30).

Idiography. Idiographic processes of inquiry typically use richly detailed description of a situation as experienced by its participants to gain understanding. Monothetic process investigate large numbers of people to establish behavioural laws that can be generalized to broader populations (Watt, 2014). Some phenomenologists “explicitly seek out idiographic meanings in an attempt to understand the individual which may or may not offer general insights” (Finlay, 2009, p.9). The phenomenological thinkers, who use IPA (Eastough and Smith, 2006; Smith and Osborn. 2003), are partial to a strong idiographic narrative element when exploring the particular health conditions experienced by the individual. IPA seeks to gain understanding of particular experiential phenomena from the perspective of particular people, in a particular context. This research project will explore the unique perspective of what it is like to be a nursing student with mental health concerns. To date the vast majority of research related to student mental health and illness has been from the monothetic perspective capturing the prevalence of students’ mental

health concerns. This research project will contribute to the literature by addressing this noticeable paucity of understanding of the idiographic, student experience. In the next section, we shall move from the discussion of Heidegger and phenomenology, which illuminates one side of the research question, to how critical theory aids in gaining understanding of mental health. In particular, the work of Michel Foucault, and his examination of social conditions lead to social constructions regarding what it is to be a person with a mental health concern. This added theoretical perspective is particularly useful in attempting to gain understanding of the nursing student's experience with mental health concerns as the nurses' experience 'is situated' in the context of the university and is inseparable from social economic and political realities.

3.4 Critical Theory: Foucault, Power and Psychiatry

Mental illness and its antonym mental health are highly disputed terms in medicine and social sciences both ontologically and epistemologically. Medicine has tended to favour an understanding that reflects a dualistic or binary framework, where mental and physical illnesses are separate entities, and mental illness is something to fix and restore. Social science has seen mental illness as more complex in nature and reacted to the simplistic medical perspective in one of the following ways (Pilgrim and Tamasini, 2012): i). Critical psychiatry- mental health problems are explicable within a common bio-psycho-social framework of understanding (Double, 1990; Pilgrim 2002); ii). Dysfunction-mental illness is a bio-medical reality where illnesses are reducible to bodily failures and dysfunctions (Guze, 1989; Baker and Menken, 2001); iii). Anti-psychiatry, mental illness is a myth and only physical illnesses are scientifically valid (Szasz, 1961); and iv). Deviancy-where mental illness is deviancy from the norm (Sedgwick, 1980). Although all four epistemological views can provide some understanding of mental health concerns, this study will take a critical psychiatry perspective were the lived

experiences of nursing students with mental health concerns will be explored within a bio-psycho-social framework using critical theory to guide analysis as to include all would be beyond the focus of this study.

A critical theoretical view begins with a historical examination of how, ideas came to be accepted as true, practices came to be accepted as normal, or how certain understanding of the world came to be accepted as normal. Foucault's 1961 research *History of Madness* is an exhaustive exploration of mental illness and psychiatry since the middle ages. Through studying Foucault's work Bracken and Thomas (2010) make the distinction that Foucault does not simply tell us how we should understand madness (mental illness today), or whether there is legitimate medical dimensions to madness and distress. Rather "Foucault wants us, as a society, as a culture, to engage with the way in which madness is encountered in all our lives" (p. 223). Foucault's classic research and his critical lens lead to an appreciation that the approach to psychiatry, mental illness and distress we hold today could have developed very differently had societal assumptions, values and priorities been otherwise. We can also conceptualize madness differently in the future if we are aware of the risks societal assumptions, values and priorities we all hold. As a post-structuralist, Foucault was sceptical of the current simplistic views of mental illness, and sought a different sensibility towards madness (Bracken and Thomas, 2010). His musings on madness with a critical lens introduce several concepts into the research lexicon: *Power, Regimes of Truth, Subjectification, Governmentality, Apparatus, Normalization, and Bio power.*

Power and Regimes of Truth. Foucault dedicated much of his work to the study of power, not simply to analyze the phenomena or its foundations but to "create a history of the different modes by which, in our culture, human beings are made subjects" (Foucault, 1983b, p.

2). Power as Foucault envisions is a relational conception, ubiquitous in nature, a network that fluctuates and permeates all social strata that produces and constrains subjectivity” (Gordon, 1999). It is not simply a property that someone possesses and uses over another it is subtle and far reaching. Power is not merely a negative, coercive or repressive force in society but it can also be productive and positive (Gaventa, 2003, p. 2). Foucault writes, “[I]t [power] produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that gained of him belong to this production (Foucault, 1991, p. 194). Foucauldian scholars surmise that power produces subjects (Taylor, 1984; Connelly, 1985; Thiele, 1986). Foucault sees power as part of a person an everyday experienced, as each person is socialised and embodied by this phenomenon. Since power permeates subjectivity, it is integral to the lived experience of a person. Power infuses the lived experience through ‘*regimes of truth*’. Foucault describe ‘regimes of truth’ as the background for discourses and practices at a given time and place, which orient what is possible to speak of as being true or false (Foucault, 1975, p. 145). These ‘*regimes of truth*’ set the groundwork for how people behave and are disciplined (O’Farrell, 2007). Foucault writes that it is imperative when producing science and exploring a phenomenon to take account how ‘*regimes of truth*’ play into the experience of the phenomenon. *Regimes of truth* may play a significant role in the lived experience of nursing students with mental health as their experience manifests through the discourses and practices set by the university.

Power and Bio power. Foucault spoke of ‘*regimes of truth*’ as the background for discourses and practices that orient what is possible to speak of as being true or false. Importantly Foucault stresses that power is not always negative, but often a positive and productive force (Bracken and Thomas, 2010). Foucault also coined the term *subjectification* to describe how the force of power acts on persons. Foucault states “It is because the body has been

‘subjectified’ (...) that the subject- function has been fixed on it, because of all this that something like the individual appeared, about which we can speak, hold discourse, and attempt to found science” (Foucault, 2006, p. 56). I believe that students with mental health concerns are subjectified, that the subject-function is fixed onto students by virtue of, what is expected to be normal student behaviour, and what young adults come to understand is mental health and illness by virtue of the discourses in the society. Foucault cautioned that power today is an inescapable pressure toward inclusion and uses disciplinary practices to order what is to be the lived experience (Dreyfus, 2003, p. 42). Foucault argues that disciplinary actions create “‘*Docile bodies*’ that can be subjected, used, transferred, and improved” (Foucault, 1977, p. 136). Power and its accompanying disciplinary practices embody what Foucault terms ‘*bio power*’. The purpose of bio power is to “manage and administer individuals and, by extension, communities and populations” (Perron, Fluet and Holmes, 2004, p. 237). According to Dreyfus and Rabinow, bio power is especially elusive and potent in driving conduct and slipped into our modern life ethereally (Dreyfus and Rabinow, 1983, p.196). Bio power has disciplinary technologies or apparatuses that are found in the depths of society; found within and between individuals, bodies, gestures, dispositions, and techniques (Foucault, 1977, 27). Techniques of surveillance, documentation, organization, administration, and examination (comparison, measurement, differentiation, and classification) are a few of the disciplinary technologies that push humans towards increasing normalization and standardization. This tendency to order is an ever-present force especially in modern day that drives human existence. Foucault warned that this tendency to greater order is not without its dangers and that madness and distress is one expression of the ‘technicalization’ of our way of life (Bracken and Thomas 2010). Whereas, *regimes of truth* must be analyzed, so should how a person’s responses to

regimes of truth. Foucault describes *Governmentality*, as a means to study the individual's capacity of self-control and *regimes of truth* (Lemke, 2000). According to Kiersay, Weidner, and Rosenow (2010) where there is conduct, veritably there will be a *governmentality* conducting it. Foucault along with Nikolas Rose further developed the notion of *governmentality* into two categories; technologies of government, which denote systems, procedures, devices and methods that shape the conduct of individuals and groups and; governmental rationalities which represent the current thought, reflections and calculations on how to govern efficiently and effectively (Rose and Miller, 1992). Governmental rationalities also include expert knowledge that *enframe*, translate, and render certain issues as significant (Triantafillou, 2004).

Power and Normalization. Related to *Governmentality* is *Normalization*, as norms and standards inform governmentality. *Normalization* is a term used in sociology that refers to a process through which behaviours come to be 'normal' within a society. The concept of *normalization* is explained in by Foucault, in *Discipline and Punish*, using the example of how a soldier is expected to behave, as the act of constructing what is considered the ideal norms of conduct, and how the ideal conduct is rewarded in those that comply or punished in those that deviate from the norm. Punishment or discipline can include the dominant aspect of society making the determination to put those that are deviant in a place where they will be rehabilitated, for example in a prison, psychiatric facility or educational institution (Fillingham, 1993). *Normalization* is therefore a powerful process that can exert maximum control with a minimum of disciplinary power (Foucault, 19977, p, 182). *Normalization* is a force that makes people homogeneous and values homogeneity. It measures differences between people, and judges. Foucault writes, that with *normalization*, "Only the aptitudes, knowledge and actions directly related to the overall needs of society are recognized or used" (Foucault, 1977, p. 138). In our

modern disciplinary society, *normalization* compares, differentiates, hierarchizes and excludes (Foucault, 1977, p. 183) and thereby controls citizens. *Psy* norms as determined by the DSM-5, and national standards or regulatory body standards are examples of how *normalization* operates in modern day society. Foucault continues to explain that *normalization*, with its established norms and standards invariably center on the individual being docile and productive, not different or acting in a manner that deviates from the norm (1980). Although the situation appears hopeless, Foucault is clear that the individual can resist power be it in the form of *normalization* or otherwise. Foucault argues that resistance is co-extensive with power and that the two concepts are not opposites rather they are “a matter of quite specific and changing struggles in space and time” (O’Farrell, 2005, p. 104). Resistance entails separating power from the forms of hegemony, within which power operates, be it in the social, economic, and or cultural context (Rainbow, 1991, p, 75). Resistance is evident when a group of deviant citizens rebel against the power and subsequently begin to create new norms and standards that define their group and further themselves from the dominant aspect of society. Within discourses, power and resistance manifest and can ‘evade, subvert and contest strategies of power’ (Gaventa, 2003, p.3).

Apparatus, Psychiatry and the *Psy* Complex. The *apparatus* is yet another concept that can further our understanding of power (Foucault, 1977). Foucault defined the term *apparatus* as “the institutional, physical, and administrative mechanisms and knowledge structures, which enhance and maintain the exercise of power within the social body” (O’Farrell, 2005, p. 129). Building on Foucault’s seminal work, and particularly the concepts of *apparatus* and *governmentality*, Rose contends that the person is amenable to the *psy* culture of the time as this *psy* culture, as does the apparatus, organizes everyday life (Rose 1996, 2003, 2007). According

to Donzelot (1979) and Rose (1996), this *psy* culture permeates our ways of knowing and acting. Rose, was compelled to understand the human experience of mental illness and through his research he realized that such exploration required examining “the ways in which the contemporary *apparatus* for “human being” has been put together: the technologies and techniques that hold personhood-identity, selfhood, autonomy and individuality in place” (Rose, 1998, p. 3). Rose conceptualized the *psychological complex*, from henceforth written as *psy complex*, as the *apparatus* from which the person knowingly or unknowingly came to be. As Rose who believes that understanding the lived mental illness experience requires sensitivity to the *psy complex*, this researcher concurs that an investigation of the experience of the student with mental health concerns requires sensitivity to the *psy complex* in which students exist. This *apparatus* determines what students; institutions and society consider truth and falsehoods in relation to mental health and illness. The pharmaceutical industry is an integral part of the *psy complex*. The *psy* industry actively constructs contemporary culture as it defines mental illness (Healy, 2009; Francis, 2013). The industry as a significant player in the apparatus subtly influences the student’s experience. Students are likely unaware that today they are arriving at university as experienced consumers of the ‘*psy*’ *complex* with diagnoses and prescriptions (Levinson and McKinney, 2013). Castel (1982) another critical theorist, sees the medicalization of youth as another tentacle of the *psy complex*. Castel (1982) argues that “moral deficiency became psychological maladjustment or emotional instability” and thereby psycho-medical techniques are the treatment of moral deficiency, which favour the *psy complex* (p. 42). This became more apparent since the 1990’s when large numbers of students began arriving in post-secondary institutions with psychiatric diagnosis who have been culturalized by the *psy complex* into believing that a normal ‘almost worry free’ life experience is possible with pharmacological

modification (Caplan & Elliott, 2004; Hyman, 2006; Rose, 2003, 2007). Castel further warns that ideologies can lead to flawed diagnosis and blaming the victim for their “maladjustment” (1982, p. 43). Research wishing to explore the lived experience of nursing students or others with mental health concerns, as Rose and Castel have demonstrated, must be sensitive to the *psy complex* if the findings are to have any significance and contribute to science.

3.5 Heidegger and Foucault: Critical Encounters

It is no secret that Foucault rejected Phenomenology and his frustration with the limitation of the theoretical perspective propelled him to develop his archeologically influenced critical perspective. He writes at the conclusion of his book *The Archaeology of Knowledge* that his research aimed “to free history from the grip of phenomenology” (Foucault, 1972, p. 203). However, some authors argue that Foucault’s early and later works show some theoretical parallels between phenomenology and critical theory (Dreyfus, 2003; Sawicki, 2003; Wyschogrod, 2003). Even Foucault himself acknowledges his intellectual debt to Heidegger. In one of his last interviews he claims Heidegger was “an overwhelming influence” (Foucault, 1982). Again, in 1984 Foucault claims, “[F]or me Heidegger has always been an essential philosopher (...).my entire philosophical development was determined by my reading of Heidegger”. Although his rejection of phenomenology is resounding at the midpoint of his philosophical writings, what is not clear is the ground for his rejection (Shriner, 1982). Shriner (1982) claims Foucault’s critique of phenomenology focuses on three concepts: the subject, the life-world, and the intentional-historical quest of origins. Firstly, for Foucault the subject is not the origin of knowledge but rather the body of anonymous rules that govern discourses (Shiner, 1982). Thus, Foucault questions a philosophy of science like phenomenology that gives justification for the supremacy of the subject (Foucault, 1972, p. 318). Secondly, Foucault rejects

the idea that one can return to the ‘things themselves’. Rather he believes a researcher should “substitute for the enigmatic treasure of ‘things’ anterior to discourse, the regular formation of objects that emerge only in the discourse” (Foucault, 1972, p. 47), meaning that discourses, would influence what is lived at any given moment, and these discourses are imbued with historical and culturally specific rules. Thirdly, Foucault discards the intentional-historical search for origins of knowledge. Instead of seeing the goal of science as revealing the original acts or essence, Foucault, “sees both the effort to describe constitutive acts in the present and the effort to penetrate traditions in order to reveal constitutive (founding) acts” (Shiner, 1982, p. 312). Science or knowledge is not an innate human attribute but rather a persons or society’s consciousness. To summarize the alleged dissimilarity central to Foucault’s rebuff,

“[It] come(s) down to a difference between the “seen” and the “said” between a phenomenology of perception and an analysis of discourse, between a perception which joins us to a world already permeated with meanings and a social discourse which orders us and our worlds by virtue of the rules implicit in various practices” Shiner (1982, p. 315).

I argue that there are lived experiences that sit at this intersection between perception and discourse and to study these experiences requires an appreciation of a world permeated with meaning and social discourses that order the world. For example, to understand the nursing students’ with mental health concerns experience requires an understanding of the social discourse, which implicitly influence the world they are living in. To elaborate, the focus of this study, the lived experience of nursing students with mental health concerns, lies at the point where the internal experience (perception) meets the external (discourses). Heidegger describes the nature of human existence, in modernity, as

“No longer the inner principle out of which the motion of the body follows; rather nature is the mode of the variety of changing relative positions of bodies, the manner in which they are present in space and time, which themselves are domains of possible positional orders and determinations of orders” (Heidegger, 1993, p. 288).

Therefore, forces in space and time determine the nature of human experience in modernity. Echoing this Dreyfus (2003) believes that Foucault and Heidegger provide a means to criticize the current cultural condition that contributes to the lived experience. Where both scholars merge is in their thinking is where they attempt to explain, “How any referent or object cognized by a human subject emerges within, and through, historically specific practices that predetermine the relationship between the subject, object, and the truths and knowledge(s) enveloping each” (Dreyfus, 2003). By expounding on the parallels between these concepts, I hope to show that Heidegger and Foucault theoretical conceptualizations are not incompatible but rather compatible and complimentary when using IPA as a methodology of inquiry to understand the lived experience of nursing students with mental health concerns. A Heideggerian phenomenological approach to understanding will provide holistic richness and depth of data required to gain insight into a phenomenon little understood, namely the lived experience of a nursing student with mental health concerns. Whereas the critical theoretical lens provides a means to analyse the discourses that influence the lived experience of the nursing student with mental health concerns, rife with influences that contribute to how a person’s experiences living with their mental health concern. A critical lens will permit analysis of interviews that will shed light regarding the discourses that nursing students with mental health concerns experience as they live out their student life. The following pages will explain the parallels of phenomenological and critical concepts that provide a theoretical foundation for this research project. Key concepts central to critical theory and phenomenology, will be explained namely: *Power and Being, Normalisation and Total Mobilisation, Bio power and Technology, and Governmentality and Enframing.*

Power/Regimes of Truth and Being/Dasein. The centrality of *Power* in Foucault's work seemingly contrasts with Heidegger's philosophical focus on *Being (Dasein)*, however, Dreyfus (2003) and Hamilton (2014) suggests parallels exist between these two concepts. For Heidegger *Being* is not a substance or a process, rather it reveals itself within a clearing (*Lichtung*) in which things and people can be encountered. In describing *Being* Heidegger states "there must always be some being in the open (*lichtung*), something that is, in which the openness takes its stand and attains consistency" (Heidegger, 1971, p. 61). Likewise, Foucault emphasizes that *Power* is not a substance, entity, institution or a process but the result of *Regimes of Truth*. Thus, both *Being* and *Power* have this non-substance quality. Foucault states that "Power is not an institution; neither is it a structure, we are endowed with; it is the name one attributes to a complex strategical situation in a particular society" (1980, p. 93). *Being* as described by Heidegger also reveals itself against "shared practices into which we are socialized provide background understanding of what counts as things, what counts as human beings (Dreyfus, 2003). *Power*, like *being*, incarnates in historical social practices (Dreyfus, 2003). Thus the two concepts, concludes Dreyfus, describe a situation whereby actions taken together, open a social space in which people, things and the real are defined (2003). When looking at Foucault's later work "we will find Foucault's view (on power and being) approaching Heidegger's as the two thinkers focus their analysis on the understanding of *being* characteristic of modernity" (Dreyfus, 2003).

Bio power and Technology. Foucault's concept of *Bio power* and Heidegger's concept of *Technology* (technicity) and related *Enframing* are similar and help to explain the lived experience. Foucault studied *power* over time and concluded that *power* had changed from classical to modernity, where modernity is both referring to the modern era (postclassical era)

but also the ensemble of certain socio-cultural norms, attitudes, and practices that represent modernity. *Power*, argued Foucault, is not an instrument that excludes, as it had once been, but rather it is an inescapable pressure toward inclusion. *Power* in modernity does not objectify, exclude, coerce or punish, but rather orders and enhances life (Dreyfus, 2003). “*Power* creates docile bodies and self-absorbed subjects, so as to produce ever greater welfare for all (Dreyfus, 2003, p, 42). This postmodern power and its practices of order embody what Foucault terms *bio power*. Heidegger and later Foucault deem that technology was much more than a tool developed from science. As mentioned earlier, Heidegger uses the term *Gestell* translated as *enframing*, to describe the destining character of technology where this *enframing* pushes the *being* in a certain direction (Sawicki, 2003, p. 59). In effect *being* is not free to act, as it will. For Foucault, technology describes both a mode of knowledge and a form of *power*. This *power* has disciplinary technologies or apparatuses that are found in society; found within and between individuals, bodies, gestures, dispositions, and techniques (Foucault, 1977, 27). Foucault warns that these disciplinary technologies are not neutral but inextricably linked to practices of domination, and techniques of surveillance, documentation, organization, administration and examination (1977, 27). Foucault further describes comparison, measurement, differentiation and classification as disciplinary technologies that push humans towards increasing normalization and standardization (Sawicki, 2003). Neither Heidegger nor Foucault believe humans can resist *power* or *technology* (*technicity*) directly because what “ultimately needs to be resisted is not particular technologies, nor particular strategies, but a tendency in the practices toward ever greater order” (Dreyfus, 2003, p. 47). This tendency to order is an elusive present force in modern day that drives human existence. Foucault warned that this tendency to greater order is not without its dangers and that madness and distress is one expression of the technicalization of

our way of life (Bracken and Thomas 2010). Although Heidegger did not explore madness or mental illness, he did believe that “technology fosters an antagonistic orientation to time, and therefore technology undermines our efforts to discover and inhabit a worldly home” (Thiele, 2003, p. 217). Disconnection with the real world is symptomatic of mental distress (CMHA, 2014). Recently Sherry Turkle, a researcher and professor at Massachusetts Institute of Technology echoes the same thought: “We make our technologies and they in turn, make and shape us” (Sherry Turkle, 2011, p. 263). Sherry Turkle writes that computers and emerging technologies are not simply tools but are part of our social and psychological lives (Turkle, 1984, Turkle, 2011). As a psychologist, she has written numerous articles on psychoanalysis and culture and on the lived experience of people’s relationship with technology. Most recently she has published the book: *Alone Together: Why we Expect More from Technology and Less from Each Other*, a critique on the effects of rapidly advancing technology on human social and psychological behaviour. Turkle warns that although we are as a society more connected, we are in effect more alone than ever before because of the technologies that claim to connect us. She claims that the technology that has become integral in the lives of youth and young adults is changing behaviour, and what is considered ‘normal’ may have deleterious impacts on how we relate to others and ourselves (2011). Turkle believes that technology is changing what is considered a healthy interpersonal relationship. Excessive dependency is now, with today’s technology that allows people to be in constant contact with others, considered the norm (Turkle, 2011). Turkle posits that emerging technology may be contributing to contemporary mental health concerns (2011).

Normalization and Total Mobilisation. A third conceptual parallel exists between Heidegger’s *Total Mobilization* and Foucault’s *Normalization*. Heidegger’s vision of modernity

is defined by a tendency toward a total ordering in *technicity*, which he terms “*total mobilization*” while Foucault’s vision of modernity is shaped by a totalling tendency of disciplinary *power* that results in ‘*normalization*’. According to Dreyfus, their concepts are one in the same (2003). Foucault speaks, in his book *History of Sexuality*, of “new methods of power whose operation is not ensured by right but by technique, not law but by *normalization*, not by punishment but by control” (1980, p. 89). *Normalization* is understood as a pervasive form of disciplinary power (Foucault, 1977). *Normalization* is a collection of “organizational forces that give shape and meaning to virtually every aspect of the modern world” (McWhorter, 2003, p. 122). Technology as mentioned earlier uses techniques (surveillance, documentation, organization, administration and examination) that increase the visibility of the individual however as defined by the standard of the technique or tool used. Consequently, how the individual is visualized, or how they appear to the observer is in relation to how they are judged by the tool. This is how technology increases *normalization* and the standardization of the population. In particular Foucault warns of techniques of examination that isolate; techniques such as comparison, measurement, differentiation and classification, as these techniques issue *normalization* judgements and thereby facilitate the discovery of the ‘abnormal’. The more an individual is seen as “abnormal” the more likely they are to become the subject of scientific concern (Foucault, 1977). Dreyfus (2003) concludes that both Heidegger and Foucault “see that there is something new and peculiar about the way in modernity, that normalization and total mobilization go hand in hand” (p. 43).

Governmentality and Enframing. Foucault’s exploration of *power* by virtue of scrutinizing madness (1961) led him to consider how the individual’s experience links to *regimes of truth*. From the exploration he distilled, the concept of *governmentality* (Walters, 2012).

Governmentality provides for a means to study the autonomous individual's capacity of self-control and its link to *regimes of truth* (Lemke, 2000). Governmentality relates to how people act in society and how they are 'expected' to act, and how social policies, institutions, and ideologies maintain ways of acting (Lemke, 2000). It encompasses the techniques and procedures that govern the conduct of both individuals and populations (O'Farrell 2005). Generally, *governmentality* is a device used to uncover the rationalities, technologies, and practices that conduct the conduct of actors (Hamilton, 2014). Where there is conduct, there will be *governmentality* conducting the conduct (Kiersay, Weidner, and Rosenow, 2010). It conducts the "multifarious types of practices occurring anywhere between various types of agents at the levels of self, family, group, institution, state, economy etc.", Hamilton, 2014. Hamilton believes that the conception of *governmentality* connects to Heidegger's conception: *enframing* (Hamilton, 2014). *Enframing* operates as an underlying power that opens the subjective space in which *governmentality* can emerge into being (Heidegger, 1977). Heidegger states that *enframing* is "modern sciences way of representing (...) and entrap[ing] nature as a calculable coherence of forces" (Heidegger, 1977, p.17). Hamilton contends: *enframing* governs *governmentality*, by introducing into human understanding a certain subjectivity through which objective representations can emerge (2014). Like Heidegger, Foucault believes that the self and *governmentality* are connected (Foucault, 2005, p. 252).

Parallels between Heidegger and Foucault's cease to be obvious at this point in the theoretical consideration. However, the critical theory conceptualization, *psy complex*, adds to the exploration of the lived experience of nursing students with mental illness. This concept speak to the subtle external influences that form the experience of *being*, which I believe play a role in experience of being a student with mental health concerns within the university.

3.6 *Being and the Psychological Complex*

Nikolas Rose is a sociologist who has done extensive work on the history of psychiatry and mental health policy and more recently on the social implications of psychopharmacology. An exploration of this relationship between the person and environment is not binary, according to Rose, but requires analyzing the person's words, the psychological *apparatus*, and the environment. For Rose the person or the self is a "coherent, bounded, individualized, intentional, and locus of thought, actions and beliefs, the origin of its own actions, the beneficiary of a unique biography" (Rose, 1998, p.3). Epistemologically, Rose believes we can never know the inner domain of a person; all we know is what they voice. Thus, ontologically an examination of the interior "psyche" of a person is an analysis of the exterior realm of language and attributes of mental status (1998). For Rose, uncovering truth in the epistemological sense, and entails examining the '*regimes of truth*', which ultimately determines the conditions, means and consequences "of the production in discourse of the effect of truth" (Rose 1979, p.11). Building on Foucault's seminal work, and particularly the concepts of apparatus and *governmentality*, Rose argues that the person is amenable to the *psy* culture of the time as this *psy* culture organizes everyday life (Rose 1996, 2003, 2007). According to Donzelot (1979) and Rose 1996) this *psy* culture permeates our ways of knowing and acting. Rose coined a new concept *psychological complex* also known as *psy complex*, which he defined as a heterogeneous but regulated domain of agents, of practices, of discourses and apparatuses which has effects on the person (Rose, 1979). Rose was compelled to understand the human experience of mental illness and realize that this required examining "the ways in which the contemporary apparatus for "human being" has been put together: the technologies and techniques that hold personhood-identity, selfhood, autonomy and individuality in place" (Rose, 1998, p. 3). In a paper presented

at a symposium in Heidelberg that sought to explore the forces that enter into the cultural construction of mental health, Rose (1991) maintained:

“that the traces, texts, procedures and practices that have surrounded, represented, explained and addressed the human person are not merely significant as representations of subjective reality or cultural beliefs (more than the unique person- or as in Heidegger’s thinking- a person is more than the body). They have constituted changing regimes of signification that provide the conditions under which persons can accord particular meaning to themselves and their lives, arrays of norms according to which the capacities and conduct of the self have been judged, techniques according to which selves have been shaped and reformed. They embody not just beliefs, but also socio-political aspirations, dreams, hopes and fears. They have been bound up with a proliferation of social programs, interventions, and administrative projects” (Rose, 1991)

Rose carefully denotes that the human *psy* experience is trussed to programmes, projects and techniques which those in authority use to shape and reform individuals. This psychological complex stanchions the regimes of judgement that make up the ethics, morals, truths and knowledge by which the person ultimately understands their lives, therefore exploring the *psy complex* that surrounds the nursing student will be significant to understanding the lived experience.

3.7 Science and the Challenge of Developing *Psy* Knowledge

For Rose science is the “outcome of the categories we use to think it, the techniques and procedures we use to evidence it, the statistical tools, and modes of proof we use to justify it” (Rose, 1991). The object of *psy* research is not a given, independent thing, which is merely discovered. It exists in relation to the *apparatus*. The domains of *psy* contribute substantively to the *apparatus*. Truth is intrinsically linked to the process through which the *psy* domain have defined the conditions of existence for the issue of concern or as to what “(...) problems, practices and activities have become psychological” (Rose, 1991). Building on Foucault’s notion of *apparatus* and related *surface of emergence* where troubles or problems are ‘rationalized’, codified and theorised (Foucault, 1972, p. 41), Rose warns that as practices, activities, and

experiences become psychological and are ‘problematized’. Therefore, a researcher attempting to expand science in the *psy* domain should realize that the very focus of concern, may itself be a psychological experience that has been unduly problematized (Rose, 1991). Consequently, a study exploring the lived experience of nursing students with mental health concerns will require a method that allows for careful attention to this possible unduly problematized psychological experience. Research grounded in critical theory as a method of analysis can be sensitive to the complexities that arise when attempting *psy* research and thus can bring us closer to understanding truth in contemporary society. Rose (1989) in his book, *Inventing Ourselves: Psychology, Power and Personhood* (1998), explains that his focus of inquiry is “concerned with the vocabularies, explanations, techniques of *psy* only to the extent that they bear upon the question of the invention of a certain way of understanding and relating to ourselves and others” (p.3). He claims this perspective of inquiry is particularly important for studies related to any *psy* discipline, where questions of inquiry often probe into the relationship between social administration and a certain conception of human abilities. Consequently, this perspective seems well suited for an exploration of the lived experience of a nursing student with mental health concerns within the university setting. Building on Foucault’s work, Rose attests he was able to “put into question the very nature of social and force us to see how it is constructed, by what operations of power and knowledge, through what strategies, under what conditions of inter correlation and dependency between the various discourses and practices which make up, and with what consequences” (Rose, 1998. P. 13). In effect, the *psy* disciplines link integrally with the transformation of *governmentality* (Rose, 1989). Rose (1998) argues that *psy* disciplines have made claims that the interior *being* can be mapped, assessed, and shaped and contemporary beings accept this as truth. This permits human beings to be regulated, to regulate themselves,

and to judge what is normal or abnormal, based on *regimes of truth* arising from *psy* disciplines. *Psy* disciplines are not merely a body of knowledge but rather an ‘intellectual technology’ that brings to light certain aspects of the internal being and how we come to understand ourselves and it is by means of these technologies that human beings are subjectified and governed (Rose, 1998, p.16). These technologies often take seemingly affirming forms, such as, programming to enhance self-esteem, social skills and empowerment, yet Rose stresses they are still subjectifying *being* (Rose, 1998, p. 35). He also argues that with the continuous developments of the *psy* disciplines, there will be further transformations in how we understand ourselves and this will necessitate critical appraisal if we are to understand the human experience. As subjectification is elusive, the norms of the *psy* discipline merge, often unobtrusively, with the person’s own values and beliefs, “in the process the object of psychology [the person] was itself disciplined. It [the person] became ‘docile’; it internalized the technical means to know it in the very form in which it could be thought” (Rose, 1998, p. 35). Rose does explain that resistance to this subjectification is possible. Resistance happens when “techniques of relating oneself as a subject of unique capacities worthy of respect run up against practices of relating to oneself as the target of discipline, duty and docility” (Rose, 1998, p. 35), meaning when a person begins to think of themselves, or understand themselves as worthy outside of the *psy* disciplines norms. Rose emphasises that the critical lens is a vital necessity when exploring issues pertaining to the human *psy* experience, “not to find failures per se but to reveal the extent to which reforms must pose as central not simply as a certain set of ends but also the means within which those ends are met” (Rose, 1998, p.11). Revealing relations of power as they pertain to the nursing student with mental health concerns is central to this study, not to find blame, but rather to encourage understanding and ultimately mental well being.

3.8 *Being* and the Pharmaceutical Industry

Since the 1980's we have seen an increased focus on mental health concerns and practices to ameliorate mental suffering. What is particularly noteworthy is the substantial increase in psychiatric prescribing and the growing number of persons identified to have mental health concerns, even children and adolescents. Dr. David Healy, a professor of psychiatry in the UK, and Dr. Allen Francis, an American psychiatrist, who chaired the DSM –IV committee, have written books that question this trend and speak to the powerful role the pharmacological industry plays in constructing the *psy complex*. This *psy complex* sets the conditions from which psychology and any mental concerns are addressed, explored and understood today (Francis, 2013; Healy, 2012). The industry has marketed to practitioners and the public the normalization of pharmacotherapy and thereby transformed ideas about personal identity, pathologies, and the potential of human experience into a construct amendable to chemical correction (Martin, 2006; Rose, 2003, 2007). Healey (2012) and Francis (2013) argue that the pharmaceutical industry also has a pervasive influence on academia and by channelling funding to research it favours the industry. This dictates what will be the focus of inquiry, the research lens used to understand research outcomes and finally how research outcomes/knowledge disseminates. Healy (2012) underscores that the *psy complex* and practices are corrupting *psy science*. Big pharma manipulates research by exaggerating the benefits, and minimizing the risk (Francis, 2013, p. 90). Furthermore, there is evidence of doctored data, compromised scientific publications (ghost writing), and or skilfully created needs, or problematizing of human conditions that will require pharmaceuticals to fix (Healy, 2012). The pharmaceutical industry is an integral part of what Rose calls the *psy complex* in that the industry actively constructs contemporary culture and mental health concerns. The *psy complex* is the context; *bio power* exists within the context. The

psy complex is the *Gestell* that students are not aware of, yet it sets the boundaries for what contributes to their lived experience. The pharmaceutical industry, integral to the *psy complex*, uses technologies, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM), to manipulate *psy* understanding. By funding the DSM, the pharmaceutical industry gains a substantial influence in defining normal or abnormal mental behaviour. This has served the pharmaceutical industry by providing record profits while problematizing normal life experience to the detriment of society and Francis warns that “the business model of the pharmaceutical industry depends on extending the realm of illness” (2013, p.28). An area of particular interest for the expansion of the industry is the creation of a market that “convinces the probably well that they are at least mildly sick” (Frances, 2013, p.28). Marketers in the industry have “allowed the focus of care to shift away from the very small cohort of really sick patients to the wider world of the worried well” (Frances, 2013, p. 88). Contemporary mental health and illness discourse demonstrates a comfort with the idea that many of life’s expectable problems are mental disorders that require correction with pharmaceuticals. As well, there are other societal forces, which promote the sense that we are more ill. One such societal trend is that while on the surface we are more accepting of physical differences our world is simultaneously less tolerant of mental/emotional differences in behaviour (Frances, 2013). Frances explains that “we have increasing less tolerance for difference or eccentricity and instead tend to medicalized (*problematize*) it into illness” (p. 82). Secondly, contemporary society continually chases happiness and sees worry as the antonym of happiness. Unfortunately, this unrealistic goal of continual happiness serves to play into the *psy complex*. Frances argues “falling short of complete happiness or failing to have a worry free life is often translated into mental illness” (2103, p.82). A third societal trend is our drive to set high, often unrealistic goals, in many

aspects of *being*; namely our intellectual, emotional, behavioural selves. Nowhere is this more visible than with the expectations place on children, youth, and young adults. Frances contends that when this population falls short of these unrealistic goals, often set by parents wanting the best, children, youth and parents become extremely vulnerable to the problematization of life and the promises of the *psy complex*. Frances laments that youth and young adults have a sense of identity that is fragile, uncertain, and unstable, which in turn leads to existential fears, precarious self-esteem, and erratic behaviours that can be interpreted as adverse *psy* symptoms (p.95).

Frances remarks it is no coincidence that pharmaceutical industry has expanded their customer demographics by pushing products onto children, youth and young adults (2013, p.95) often under the guise of promoting attention, calming emotions or managing disruptive or eccentric behaviours. Castel (1984), another critical theorist, also saw a powerful trend that contributes towards the medicalization of youth. Castel's critical work looked at the history of the mental hygiene movement and the dynamic between professional knowledge and the power to construct social realities. The mental hygiene movement, a precursor to the American Psychiatric Association, the authors of the Diagnostic Statistical Manual, conceptualized mental illness and health. The mental hygiene movement contributed to the transformation of juvenile delinquency into psychiatry of maladjustment in childhood. Thus Castel warns that since the turn of the last century the *psy complex*, "was and continues to be a driving force in sponsoring research that favours the problems of delinquency, psychiatry and childhood"(1984, p. 38). The *psy complex* dictates what normal behaviour is and prescribes pharmaceuticals to control any abnormal behaviour. This became more apparent in the 1990's when large numbers of students began arriving in post-secondary institutions with psychiatric diagnosis who have been culturalized by the *psy complex* into believing that an "almost worry free" life experience is possible with

pharmacological modification (Caplan & Elliott, 2004; Hyman, 2006; Rose, 2003, 2007). In the current study I will question if the nursing students lived experience with mental health concerns is a distillate of the *psy complex* where to be “normal” students requires *psy* chemical support.

The *psy* expert, the *psy complex*, and neoliberalism. According to Castel (1984), those deemed experts in the *psy* domains have become specialists in “psychological maladjustment” (p. 43). How one describes or addresses psychological maladjustment depends on the socio-cultural- political ideology in which the *psy* expert is situated. Ideologies can lead to flawed diagnosis and blaming the victim for their ‘maladjustment’ (Castel, 1984). Castel uses poverty as an example of this inter-ideological relationship. For example, many in the USA believe the over-arching political view was of the “wealth apologists”, poverty does not exist as a social and political phenomenon, but the poor exist because of their own actions (p. 43). Similarly, the neoliberal view is purported today; where the individual is an autonomous being and thus ultimately responsible for his/her self, and has made choices that have led them to their current situation. This framework sets the tone for blaming the student with mental health concerns for their behaviour and negates the role of outside forces on the individual. Levinson and McKinney (2013) carefully examine the role of the *psy complex* in the corporate university and its affect on students with mental health concerns. They write:

“Corporatization is the organizational trend toward adopting neoliberal management strategies in higher education, emphasizing efficiency and outcomes as well as the expansion of special initiatives and services over teaching. The emphasis on accountability and individual responsibility dovetail with campus efforts to increase awareness of the stresses of college life and to promote self – care for the prevention or management of mental health problems, through professional activities (therapy or medication) or community ones)” p. 372

This corporate environment fuels a model where academic success is measured by numbers and efficiency where students either reach the benchmarks and are thus deemed to be a success, or not. This model also propagates the ideology that students are wholly responsible for themselves,

their choices, behaviours, actions and thus the results of their efforts are solely of their own doing. Thus, all accountability ultimately rests with them and none with the institution/university where they are studying. A study that explores the lived experience of nursing students with mental health concerns will require an exploration of *being* a university student and a critical appreciation of the *psy complex* within the corporate university.

3.9 *Being* a student within the University

“What about this ‘life’ at and in the university? Is it the way the university is taken up and experienced? Indeed, the question must be posted concretely: how do we here, now, today, take it; how do we live it” Heidegger (2001, p, 57)

In medieval times, the University was as a society, company, corporation, or community within which the collective of teachers and scholars engaged in giving and receiving instruction in higher education. In Europe, universities began in cathedral schools and monasteries. In Germany, the role of the university was to conduct research where specialized professors helped student apprentices. In England, a strong emphasis was placed on providing an education “that embraced moral and emotional as well as intellectual development of the student” (Bok, 1982, p. 61). In the 19th century, the role of the university in North America began to depart from its European counterparts. North America was rapidly developing as an economic force and needed trained work force to feed productivity. Universities served society by providing knowledge and human resources. When World War II broke out, all universities focused their activities on the war effort, significantly changing the focus of higher education globally (Bok, 1982, p. 62). The post-war period saw universities responding to swelling numbers of students (the baby boomers) and with this came the need for more faculty and therefore more graduate schools. With societal pressures and increasing enrollment also came the demand for program diversity and the multiversity was born (Bok, 1982, p. 62).

Universities in Canada. Although some universities in Canada date back to the 19th century most Canadians in and outside of academic institutions began to debate the role of universities in Canadian society only in the post war years. Following WW II, The Royal Commission of National Development in the Arts, Letters and Sciences, also known as the Massey Commission (1951) determined that universities encourage cultural communication between provinces, supply the trained individuals and expertise necessary for continued economic growth and prosperity (Lexier, 2013). Later, the Gordon commission concluded that universities are the source of highly skilled workers whose knowledge is essential to industry (Gordon Commission, 1957). A third report published in 1965 by the Association of Universities and Colleges of Canada (AUCC), chaired by the Dean of the University of Toronto, determined the need for more governmental funding for post-secondary education to prepare for Canada's need for skill and knowledge workers. This report also highlighted the personal gains education provided for the individual. According to the Canadian historian Lexier (2013) these reports emphasize why universities were important, including cultural development, economic expansion, and personal advancement. In the decades that followed Canadian universities developed programs and services with the goal to contribute to economic, cultural, and personal enhancement. Canadian universities predominantly offered non-commercial academic disciplines with the Universities of Waterloo and the Ecole Polytechnique as exceptions (Tudiver, 1999). Post-secondary education was a priority to Canadians and supported by elected governments. Student numbers increased, programming proliferated and the multi-university became the norm. However, by the 1980's, Paul Axelrod (1982), writes in *Scholars and Dollars: Politics, Economics and the Universities of Ontario, 1945-1980*, that the public support for higher education began to dwindle, and by the 1990's governments began to lesson financial support for

colleges and universities. To address the short fall of funding universities sought partnerships between academia and the business community. The Corporate University is now an economic model touted as the means to a financially sustain post-secondary education in Canada (Tudiver, 1999).

Corporate university and the *psy complex*. The mystic of the university is its tradition, rooted in history, stable overtime, a homogenous social space. Discourses used to describe the institution include the ‘ivory tower’, an entity that is distinct from its surroundings, elite, pure in purpose and not marred by self-surviving interests such as business and politics. However according to many authors this is far from reality (Shore, 2008, 2010; Readings, 1996). The university persists because it adapts to social, political, and economic currents and not because it is immune to these forces. Consequently, to understand the life of a university student, at a given time, requires, as Heidegger stressed, seeking to understand “how we here, now today, how we live it” (Heidegger, 2001, p, 57), requires an appreciation of the corporate university. Student life links to programming, services, physical, and human resources (faculty, administration) which are bound to the social, political, and economic realities of a given time. An investigation of modern day university life reveals that post-secondary education has morphed, especially over the last five decades, from independent academic centres into business enterprises. Institutions of higher education now use the term “Corporate University” (Gould, 2005; Myrick, 2004; Readings, 1996) to describe the academic –business partnership models that sustain economically strapped post-secondary institutions in modernity. A corporate university is said to be “the strategic umbrella for aligning, coordinating, and focusing all learning efforts, for employees, customers, and suppliers in order to meet an organization’s [University’s] business strategies and goals” (Corporate University Xchange, 2002). According to Reading, this liaison

of necessity is dangerous (1996), with the potential of impeding the role of the post-secondary institution in society. Tudiver (1999), warns that “academic and corporate fusions are incalculable” as universities are crucial for critical thought, thinking beyond the conventional and fostering independent inquiry without the fear of producing a profit, the central driver of business (p. 5). The loss of independence of thought production in the university/institution thus threatens society and innovation. The Massey Commission (1951) forewarned that when a university denies its intellectual and moral purpose, it compromises the common good, and Canada will be nothing more than a materialistic society (Massey Royal Commission, 1951). Furthermore, corporate sponsorship threatens academic pursuits and integrity as obtaining financial support for research requires the approval and promise of commercial gain for the corporate sponsor.

Nursing schools are not immune from the negative consequences of the academic – business partnership. Rolfe maintains that the recent market-oriented mission of the university does not reflect the values and purpose of nurse education and scholarship (Rolfe, 2012) and thus threaten the integrity of programming and the future of the profession. Central to nursing education is preparing practitioners to see the most of each person’s experience, encouraging independence which may include limiting interventions, cultivating empathy, an appreciation for diversity and a climate of self-reflection in the practitioner, none of which are neatly packaged into business pursuits or easily measured by audits. Nursing does not fit well with simplistic procedural and pathway driven approaches to education and practice as each person’s care is unique. Myrick (2004), a Canadian nursing scholar, warns that there “has been a subliminal infiltration of corporate thinking into the university ethos, a hegemonic process that has insinuated itself upon what academics teach and research and has had a pedagogic impact

not only on what students think but on how they think. Tudiver (1999) contends that nowhere is the self-serving, narcissistic nature of the corporate university more obvious than with the university pharmaceutical industry partnerships: “in 1996 universities spent 12 million, roughly one-third of the 36 million dollars disbursed in the United States on research and development for pharmaceutical innovation” (p. 173). Some authors argue that the proliferation of the *psy culture/complex* among young adults goes hand in hand with the corporatization of the university in which neoliberal business structures have altered traditional models of teaching and scholarship (Aronowitz, 2000; Giroux, 2002, Hyslop-Margison & Sears, 2007; Jancius, 2008, Strickland, 2002). The corporate university culture could be a contributing factor in the increase in mental health concerns on campus. It does so by forcing values inherent to corporatization or by the discourses that comes out of the corporate university experience which are not necessarily conducive to mental wellbeing. Levinson and McKinney (2013) show that, the *psy complex* and the corporate agenda, share common values. Values that emphasis individual responsibility and accountability, the need to market mental health services and medications that enable many students to pursue a college education (Prescott, 2007; Young, 2003), and to brand the post –secondary institution as better than others in a highly competitive market where any mental health tragedy can be detrimental to future enrolment (Levinson and McKinney, 2013). Mental health services in the corporate university “have also contributed to the expansion of *psy culture* and the medicalization of personal and academic distress” according to the same authors.

Being a student in the corporate university. Readings suggests that power is shifting from academics to administrators in the university setting and this is obvious in the discourses shared in the institution (Readings 1996). The same author argues that thought has been replaced

by efficiency and profitability and students are now customers (Reading, 1996). A customer is a person who buys goods or services. On the other hand the concept of a student finds its origin in Latin and means applying oneself to 'painstaking application' (Oxford Dictionary, 2014). The first noun, *customer* relates to an action done to another or a product provided for another, made by another. The second noun student refers to something a person does, it requires action on behalf of the self to transform or become something through a conscientious endeavour. This monumental shift in language, argue Rolfe (2012) and Strickland (2002), is significant to the student experience of the university and to how university staff relate to students. Faculty may use the term student and expect a relationship whereby they tutor or mentor a student towards becoming their chosen profession. Administrators may use the term customer and expect that offerings satisfy an individual's need for certification or for the marketplaces' need for human resources. This disparate discourse leads to tension between faculty and administrators of post-secondary institutions (Kitzrow, 2002; Myrick, 2004; Rolfe, 2012). This creates environmental tensions perceived by the students. Those attending university will find themselves at the centre of this metaphysical debate, were '*being*' and is influenced by socio, political and economic realities and their experience of university will be marked by this tension. Furthermore, the student that embraces and embodies the customer verbiage see himself or herself as someone who is in the process of purchasing an external qualification rather than an education whose worth is mostly intrinsic. This shift in understanding as to what is the purpose of the university experience will have a significant impact on the perception of self and personal capabilities. Maslow's hierarchy of needs explains what a person believes they have accomplished and can achieve contributes to person sense of self and will ultimately affect their mental health and well-being (Huitt, 2007). In Aronowitz's (2000) book *The Knowledge Factory. Dismantling the*

Corporate University and Creating True Higher Learning, he claims in modernity it is becoming increasingly difficult to ‘find a place where learning as opposed to “education” and “training” is the main goal’ (p.1). Traditionally education meant more than just training. Lexier (2013) attests traditional post-secondary education included cultural development, economic expansion, and personal advancement. This involved the contact of professors and students, which Myrick purports, is often not the reality today with the advancement of teaching technologies (2004). Technologies Noble argues distance faculty from students and the teaching process (1998, p. 183). To illustrate this point Myrick (2004), speaks to how faculty today use learning technologies that allow for the teaching of undergraduate students in classes that are so large that it is impossible to get to know students, their needs, and be involved in their learning experience. Faculty-student relationships, once considered the foundation of education, where professors served as mentors or tutors thereby students paid “tuition” for the post-secondary education experience, are now nearly non-existent (Myrick, 2013). With the emergent corporate university culture Aronowitz (2000) cautions that the major goal of post-secondary education is to become a “knowledge factory” (p. 38) not a place of personal actualization. Chris Shore (2008) pens,

“What we have witnessed here is the transformation of the traditional liberal and enlightenment idea of the university as a place of higher learning into the university as corporate enterprise whose primary concern is the market share, servicing the needs of commerce, maximizing economic return and investment, and gaining competitive advantage in the ‘Global knowledge Economy’” p. 282.

This movement towards the corporate university is leading to untenable discrepancies between what academics and administrators deem the priority of education (Whelan, Walker, and Moore, 2013). The result of these opposing views is a tension filled, anxious environment, where two identities fight for their positions. This tension imbues student life experience, much like when a youth tries to develop whilst the tension arising from parental discord. The literature does

provide extensive commentaries on the relationship between neo-liberalism and the university staff and warns of the consequences to student education and university experience (Aronowitz, 2000; Harper, 2013; Myrick, 2004; Reading, 1996; Rolfe, 2012; Wilken & McCrea, 2013).

Harper surmises:

“The main observation is that neo-liberal discourses have a worrying capacity for changing the relationship of the student to the university from one of learner to one of consumer, whereby the product that they consume is their own educational transformation. (...) The outcome of this is that students are ultimately positioned as products of the educational ‘machine’ emerging as ‘skilled and qualified bodies’ that can be put to work in the global knowledge economy”, Harper, 2013, P. 31-32.

People transformed into products will serve as useful to society. Thus, ‘*being*’ is valued only for its utility as determined by the needs of society and ‘*being*’ a student is the transformation into something useful to society no longer that of becoming an actualized being. Furthermore, numbers and evaluative matrixes in the corporate university form a ‘culture of excellence’ judge the value of programs and students, based on performance measures. Heidegger forewarned of the danger in modernity of human existence becoming corrupted by senseless belief in technology and tools of measurement and that *Dasein* or ‘being’ can become severely compromised if these influences are not understood. This researcher questions how the technologies used to evaluate nursing programs and students play out on the lived experience of nursing students with mental health concerns.

Governmentality and regimes of truth in the corporate university. Foucault’s *regimes of truth* and the concept of *governmentality* are also present in the corporate university structure. Holmwood (2010) maintains that modern day post-secondary institutions are corporate in nature and governed by an all-pervasive audit culture. Shore (2008 p. 292) contends that an “audit is not just a series of technical practices”, but it is a form of *governmentality*, that is a “process and a set of management techniques”. Performance indicators, adopted from business

(also known as, KPIs- key performance indicators) are systems used to rank departments and faculties. In effect, departments who rank higher on the scale as determined by administration are rewarded financially or otherwise by the corporate university (Tudiver, 1996, p. 181). These scales and ranking systems serve as the methods of control for the *regimes of truth* that currently exists in universities. The outcome in Nursing is measures that favour the *psy complex* rule. Although Canadian statistics were not available Levinson and McKinney (2013) quote Dillon's (2010) study that showed that from 1998-2008, as corporatization of universities expanded across the US, the amount of financial resources used in institutes of higher education for student services, in private universities and public institutions, was higher than spending for instruction (Dillon, 2010). This means that in modern day university more spending goes to student services, imbued with the *psy complex* tenants, then in teaching and mentoring. Yet despite the pouring of financial support into student services, mental health concerns amongst university students continues to be of significant issue.

The threat of the Corporate University on student mental health. The corporate university is an anxious institution where those within are subjected to an “increasing pace (...) economic and social pressures (...) and uncertainty over the future” (Nicoll & Fejes, 2008, p. 1). Neo-liberal discourses “function to dehumanize both students and staff and position them as parts in an education machine” (Harper, 2013, p. 513) and hinder the experience of *being*. I believe that for a study exploring the experience of nursing students with mental health concerns, it is imperative to consider what impact this tense environment will have on the student mental well-being. Harper (2013) also questions how insecurity about the future and how the need to compete for limited spaces and employment will play out emotionally for students who are being encouraged at increasing numbers to enter the university system (p. 513). This breeds an

atmosphere of hopelessness. A sense of hopelessness can manifest itself as anxiety, mood imbalances, substance abuse, or maladaptive conduct all of which are predictors of student failure in university (Kessler, Foster, Saunders and Stang, 1995, p. 1029).

Another stress factor is student poverty. It is an ever-increasing problem as tuition costs rise relative to wages. Part time employment is a financial necessity for many students, attempting to balance the demands of school with the requirement of education. This poses a serious threat to student mental health (Stanley & Mantorpe, 2001). If student scholarships or bursaries are not a priority, poverty will further push students into mental distress. Surely, university administrators must see that ever-increasing financial burdens directly affect student mental wellbeing. Tuition continually rises as corporate models see the need for profit as a priority above the need of students. Universities are a business and the fiscal wellbeing of the institution is a priority. Even if universities claim to make student mental health a priority more often than not, argue Stanley & Mantorpe (2001), their motives are steeped in a means to market their institution to concerned parents. The goal is not to provide the best support and care for post-secondary students' mental well-being, rather it is to support the corporate agenda, mitigate parental concerns, and improve the marketed image of the institution. Higher education institutions have come to define themselves as providers of education in a competitive marketplace; they see students as consumers of services and therefore can abrogate the responsibility of nurturing or protecting students' wellbeing (Stanley and Mantorpe, 2001).

3.10 Stigma

Normalization as described by Foucault also plays into the corporate university experience. Sadly, modern day education, steeped in an audit culture where standardize measures deem success or excellence, will corral students towards a norm. Students that diverge

from the norm are at risk of failure or being abnormal. Being divergent from the norm as a young adult threatens identity, is emotionally traumatizing, and leads to isolation and stigmatization (Goffman, 1962, p. 151). Stigma as defined by Goffman as a concept that is situated where normal and abnormal meet and has implications for how a person comes to understand their self-identity, or state of *being*.

The origins of the word Stigma come from the Greek word, *sti*. It signified the marks placed on slaves to denote their inferior social status (Falk, 2001). According to Stuart (2008) stigma as a depreciatory term appeared in the late 16th and early 17th century, a period Mason (2014) refers to as early modern society. At this point in history, the state became increasingly involved in the institutionalization of marginal populations such as the mad or insane. Fabrega (1991) contends that many historians and critical theorists have criticized the role played by the emerging psychiatric profession in stigma. Current thinking regarding stigma stems from the work of sociologist Irving Goffman (Stuart, 2005). Goffman (1963) determined there are three forms of Stigma: Overt or External deformation, deviations in personal traits such as mental illness, and tribal stigmas, traits that deviate from the normative expectations of the group (p.4). Stigma in relation to personal traits and deviation from normative expectations are of particular interest to this research project. Goffman, like Fabrega (1991), was deeply critical of mental health services, for their stigmatizing and anti-therapeutic effects on those with mental health concerns (Stuart, 2008). Like his contemporaries Szasz (1960) and Scheff (1966), Goffman's research strengthened the argument that stigma is enmeshed with how we organize psychiatry. Stigma is a by-product of the *psy complex*, and the tendency of large-scale bureaucratic organizations to treat all members equally (Goffman, 1966). Stigma arises from culturally endorsed based on norms and standards that deem what makes for a certain condition or

diagnosis (Goffman, 1963). These diagnoses, determined by *psy* norms, come to represent a character flaw, something that is socially undesirable (El-Badri & Mellsop, 2008; McDaid, 2008). For example, a person with a *psy* diagnosis is weak, irrational or emotionally unbalanced (Horsfall, Clearly & Hunt, 2010). Apportioning these negative qualities to the character of the person deeply discredits the person within society and leads to rejected (Goffman, 1963, p. 14). Stigmatised transforms mental distress into an intrinsic matter of a person's character. This transformation leads to blaming those with mental health concerns for their condition. Looking at the intrinsic nature of stigma, Goffman went beyond labelling, stereotyping, and faulty thinking by the perpetrators of stigmatisation. Goffman explored how imputations arising from character judgements play out overtly and covertly between individuals in everyday activities (Horsfall, Cleary and Hunt, 2012) and in how a person comes to understand their sense of identity when stigmatized (Goffman, 1963, p. 67).

Through his extensive exploration of Stigma Goffman maintained there are stages in the stigmatized experience. The stigmatized person goes through a period of isolation, which comes later to be seen as a time when the individual was able to think through his problem, learn about himself, sort out his situation and arrive at a new understanding of what is important and worth seeking in life (1963, p. 53). In addition, if a person with a stigma has repeated encounters with the stigmatized, gradually over time, their stigma becomes less “something like a daily round of normalization may hopefully develop” (Goffman, 1963, p. 68). Goffman determined that persons who have a particular stigma tend to share “similar learning experiences regarding their plight, and similar changes in conception of self- a similar *moral career*” (1963, p. 44). This *moral career*, has stages as well, the first being when the stigmatized person learns and incorporates the norms and standards of society into their being (identity), and the second when

the person learns in detail the consequences of having the stigma (Goffman, 1963, p. 46). This *moral career* experience favours new relationships with others who are stigmatized (Goffman, 1963, p.49) and in these new groups of the 'stigmatized', members find connectedness and come to see others in this new group to be ordinary or 'normal' (Goffman, 1963, p.52). This is much like Foucault's description of the relationship between *normalization* and *resistance* in that power exerted by norms and standards can shift (Foucault, 1977) resulting in a different experience of being.

Goffman's important work produced a way of understanding how stigma permeates into lived experience of a person with a mental health concern and contributes to their sense of being. To the person experiencing stigmatisation, stigma is far reaching and has excessive, incorrigibly damaging effects (Goffman, 1963, p.67). Goffman believes that stigmatization will deepen the mental health concern experience of a person. Pilgrim & Tomasini (2011) further substantiated this claim and showed that stigma, associated with mental health concerns, arouses processes of fear, social distancing, and a disproportionate response to threat, real or imagined.

According to Goffman Stigma can result from attributions given from one person to another but it can also take hold when a person ascribes negative attributes to themselves. This is *Self-stigma*, which denotes internalized feelings such as guilt, shame, inferiority and the yearning for secrecy is common to those living with mental health concerns (Goffman, 1963). Typical experience of self-stigma include disgrace, diminished self-efficacy, and anger (El-Badri & Mellso, 2007; Jones & Crossley, 2008; Van Den Tillaart et al, 2009). Alas the concept of *self-stigma* further complicates the lived experience with mental health concern, as members of society, they will be subject to '*regimes of truth*' and likely to hold common stereotypical attitudes inherent in the society at large (Corrigan & Wassel, 2008). These compounding forces

will leave a person with mental health concerns to believe they are weak and characteristics that block themselves from any possible recovery (Bellack, 2006; Browne, Hemsley & St John, 2008). The person, or student, with a mental health concerns, succumbs to societal norms and standards, believes the messaging of contemporary *psy complex*, self-stigmatizes and consequently their lived experience with a mental health concerns is marred yet further.

Goffman (1963) also describes *courtesy stigma*, or stigma-by association, whereby all those linked to the stigmatised succumb to the same negative characteristics. This phenomenon is especially apparent surrounding those with mental health concerns (Falk, 2001, Smith 2002). For example, health care providers and policy makers themselves are ‘abnormal’ by association, and therefore actively seek to mitigate the problem or normalize the condition (Stuart, 2005). This phenomenon may be at play within the corporate university where fear of association could drive, faculty, administrators and policy makers to distance themselves from those with mental health concerns or to encourage students with mental health concerns to get *psy* interventions, *psy* medications, or *psy* accommodations to alleviate any risk of negative mental health behaviours on campus.

Discrimination often accompanies stigma, which refers to inequitable treatment of people with mental health concerns (Stuart, 2005). It is the reaction from others to the stigma. Discrimination is found at the interpersonal and structural level. People with mental illness are, overtly or covertly, excluded from public life by virtue of legal, economic, social, and institutional means (Fink and Tasman, 1992; Link & Phelan, 2001). Schulze and Angermeyer, (2003) emphasize that discrimination often causes more suffering, is more devastating, life-limiting and long lasting than the illness itself. Because of discrimination, the person is treated less than whole, disqualified from full social acceptance, discredited and diminished in

comparison to those believed not belonging to the stigmatised group (El-Badri & Mellso, 2008; Jorm & Oh, 2009; Mcdaid, 2008). The stigmatised, experience undue self-presentation concerns, they are preoccupied with what they will and will not say and how they behave socially than those who are not stigmatised (Jones & Crossley, 2008). This sensitivity and vulnerability may play to the favour of the *psy complex* as the stigmatized or self-stigmatized may be more defenceless to the powerful messages of the 'regimes of truth' peddling the dominate *psy* interventions. Goffman and other social scientists, believe researchers must be careful to examine the phenomenon from a broader ecological view which includes influences that can capture the complex interplay of social-structural, interpersonal and psychological factors in the construction and preservation of stigma in our society (Link, Cullen Streuning, Shrout & Dohrenwend, 1989). This research project will heed this advice.

3.11 Theory of Recovering

Jacobson (2003) in, *Defining Recovery*, explains that recovery first surfaced in the literature in the 1960-70s with the psychiatric survivor movement, stemming from the anti-*psy* literature, that critiqued psychiatry and mental health services in hope of promoting individual empowerment. A second impulse was the psychiatric rehabilitation movement that entailed teaching skills and coping strategies to maximize an individual's quality of life. William Anthony, director of the Boston Center for Psychiatric Rehabilitation wrote one of the first definitions of recovery claiming it is, "a deeply personal, unique process of changing attitudes, values, feelings, goals, and /or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. "Recovery involves the development of new meaning, and purpose in one's life" (Anthony, 1993, p. 12). This movement stems form research such as The Vermont Longitudinal Study of Persons with Severe Mental Illness, that

demonstrated that two thirds of the people with severe mental health concerns recovered over time with or without *psy* intervention (Harding, Brooks, Asolaga, & Breier, 1987). This research put to question *psy* expert thought that believed the trajectory of severe mental illness was poor and permanent and contributed substantially to the budding recovery movement. More recently, a systematic review by Leamy, Bird, et al., (2011) showed that the greatest interest in the conceptualization of recovery has come from USA, UK, Australia, and Canada. The Canadian Mental Health Commission, Ontario chapter, defines recovery as “the personal process that people with mental health conditions experience in gaining control, meaning, and purpose in their lives (...). For some, recovery means the complete absence of the symptoms of mental illness. For others, recovery means living a full life in the community, while learning to live with ongoing symptoms” (Mental Health Commission of Canada, 2015, p. 1). Recovery is a unique experience, self-driven but not done in isolation. The measurement of recovery is often some level of involvement with community. Jacobson and Greenley (2001) claim that it is not an end but a process, a journey, therefore recovering people describe themselves as ‘being in recovery’.

In order to promote recovery, The Substance Abuse and Mental Health Services Administration established Ten Fundamental Components of Recovery (SAMHSA, 2012). They state that recovery is: 1). Self-directed, a unique path: 2). Individualized and person-centred: 3). Empowerment, where people have the authority to choose from a range of options and thereby gain control over their life: 4). Holistic and encompasses a person’s whole life: 5). Non-linear, accepting that there will be setbacks on the path to recovery: 6). Strength based, focusing and valuing capabilities, coping abilities talents and inherent worth of persons: 7). Peer support including sharing experiential knowledge and skills that is invaluable in recovery: 8).

Respect, at a systems level that there will be social acceptance and appreciation for those with mental health concerns: 9). Responsibility, that people with mental health concerns have personal responsibility for their won journey to recovery: 10). Hope is central to recovery, described as the catalyst for the recovery process. Hope entails the belief that people overcome barriers and will have better future. ‘Being in recovery’ and the experience of hope dependent on internal and external influences appeared in Jacobson and Greenley (2001) research. Their research on recovery, illuminated that hope, central to ‘being in recovery’ could be fostered or squelched at multiple levels, be it personal, organizational at the service providers level, or systemic level, through the presence or absence of policies designed to support a recovery oriented care system. Brown and Kandirikirira (2007), in their narrative study, built on Jacobson and Greenley (2001) work, and identified six internal and six external elements required to foster ‘being in recovery’. Internal elements include: Belief in self and developing a positive identity; Knowing that recovery is possible; Having meaningful activities in life; Developing positive relationships with others and your environment; Understanding your illness, mental health and wellbeing, taking note of triggers and; Actively engaging in strategies to stay well and manage setbacks. External elements that promote ‘being in recovery’ are environmental and social in nature. The environmental elements are availability of treatments and services; financial pressures; and perceived stigma. Social elements that influence ‘being in recovery’ are: flexibility and responsiveness of services; willingness for family friends, peers to encourage, enable, empower individuals to take risks and; willingness and cooperation of others not to undermine individuals by allowing them the right to self-determination. Leamy et al. (2011) conducted a systematic review, entitled, *Conceptual framework for personal recovery in mental health: A systematic review and narrative synthesis* and came to describe the recovery

process, as it is experienced at a personal level, by five categories using CHIME as the an acronym for the five categories: Connectedness, Hope, Identity, Meaning in life and Empowerment. They also noted that personal recovery happens within a larger context and requires orienting mental health services towards recovery.

Although little research directly related to the phenomenon of recovery as it related to mental health concerns was conducted in Canada, at a systemic level the country has embraced the goal of directing mental health services towards a recovery model. For example, the final report of the Standing Senate Committee on Social Affairs, Science, and Technology, *Out of the Shadows at Last*, asserts that recovery must be at the centre of mental health reform. As well *Open Minds, Healthy Minds*, the Ministry of Health and Long-Term Care's mental health and addiction strategy (2011), calls for a strategy to be based on the principles of recovery and, *Changing Directions: Changing Lives: The Mental Health Strategy of Canada* (2012) recommends the same. In response to the strategy and to the call to do the hard work to put the strategies into practice, The Mental Health Commission of Canada published *Guidelines for Recovery- Oriented Practice: Hope, Dignity, Inclusion* (2015). The guidelines affirm that recovery occurs within the context of one's life and must be sensitive to recognizing personal values, must support social inclusion and must address stigma and discrimination. The guidelines go on to challenges all Canadians involved in providing care to those with mental health concerns to embrace recovery oriented practice the guidelines also stress that recovery is about transforming services and systems.

In conclusion, this chapter has provided the explanation for the theoretical foundation that will support this study. The research will use an IPA methodology complimented with a critical lens. This method of inquiry seeks to understand how the knower understands *being* and

how the knower makes sense of the worldly experience. The theoretical framework aligns with the research question recognizing that how the knower experiences makes sense of the experience may best be understood through a lens which is sensitive to socio, cultural, and economic realities. Interpretative Phenomenological Analysis, which stems directly from the philosophical phenomenological movement, compliments the aims of this study.

CHAPTER FOUR

METHODOLOGICAL CONSIDERATIONS

4.1 Introduction

Creswell (2007, p.16), maintains that good research requires carefully aligning the research question with an appropriate method of inquiry. This study used Interpretative Phenomenological Analysis to explore the lived experience of nursing students with mental health concerns. IPA focuses on finding meaning and is dedicated to understanding the first-person perspective (research participant) from the third person position (researcher). Proponents of IPA accept that insight into the person's perception of a phenomenon, through living and being with it, provide rich and elemental understanding of otherwise perplexing realities (Smith and Osburn, 2003). According to Smith and Osborn (2009), this research methodology captures the personal and social world of the participants where "the main currency for an IPA study is the meanings particular experiences, events, states hold for participants" (Smith, Larkin, Flowers, p. 53). Problems in health care are multifarious in nature and finding solutions requires understanding the unique position of many stakeholders. Bigger, Staff and Thompson (2008) attest that IPA has made a real contribution in the literature about "understanding healthcare and illness from the patient perspective". Health Psychology has used IPA extensively, as evidenced by Brocki and Wearden's (2006) systematic review of fifty-two studies that explored the lived experience of persons with illness or health challenges. Nurse scholars also iterate that research that captures the person's perspective of their health and illness experiences is exceedingly valuable to the profession. Since 2000, seventy-six publications in peer reviewed nursing journals describe nursing research that has used IPA (Pringle, Drummond, McLafferty, and

Hendry, 2011), proving that this methodology is gaining momentum and is showing promise as being beneficial to the development of nursing knowledge.

Seeking a methodology that is congruent with a given research question is paramount to quality research outcomes (Creswell, 2007, p.16). Research that seeks to understand the lived experience of nursing students with mental health concerns in light of the socio, economic and political realities is well suited to using IPA. The methodology is person centred, thus ideal in gaining insight into the unique experience of mental health concerns as despite the ever-mounting collection of articles that speak to the mental health crisis among post-secondary students, little research has asked students with mental health concerns their perspective. IPA provides a framework to begin this important novel and foundational research. By using this open-ended research methodology, whereby nursing students with mental health concerns shared their lived experience, others will become empowered, as currently this group of students may be at risk, as other groups with mental illness, of being 'silenced' or denied existence (Liegghio, 2013).

4.2 Design

Interpretative Phenomenological Analysis grew out of the Phenomenology philosophical movement. Harper affirms that two forms of Phenomenology exist: descriptive and interpretative phenomenology (2012, p. 2792). Descriptive phenomenology reveals the individuals experience in their own terms, while interpretative phenomenology, presses beyond the text and tries to interpret and find deeper meaning whilst placing the participant in a broader social, cultural, and theoretical context (Larkin and Thompson, 2012). Interpretative Phenomenology evolved into Interpretative Phenomenological Analysis (IPA), a current, well-established research method

used primarily in mental health, health psychology, and psychotherapy (Smith, Flowers, & Larkin, 2009 p. 12, Smith, 2004).

IPA first appeared in the literature in 1996 in a hallmark publication by Jonathan Smith entitled “Beyond the Divide between Cognition and Discourse: Using Interpretative Phenomenological Analysis in Health Psychology” (Smith, 1996). Smith (2008) attests that IPA arose because researchers found there was a need to strive beyond description and aim for understanding of the participant’s psychological world and a need to try to capture the complexity of the meanings and beliefs associated with the participants lived experience. Current claims for the use of IPA as a methodology, made by Larkin (2013) are that this methodology can help to understand the experience of a particular group of people. It can develop and evaluate therapeutic services and interventions and interpret the associative findings from conventional quantitative research (Larkin, 2013). IPA can also situate and understand people in their social and cultural context; evaluate and reflect upon the role played by therapeutic, institutional, and legislative cultures; and re-evaluate existing theory (Larkin, 2013). This study aligned with IPA’s strengths as described by Larkin (2013) as described in the discussion of this thesis. Data gleaned through this methodology also lead to reflection upon the role played by faulty service providers, peers, and the institution.

The primary concern of Interpretative Phenomenological Analysis is the lived experience of the person (Smith, Larkin, Flowers, 2009) and first-person accounts serve as the basis for data. Verbatim records obtained rich narratives that were detailed and reflective. In order to collect such data, it required that the person with the lived experience is articulate, forthcoming and have experience with the phenomenon of study, the lived experience of nursing students with mental health concerns. Bonnie Barstow (2013), in her article entitled *A Rose by any other name:*

Naming and the battle against Psychiatry, emphasizes that the language we use to describe a person can lead to misunderstanding and pain. Using medical terminology such as mental disorder, mental illness, and mental disability to describe a person is disempowering. Therefore this researcher invited nursing students that self-identify themselves as having a mental health concern, that they believe may have had consequences on their post-secondary experience to participate in this study. By using validating terms, not disempowering terms, the research findings contribute to models of resilience, not pathology. I found that post-secondary nursing students were capable of articulating their experience just as Maria Liegghio (2013), found people with mental health concerns are very willing to speak of their experience when invited, as often they are voiceless or worse their denied an identity. I believe the experience of mental health concerns disqualifies nursing students as legitimate knowers. Their voice is silent in the current research literature as well as within the current institutional discussion to support students with mental illness in post-secondary institutions. It was my hope that in extending the invitation to nursing students with mental health concerns and in making their voices heard the discussion of the issues, services and possible intervention would be richer.

IPA and Nursing research. Several nursing authors (Willig and Stainton-Rogers, 2008) believe that IPA fits naturally with nursing research. Particularly in psychiatric nursing gaining an understanding of the person and their experience is required for good practice. Nursing expects practitioners to engage with and attend very carefully to the personal accounts of people. Willig and Stainton–Rogers (2008) write the following about nursing: “A person is embodied, meaning making being “always ready” immersed in a linguistic, cultural and physical world; their experiences are in the context of ongoing personal and social relationships, of which the researcher and nurse forms a part” (Willig and Stainton–Rogers, 2008).

4.3 The Setting

The purpose of this study was to explore how individuals with mental illness and problems experience their journey as a student enrolled in post-secondary education. The context for this IPA study was the post-secondary institution where the nursing students were being educated. The setting was a University that has a large nursing school, with an enrolment of where close to 1500 nursing students in one of the four years of the BScN program. All participants attended the same university program but were not necessarily in the same year. The interviews took place on campus or off campus depending on what suited the participant best.

4.4 Sampling Strategies

Sampling in IPA is purposeful and requires the researcher to identify and recruit participants who can offer a meaningful perspective on the phenomenon of interest (Larkin and Thompson, 2012). IPA is idiographic, meaning it is concerned with particular phenomena in a particular context (Larkin and Thompson, 2012). Participants who were nursing students with lived experience with mental health concern shared their narratives. It is important to remember that these participants represent perspective, not the population (Smith and Osborn, 2003). Furthermore, the topic of study was an area of concern to the participants and something they knew they could share their valuable perspective as required by Larkin and Thompson (2012, p. 3118).

The researcher asked faculty for permission to make a brief 5-minute presentation, expanding the study, in their nursing classes. Following the presentation, I invited nursing students with mental health concerns to participate in the study. A letter that explained the purpose of the study extended an invitation to nursing students who describe themselves as having a mental health concern and described the time commitment should students wish to

participate was left following the presentation, as well my contact information was placed on the classroom white board. Permission was sought from Health Services to display a poster that describes the study and who was being recruited. Contact information was on the poster and the letter so that students could contact the researcher should they wish to participate. When the participant contacted the researcher, the researcher verified that the student was in the BScN program, not registered at the institution where the primary investigator taught, and most importantly describe themselves as having a mental health concern. This purposeful sampling required all participants to meet the study criteria. Twelve students met the criteria. All twelve students underwent a detailed explanation of the purpose of the study as well as expectations and time commitment. Data collection and storage was described to the students. It was explained that data would be collected using pseudonyms to assure confidentiality. They were told that the researcher's role was as data collector, data protector, and primary investigator to the participants. I clarified that their role was to share their lived experience with mental health concerns. Students had the opportunity to asked questions and to seek clarification if needed. Although the researcher was a professor in a nursing program at a community college, she had no direct involvement with the students at the campus where the study took place. The researcher shared that her interest in the students experience stems from 15 years of experience with nursing students who have at times disclosed their own mental health problems and concerns. Participants signed voluntary consent forms and had multiple opportunities to re-state their consent to participate or their desire to end their participation. It was explained to the participants that at any time during interviews, they could stop the recording device, which would implicitly indicate they did not wish to participate in the study and absolutely no explanation as to why the

participant wishes to withdraw was required. During the introduction, students also shared their expectations of the study.

Striving for homogeneity is imperative to IPA inquiry (Crist and Tanner, 2003). The researcher selected a group that is reasonably homogenous as per IPA protocol (details following shortly). Being that each person lives a unique life and experience, there was inevitably some variation. As part of the analysis phase of IPA, variation was identified, and in particular, variation identified by the person as contributing to the unique lived experience was noted. In this study, all participants were nursing students; full time status students; enrolled in the same university BScN program; self-reported having mental health concerns; may have had more than one mental health concern; were able to articulate their narratives in the English language and were not or could not be students of the principal investigator. The central priority of participant selection was that the chosen participant could offer insight into the lived experience of being a nursing student with mental health concerns, and thus respecting homogeneity, as per IPA protocol.

IPA inquiry is done with small sample sizes as the primary focus (Larkin, 2013). IPA is a detailed account of the individual experience, the case, where complexity may be explored thus the emphasis is on quality of the account not quantity. Smith et al., (2009) suggest that at the PhD level between four to ten cases would be sufficient to develop meaningful points of similarity and difference between participants (p.59). The same authors stress that “it is more problematic to try to meet IPA methodological commitments with a sample that is too large, than one that is too small” (p.59). IPA seeks theoretical transferability not empirical generalization, thus interviews from each case should be rich, transparent and contextualized providing the foundation for transferability (Smith et al, 2009). This study attempted to adhere to

recommendations by Smith (2008), Harper and Thompson (2012) and Larkin (2011) and sought 10 cases so as to permit for rich, compelling, in-depth data which is vital for analysis while respecting the tradition of IPA (Creswell, 1998; Smith et al., 2009). In the spring of 2015 when the researcher addressed students at the start of their nursing classes to invite them to participate in the study more than ten students came forward. Over a period of two weeks, a total fourteen students came forward to share their lived experience. All fourteen students claimed to meet the study criteria; however, during the interviews two students divulged that there was a risk that they were or could have been taught by the principal investigator, who is a nursing professor at a regional college in the vicinity of the university where the study was conducted. Curiously, although the investigator clearly stated that the student's interviews could not be part of the study, because of the potential ethical conflict, both students wanted the investigator to hear their stories. When asked why the student had made the false claim, the student replied, "I thought you would not interview me, if I told the truth. It was important for me to tell you about my experience". (Field notes, Meredith, April 2015). The second student also insisted on telling his story (Field notes, Vance, April 2015) and the researcher felt listening was important to the students. Their stories supported the overall research findings although they were not transcribed or analysed. The students' desire to speak about their lived experience with a mental health concern was important to these two students and to deny them their voice would have been to deny their experience.

In total, the researcher recorded, transcribed and analyzed twelve interviews. These twelve participants met the criteria and all wanted to share their experience with the researcher. I came to realize that nursing students wanted to speak about their mental health concerns and by speaking out, they believe they could make a difference in the lives of others. Students in the

BScN program came forward quickly to share their experience with the principle investigator. In a manner of two weeks, all 12 interviews were conducted. This brought to light how important having their stories told was to the nursing students with mental health concerns in this study.

Table 4.1 Participant Demographic Data

Participant (Pseudonym)	Age	Sex-	Year of Study	Mental Health Concern	MHC First Onset
Andrew	21	Male	3	Depression Addiction Anxiety	High School
Eleanor	22	Female	4	Depression Anxiety	High School
Jane	29	Female	4	Depression Anxiety OCD Panic	High School
Jessica	22	Female	4	Depression Anxiety Panic	In Nursing School
Julie	18	Female	1	Depression Anxiety	High School
Leila	20	Female	2	Depression Anxiety OCD Eating Disorder	High School
Sasha	22	Female	2	Depression OCD Eating Disorder	High School
Mariam	23	Female	4	Anxiety/ GAD	High School
Mary	21	Female	3	Depression Anxiety	High School
Sophie	20	Female	2	Depression	High School
Summer	18	Female	1	Depression Self-Harm	High School
Winter	18	Female	2	Depression Addiction Eating Disorder	High School

The demographics of the twelve students whose interviews were included in this study are as follows. Eleven of the participants were woman, one a man. The ages of the students range

from 18 to 29, with the mean age being 22. Two of the students were at the end of their first year of study, having completed their second semester. Four of the interviewees were in their second year of study, at the midpoint of their four-year baccalaureate studies. Two nursing students who volunteered to share their stories had completed their third year of nursing school at the time of the interview. The remaining four students that interviewed were at the end of their Nursing Baccalaureate studies having completed four years or eight semesters of the university program.

4.5 Data Collection

In the IPA approach to inquiry, researchers are interested in the individual and the particularities of their understanding of their lived experience, however participants are not seen as “passive actors in a drama” (Firth, H. & Gleeson, K., 2012, p. 1993). When using the IPA method researchers conduct semi-structured, face-to-face, in-depth interviews with open-ended questions. Interviews began with a very few open questions rather than a detailed interview schedule. Open ended questions, found in the appendix A, were used that focus on experience and/or understanding of a particular people in a particular context with the goal of being exploratory rather than explanatory (Larkin and Thompson, 2012, p. 3119). These open-ended questions asked participants to identify, describe, and understand two related aspects of a participants account: the “object of concern” and the “experiential claims” made by the participant (Smith at al. 2009, p. 54). Research questions focused on how nursing students understood their experience of being a nursing student with self-reported mental health concern. Questions divided into first and second tier question. First tier provided a framework for detailed examination of the lived experience and were always asked. Second tier questions engaged with theory that might support gaining an understanding of the socio, political, and economic realities that might be influencing the students lived experience. Second tier questions did not build

theory but rather “its analytic outcomes can be used to open a dialogue with extent theory” (Larkin and Thompson, 2012, p. 3119) that might help a person make sense of their experience (Smith et al. 2009). Several authors (Smith et al. 2009, p. 55; Larkin and Thompson, 2012 p. 3129) claim it is useful to develop a few theoretically infused questions when using IPA.

The interviews lasted for 45-90 minutes and took place in a private location at a time convenient for the participant (Larkin and Thompson, 2012). Only one interview was conducted per person but Larkin and Thompson suggest scheduling an optional second interview which could be used to facilitate understanding between the researcher and the participant, clarify issues, and obtain supplemental data, along with an opportunity to verify the accuracy of the responses from the first interview (Larkin and Thompson, 2012, p. 3150). All twelve students were offered a second interview and all declined. At the beginning of the interview, participants choose a pseudonym to refer to the participant throughout the study. All audio interactions were digitally recorded, and transcribed. The researcher kept a field journal to record non-verbal interactions, physical expressions, gestures, observation as well as capture the researchers own opinions, beliefs and initial perceptions. According to Gleeson and Firth (2012, p. 2051) field journals support data and help researchers identify biases and priori assumptions and thus can add to the credibility of the research.

4.6 Data Analysis

In IPA, common processes and principles set data analysis. The processes assist the research and participants to move from a particular to a shared position. The processes are applied flexibly (Reid, Flowers and Larkin 2055) in an iterative and inductive fashion (Smith, 2007). The principles that guided this IPA process were; a commitment to understanding the participant’s point of view and; the psychological focus on personal meaning- making in a

particular context. The data collected in this IPA study was in the form of verbatim digital recordings that were first person accounts of the lived experience under study. Transcriptions typed from the digital recordings and two people verified the transcriptions for accuracy. Gleeson and Firth, (2012) affirm that analysis in IPA “begins with the researcher staying close to the data for as long as possible” (p. 2051). The researcher first looked across the data to find patterns, then deeper to identify themes. Only later in analysis, was data looked at again through a theoretical lens to help the participant find meaning (Gleeson and Firth, 2012).

The first of four steps in IPA analysis, or as what Larkin (2013) describes Analysis A, began with the researcher reading through the transcripts in an attempt to immerse herself into the original data, actively engaging in the process of trying to enter into the participants world (Larkin 2013). At this point in the analysis the researcher examined semantic content and language used on an explanatory level. As I read the transcript, I jotted down thoughts and ideas that come to mind. This primary step of free and open coding had the important function of identifying and bracketing the researchers own preconceptions (Larkin, 2013).

The second step of IPA analysis was to begin the process of phenomenological or descriptive coding (Larkin, Watts, and Clifton, 2006). This step entails rereading each transcript and paying close attention to each line to discover “experiential claims, concerns, and understandings of each participant” (Larkin 2013). At this second step in IPA analysis it is important to try to identify things that matter to the participant, those objects of concern and ways in which the researcher might characterize the participants stance in relation to these things (Larkin, 2013). At the end of this step the researcher generated “a descriptive core of comments, which have a clear phenomenological focus, and stay close to the participants explicit meaning” (Smith, Larkin Flowers , 2009 p. 85).

The aim of step 3 (Analysis C) of IPA is the identification of emergent patterns and commonalities which Shinebourne and Smith refer to as themes (2010). Themes arising from the experiential material will be underlined and comments made by the researcher in the margins of the transcripts (Eatough and Smith, 2008). This process completed on a single case then across all cases. Analysis then moved on to step 4, in the IPA analysis process.

Step 4 was an iterative process where the researcher went back to the experiential data and asked if the emerging themes represent the participant's perspective. Themes compared to a master table of themes in an iterative process. The researcher also illustrated relationships between themes. This structure can be in the form of a table, hierarchy or a circular schematic (Larkin 2013), see Chapter 5, Analysis Table 5.1. The researcher then organized "all of the material in a format that allows for the coded data to be traced from the initial coding of the transcripts, through the clustering and thematic development into the final structure of themes" (Larkin, 2013). This final step of the analysis process produced a narrative account that clearly links material experiences to researcher findings. Larkin and Thompson (2012, p. 3190) maintain that the goal of the IPA analytic process is to develop an organized, detailed, plausible and transparent account of the meaning of the data and this researcher has presented the findings in chapter 5.

4.7 Rigor and Validity

In an IPA study, rigour is evident when the researcher "conducts multiple levels of data analysis from the narrow codes or themes to broader inter-related themes to more abstract dimensions (Creswell, 2007, p. 46). Smith (2006) stresses that although the IPA researcher is operating close to the text, "there is still a reader doing the reading and influenced by all his/her biological presence when doing the reading. Consequently, it is paramount that the researcher

stays grounded and attentive and follows a disciplined reiterative process (Smith, 2006). Member checking was also used to enhance the trustworthiness of the data by ensuring that the individual lived experience is accurately captured (Yardley, 2008). Member checking happened during the interview process by restating and summarizing information and then questioning the participant to determine accuracy.

Reflexivity. According to Larkin et al., (2006, p. 106) “it is not actually possible, even if it might be desirable, to remove ourselves, our thoughts, and our meaning systems from the world, in order to find out how things really are in some definitive sense”. Consequently, this IPA researcher needed to be reflexive regarding her biases. To do this I needed to be aware of the values and preconceptions which I brought to the process of analysis (Larkin, 2013). The aim of the reflexive activity is to be open, relevant, and integrative when presenting and evaluating one’s work (Larkin, 2013). The reflexive activity was written in the first-person voice in a journal.

Epistemic Stance. This researcher is a nurse, who has worked in mental health settings and a professor of psychiatric and mental health nursing. As a professor in a community college, I have experienced students disclosing that they have mental health concerns and at times were struggling to meet course requirements. As a professor, I came to know the institutional perspective on what was the expected action according to the post-secondary school policies to assist students with mental health concerns. Frustrated by the institutions hands off attitude and limitations in supporting students with mental health concerns, I have experienced internal conflict arising from a professional perspective as a mental health nurse and as a professor within an institution dealing with nursing students with mental health concerns. As a professor, I have heard the frustration of students with mental health concerns as they learn to be empathetic to

others with mental health concerns yet question the empathy afforded them by the institution and its representatives, professors, staff and administrators. I am aware that my own experience will contribute to the analysis, as it is impossible to separate personal experience from the analysis process.

Audit and Credibility Checking. When using IPA the researcher made every attempt to perform audit or credibility checks. The following questions were central to audit and credibility checking: Is the final account coherent and plausible? Is there evidence for the analytic claims made? Is the researcher able to see and reflect upon alternative versions of the findings? Are any theoretically informed inferences cautiously entertained (Larkin, 2013)? My co-supervisors reviewed each of these questions and answers to support this study's credibility.

Transferability. When using an IPA methodology, it is paramount that the researcher does everything possible to make known to the reader the context, and the population. The data was rich and interpretation of this data was clearly sourced, as was the process of analysis used. By doing so, the data spoke for itself allowing for understanding in a given context (Larkin, 2013).

4.8 Ethical Considerations

A possible ethical issue arising in this proposed study was the concern regarding the study of what a vulnerable population, the person with mental health concerns. Seeking a response to this ethical consideration I used the argument developed by Larkin and Thompson (2012) who wrote:

“The use of these terms *vulnerable population* risks participants in mental health research (particularly service users) becoming disempowered through placing emphasis on the perceived need for protection which relates to the paternalistic researcher stance.” (p. 1136)

This research project was situated in the practice belief that people with mental health concerns are resilient and do recover. Therefore, I did not see nursing students with mental health concerns as representatives of a vulnerable population in the paternal sense, requiring protection. Larkin and Thompson also posit that “seeing a group as inherently vulnerable or sensitive is clearly at theoretical odds with such constructionist and critical theory” (2012, p. 1145). Thus, I made every effort to revisit my attitudes towards people with mental health concerns throughout the analysis by journaling to minimize my risk of falling into this trap.

A second ethical issue that arose when two students that came forward to share their experience with mental health concerns, although they did not meet the inclusion criteria. I felt that ethically, and professionally as a professor and a mental health nurse, it was necessary to allow the students time to voice their experience, as it was clear it was very important to the nursing students with mental health concerns to share their story. The students heard from the researcher that their stories were invaluable and contributed to the researchers understanding of the phenomenon of study but that their transcriptions would not be part of the analysis process in this thesis. This assured transparency should one day the student read this thesis or any publications arising from the research.

Informed Consent. Informed consent in the form of “ongoing consent”, as per Gleeson and Mortimer (2012, p. 1175), was central to this research study. Consent was ongoing as participants had the opportunity to reaffirm their wish to continue to participate in the study throughout the research process.

Clarifying Boundaries. Clarifying and maintaining boundaries is essential in qualitative research. It was my responsibility to clarify and maintain boundaries. The role of the researcher was to listen to the accounts of the participants, collect their narratives, and analyze their lived

experience using the IPA method. The role of the participant was to share their experience and their understanding of their experience. To deal with infringement of boundaries and other ethical threats arising, Gleeson and Mortimer (2012) advocate the importance of solid thesis supervision that places an emphasis on reflection and learning rather than purely completing a task. My thesis co-supervisors monitored my conduct throughout the research project and thesis completion process. Throughout the research project, I met with one of my thesis co-supervisors to discuss issues arising.

CHAPTER FIVE

RESULTS

Step one of IPA requires the researcher to immerse themselves in the data to enter into the participant's world and to examine semantic content and language used. What stuck this researcher was that nursing students with mental health concerns describe themselves, in terms of *psy* labels. In order to participate in the study a nursing student did not have to have a DSM diagnosis. In order to allow for students varied experience and not limit students' description to diagnostic labels, the interviewer asked participants to tell her 'in their own words', what their mental health concern was. Curiously, all twelve participants used words that spoke to *psy* labels. All participants had seen a *psy* expert and obtained a *psy* diagnosed prior to the interview. Sophia was the only participant to have one *psy* label. The other participants had received at least two of the following psychiatric labels: depression, anxiety, obsessive-compulsive disorder, and eating disorders. Four of the twelve participants shared the experience of using self-harm as a means to cope with emotional distress and used terms like "cutter" at times to describe themselves. Only one participant struggled with substance misuse, having an addiction to nicotine, which he used to cope with anxiety. Their choices of words were reflective of the *psy complex*. Another important finding was that multiple mental health concerns were common among the participants. Curiously, the number of *psy* labels given did not change their sense of *being*. If anything Jessica, who was most recently given a *psy* label, was the most distraught, whereas Sasha, who had multiple *psy* labels ascribed to her mental health experience, seemed at ease, using humour to bring levity to her understanding of her experience,

I am pretty good. Obviously, I would not be doing the program if I was not, but I do have a history (...) I had depression, an eating disorder, it was not specified. It was kind of a mix of anorexia and bulimia and I had severe obsessive-compulsive

disorder, which [is a] good profession to be in for that [participant laughs], Sasha, 70-74

The second step of IPA analysis was to begin the process of phenomenological or descriptive coding (Larkin, Watts, and Clifton, 2006). At this point, the researcher reread each transcript to discover how the nursing students experienced their mental health concern and what understanding they attributed to the experience (Larkin 2013). The things that matter to the participant were identified. The researcher generated descriptive comments, that mirrored the participants explicit meaning (Smith, Larkin Flowers, 2009 p. 85). These comments noted on each transcription formed the basis for Step 3, where emergent patterns and commonalities grouped into themes (Shinebourne and Smith, 2010). Themes arising from the data of one case were then attributed to other cases. The researcher then examined all themes and clustered them into major themes according to conceptual similarities (Shinebourne and Smith, 2010). Analysis then moved on to the iterative process of step four. At this point in the analysis, themes, categories, and sub categories were compared to a master table of themes where relationships between themes evolved. Table 5.1 provides an illustration of the relationship between themes, categories, and sub-categories. This final step of the analysis process is the narrative account that links participant experiences to research findings. The remainder of this chapter will provide the reader with an organized, detailed, plausible and transparent account of the meaning of the data as per phenomenological analysis as well as where applicable through a critical lens of analysis as per IPA protocol.

Table 5.1 Themes, Categories and Subcategories

Theme 1. Concerned Self			Theme 2. Psychiatrized Self			Theme 3. Recovering Self		
<i>Category</i>	<i>Sub Category</i>	<i>Sub-Sub Cat.</i>	<i>Category</i>	<i>Sub Category</i>	<i>Sub-Sub Cat.</i>	<i>Category</i>	<i>Sub Category</i>	<i>Sub-Sub Cat.</i>
Student Stress	Finance Grades Workload Isolation Amotivation Self-Care Technology		Consequences	Docile Self	Multifaceted Hospitalized Medication Talk Therapy	Feelings	Hopeful Motivated Balanced Belonging Supported	
Triggers	Past Trauma Transition A Number Nursing School	Course Content Teaching Style Role Dissonance Responsibility	Regulated Self	University Rules	Standardized Efficiency	Becoming	Gifted Person Gifted Nurse	Understanding Self Understanding Other Empathetic Empowering Holistic
				Insurance Rules	Competency Myths			
			Stigmatized Self	Stigma from Others	Insecurity Mixed Messages Flawed Citizen Unfit for Practice Self-Stigma I am A fake Self-Silencing Impeding Recovery			
Feelings	Frustrated Hopeless Out of Control Alone							

As per IPA protocol participants, twelve nursing students, were asked open-ended questions designed to explore their lived experience with mental health concerns during a face to face semi-structured interview that lasted from 45 -90 minutes. The transcriptions, developed from the interview recordings, were carefully analysed by means of the IPA analysis process: free and open coding; descriptive coding; identification of emergent patterns; and the final interactive process whereby the researcher asks if the emerging themes do indeed represent the participant's perspective. The table illustrated on page 156 (Table 5.1) represents the three major themes that arose from the data: *Concerned Self*, *Psychiatrized Self* and *Recovering Self*. Each of these three major themes has categories, sub-categories, and at times sub-subcategories that serve to clarify the meaning of the major theme.

In hoping to gain an understanding of how nursing students understand their experience as a student with a mental health concern, the interview began with an open, inviting question "How would you describe yourself as a nursing student?" All twelve participants responded with affirming, positive statements that confirm that the students believe they are capable baccalaureate students. Eleanor shared, "I've always been a really dedicated student (...) I go to class regularly, (...) I've gotten good grades (...) my primary focus has always been school." (Eleanor, 10-17) Jessica tells the interviewer "I'm very determined I'm very studious" (9-10). Mary articulates, "I would say studious, caring, what else, dedicated" (Mary, 4). Sasha claims with pride but also reservation, "I'm maybe a little too much of a strong student in the sense (...) grades are really important to me. (...). Like I get all A +'s, so far this program" (Sasha, 53-60). In addition, many students comment on how they believe that nursing is their passion; they are compassionate and empathetic individuals who believe they have found their place in the profession. "I have a lot of compassion (...) I feel like I'm exploring something that I'm really, really, really interested in and excited about" (Summer, 25-28). Sophie exclaims, "I'm

understanding and empathetic towards patients” (Sophie, 25). Jessica admits, “I found my passion as a nursing student” (Jessica, 10) and “I really love nursing” is proudly stated by Mary, (5). Julie is the only participant unsure about her academic accomplishments. She is certain that she wants to help others: “I want to be able to help people as much as I can, (...), I’m hopeful “(Julie 26-28). Thus, the responses to the first question asked in the interview, was that an overwhelming majority of the participants described themselves as dedicated, academic achievers, who are committed to their nursing studies and also to the profession. They want to be nurses, they see great value in caring for others, and they are willing to work hard to become a nurse. They take their studies seriously and at times put pressure on themselves to be perfect as they see doing things perfectly, as important to nursing practice. Based on their descriptions of themselves, these students would easily have made the entry requirements for the baccalaureate program, and with their study attitudes and commitment to nursing, they likely would maintain a high CGPA (cumulative grade point average). Likewise, compassion and empathy are qualities that are highly prized in the nursing profession. These qualities are taught and evaluated particularly during clinical/ practicums (as per Program Course Outlines). Based on their responses faulty in nursing would likely deem these students to be ‘good’ students because they have high grades, conscientious attitude, and are compassionate and empathetic. At this point in the interview the nursing students consistently portrayed themselves as being a good nursing student and having what it takes to one day ‘be a nurse’. The participants did not see themselves as ‘less than’ another student nurse because of their mental health concern.

The interview focus then turned to asking questions about the experience of nursing students with mental health concerns. At times, the interviewer used secondary question to probe deeper into the mental health experience by asking: “What do you experience, or how do you feel?” and the participant’s reflections often brought them to remember when they first recognized their mental health

concern. Eleven participants began to describe their mental health concern as beginning in high school. The nursing students recognized that something had changed in their relationship to their interests, school, others, or themselves.

I just didn't want to go to school and I skipped a lot of school I missed a lot of [high] school. Eleanor, 28-29.

I guess I would have been like 13 (...) it was really down really sad and I knew I was but I didn't really know that there was any issue. Summer, 50-53.

They did not see the need to seek out help from others because they did not have the understanding of what 'it' was they were experiencing. The mental health concern felt, not understood. Students tried to make sense of the experience of the mental health concern by putting culturally acceptable explanations to the unexplainable. However, this proved useless.

I was in grade 7 or 8 by the time. I did not know what it was because I was like a pre-teen. I just thought that was (...) a natural part of growing up because I was told you know like teenagers are moody (...) then it got worse and worse and worse. Mary, 22-25.

An important finding was that the lived experience with the mental health concern began before the participants came to the university, for all but one participant. This speaks to two points of interest, firstly the participant were experienced in living with a mental health concern prior to coming to the university and secondly they were more than capable to meet all the pre-requisites for the nursing program while living with a mental health concern. Only one participant shared that her first encounter with a mental health concern began in nursing school and she believes her mental health concern surfaced because of the stress associated with the program. The interview questions continued to probe how each participant understood their mental health concern. The data amassed, for the most part, under the major category: The Concerned Self.

5.1 Theme One: The Concerned Self

To gain an understanding of the experience of being a nursing student with a mental health concern the interviewer asked the following two questions: (1) Can you describe to me what it is like to be a student in a post-secondary institution and have your mental health concern? (2). Can you describe to me how your mental health concern affects your student life? The responses to these questions were extensive and made up more than a third of the data captured in all twelve interviews. When winnowed down, this data, as per IPA analysis formed the foundation for much of the first major theme to emerge in the study: The *Concerned Self*. The word concern as a noun refers to something that affects a person. As a verb, it describes an action whereby someone focuses his or her attention on something of importance or a significant interest. Synonyms of concern include fear, worry, distress, unease, apprehension, and disquiet. In this study, The *Concerned Self* describes responses where nursing students expressed distress regarding how living with a mental health concern affected their lives as students. Concern here would be a noun as a student life is affect by the mental health concern. The *Concerned Self* also includes participants' worries about aspects of student life that fostered a mental health concern, for example finances or workload. Here concern is a verb, the action of worrying about finances adds to the experience of the mental health concern. Both the experiences of student life that threaten mental health and the mental health concerns that affect student life are subsumed in the category of student stress under the theme of *Concerned Self*. *Student Stress* is further sub divided into sub-categories that give name to significant interests that repeatedly surface in the students' narratives: Finances, Grades, Isolation, Amotivation, Self-care, Workload, and Technology.

A second category, classified under the *Concerned Self* is *Triggers*: Participants understand this category to be sparks that ignited their mental health concerns or more precisely set the negative aspects of their mental health concern into motion. *Triggers*, further divides into four subthemes: Past-Trauma,

Transition, Being a Number, and Nursing School. The sub category of Nursing School further sub divided into sub-sub categories as student's expounded in great detail regarding how aspects of Nursing School: namely, Theory Content, Patient Stories, Faculty Expectations, Faculty Teaching Style, Role Dissonance and taking on Responsibility all added to their mental health concern experience.

The third category under *Concerned Self's Feelings*. Here students express how they felt living with their mental health concern. Feelings that they conveyed became the sub categories: Frustrated, Hopeless, No-Control, and Alone.

5.1.1 Student Stress

Stress is a state of mental or emotional strain stemming from adverse or very demanding circumstances. Stress is experienced as continuous pressure or tension and can fuel a mental health concerns. Nursing students frequently spoke about stress and its contribution to their mental health concerns.

Finances. Concerns regarding the financial cost of the nursing program were articulated by eleven of the twelve participants. Five applicants were paying for their education and they related they experienced anxiety in needing to find the funds to pay for tuition aggravated their mental health concern.

I mean not being able to pay tuition creates so much stress. To the point where (...) people even take their lives for it because they cannot pay (...) school costing so much is definitely a huge thing that puts pressure on every single one of us (...) and if they have a pre-existing mental health problem I mean if you already have anxiety that is a constant cloud, Winter 700-708.

Finances are a constant burden that threatens overall mental health of students. Furthermore, the need to channel all available funds into tuition robs nursing students of the ability to take care of their own mental well-being, setting the stage for aggravation of mental health concerns.

[W]hen you have the money, you've got time and resources to take care of yourself and when you don't, you know, when you're a broke university student living off KD, not so much. Sasha, 829-832.

Participants also mentioned stress arising from having financial support and this is a new finding not found in the literature. One nursing student expressed guilt about how she was wasting money that her parents had painstakingly saved, if she could not attend class because of her mental health concern. Upon closer examination, this is both a concern about limited finances, as clearly this student perceived that her parents worked hard to save. However, it also demonstrates the sensitivity that this student has regarding relationship and what her actions mean to the others, this illustrates as a sense of 'responsibility' another attribute that is valued in nursing but might add to the mental strain experienced by the student.

I still feel kind of bad when I know that thousands of dollars are going towards my tuition and then here I am I can barely go to class. (...) that makes me feel bad. But I know that I'm not in any kind of situation where paying for school would be an issue it's just me feeling guilty (...) because I'm wasting it [money]. Julie, 526-532

Another quandary that nursing student face, is that of their short-term need, to have the financial resources to pay their tuition, versus their long term mental health needs which requires finances to access mental health support. The high cost of tuition competes with the high cost of private mental health care. Talk therapy that is often not supported by public services therefore students pay privately for the service. Summer knows the cost of her mental health care and fears that if she were to relapse that would entail a significant cost for treatment. The need to pay tuition would be at odds with purchasing the counselling and medication she needs to restore her health and *well-being*. Fear of the financial burden of relapse festers and adds to her anxiety, central to her mental health concern.

It is always a little bit (...) scary to think that you know relapse. [It] may (...) not necessarily be an option. You might not have (...) the means to go through a

relapse. (...) If I went back and I got to where I was before really bad depression very down and not very productive like the self-injury it's like can I afford to do that you know as a student and am I going to be able to afford medication or counselling or that kind of thing? Summer 1105-1114

As a nursing student, and as a person who has lived with a mental health concern, Summer knows what she needs to maintain her mental well-being. The student worries about the cost of relapse, leaving the *concerned-self* with the mentally and emotionally charged personal quandary: to pay for tuition or self-care needs.

Grades. Following finances, grades were the next interest to mentally and emotional preoccupy nursing students and contribute to their lived experience with mental health concerns. A majority, nine of the twelve participants, voiced that to stay in the nursing program they needed to maintain a certain cumulative grade point average or to access certain learning experiences and this grade stress aggravates their mental health concern. For most of the participants, ten of twelve, their drive for high grades started in high school. Teachers rewarded them throughout high school for their high grades. They secured their seat in the BScN because of their high grades. Their need for high academic achievement continued into the BScN however not without negative consequences to their mental well-being. The emotional strain of obsession with high grades is palpable.

I spend most of my days studying during the first year (...) did not hang out with friends because I wanted to study because I would be really scared of that (...) am I going to get 95 and know that would make me happy. Winter, 181-185

In the early years of the BScN students' evaluation is primarily by multiple-choice examinations that are translated into numeric and letter grades Nursing students with mental health concerns would appear as doing well externally, based on standards of evaluation, while suffering internally because of their drive for perfection. Grades contribute to mental health concerns when high achieving nursing students do not realize their unattainable goals. "I think the fact that I'm

not doing well in school (...) it brings me down and I feel like I can't get up again", Julie, 154-156. The nursing students judge themselves as 'good' or 'bad' nursing students based on measures that further drive this over achiever, perfectionist perspective in most of the participants in this study. "I got like an eighty-three on a test and for me that was bad I was like I wanted a ninety I thought I'd get a ninety, (...) I couldn't cope with it I couldn't get past it", Summer, 887-891. The need for a perfect grade is equated with self-worth and *being* a 'good nurse'. "In nursing the fact that you have to get a certain grade that would definitely affect some people (...) if I'm not getting this maybe I'm not good enough to be a nurse and it really does put them down" Winter 486-489. Students perceive that the nursing profession requires these perfect grades and nursing students must earn these grades to demonstrate that they can be a nurse. In the participants 'nursing program few measures beyond numeral grades were provided, thus cumulative grade point average become the measure of a 'good nurse'. Nursing students come to value themselves and their ability as a developing nurse by grades. This norm referencing exacerbates their mental health concern by adding more stress or emotional tension to their lived experience. "I don't see the positive part of myself [developing nurse] so like even when I'm working really hard and I get a good grade I'm like oh I could have done better", Mary, 122-125. Sadly, Mary's norm referenced means of measuring her nursing ability, never brings satisfaction, as she never reaches the state of perfection she believes she requires to be a nurse and this negatively impacts her identity as a developing nurse.

Grades also make for competition. Several students shared that comparing grades, something common between students in the BScN program, further fuelled mental health concerns. "I was really competitive with school and exams and tests and always comparing with my friends what did you get? Andrew 163-165. "I have another friend in nursing and she's just

doing so well she has like 90s (...) I wonder where I'm going wrong, (...) I think certainly [it] does contribute a little bit to how I feel", Julie, 289-293. However, when digging deeper into the data it appears as though comparison is not to compete with others, to judge oneself as better than another, but rather to judge where one belongs in relation to others in the program. In fact, nursing students with mental health concerns seldom consider themselves good enough to be in the program despite proving otherwise. Mary asks herself "why am I not as good as this other nurse?" 126. Julie asks "where am I going wrong?" 290. This need to compare oneself to another was very common amongst the participants and not understood as problematic. Only one participant perceived this practice as deleterious and expressed that she decided not to compare her grades. "First year like grade wise I struggled a bit and like some friends did really good and stuff and it just made me feel worse so I hate when people like compared grades and stuff my goal is just to finish nursing and be the best nurse I can", Sophie, 190-192. It is important to note that the nursing students in this study did not compare grades to outperform another, as would be the case in a competition, but rather to test or determine where they might find themselves ranking in relation to the class. This is more of a norm referencing exercise than a pure competition. By comparing grades, they determine where they gain a sense of their identity, where they fit relative to the norm. This is not an exercise of wanting to be the best, rather nursing students focus on judging themselves, as a 'good' nurse relative to the norm, where *being* perfect is what a nurse needs to be. The nursing student with mental health concerns believe being a 'good nurse' requires them to be high academic achievers that a 'good nurse' would have near to perfect grades. This comparing of academic performance leads to self-judgement which is recognized by nursing students as contributing to mental health concerns but it is not understood as a mental health concern in itself, for example an obsession. When nursing

students with mental health concerns were asked: Can you describe to me how your mental health concern affects student life?, not one of the participants equated obsessing about grades or evaluating themselves based on academic performance as being problematic. In other words, the need to attain high grades was as a stressor that contributed to mental health concerns, but the need for perfect grades or the valuing of self in relation to grades was admirable and not problematic.

Workload. Ten of the twelve participants claimed that a high workload in nursing school contributed to their mental health concern.

[I] wake up at 5:30 and then, then clinical ends at 3:00 and then I go home and do whatever work I need to do after clinical and then whatever work I need to do for my three other courses. (...), I go to bed at like, you know, midnight or 1:00 in the morning and wake up again at 5:30 and there is literally no time. Sasha, 232-237

The nursing students in this study perceived program expectations as exceeded what was physically and emotionally possible to achieve. Students' perceptive overwhelming pressure percolating throughout the nursing program and this sets off their mental health concern.

“There's this expectation that you're always on (...) have to read one or two chapters for each lecture. Each chapter is like 60 pages. That's several classes (...) at the same time (...) you can't think straight when you're so anxious about all this stuff to do”. Mariam, 145-150. What is interesting is that the nursing students do not question the program expectations but see the overwhelming workload as part of the 'training' for becoming a nurse. The frantic pace of the program and the extreme demands is part of what a nurse should expect. Although students believe that the demands of the program go beyond what is humanly possible to learn within the four-year period of the program, they will do it to *be* a nurse.

It is kind of unrealistic in the sense that, yes, as a nurse you are (...) taxed and you do need to, you know. Be able to multitask and juggle multiple things at once and

expect the unexpected. I think that the program just (...) academically expects a lot. Sasha, 106-109.

The nursing program is perceived as rich in information but poor in facilitating learning, with no time to process: this exacerbates mental health concern. The unattainable nature of the curriculum workload stems from the students' perceived faculty values that this prepares nursing students for 'real' nursing. Yet the students understand faculty thinking to be flawed, and not in line with 'real life' nursing, as practicing nurses can access information with technology as needed. This disconnect between faculty and student thinking leads to frustration, distrust of faculty, victimization and hopelessness:

I would probably just give up on everything. Maybe I would jump off a bridge (...) and the sad thing is other students are like, do not worry. There will be a bunch of us on the bridge jumping together. (...) [Participant names institution of study], this is your fault. Because we were so stressed (...) stress that should not have happened. Jane, 1042-1044

Sasha concurs with Jane when she pronounces, "Are they just trying to make our lives, (...) more stressful than it has to be, or, you know, it's the nature of the beast [nursing school] we signed up for". Sasha, 121-123. Nursing students with mental health concerns believe that they have to bear and live through this stressful, intense learning experience of nursing school and have no alternative. They perceive themselves as powerless in face of these unrealistic expectations. While adapting to an increased workload at University is typically a challenge for all students (Storrie, Ahern, Turkett, 2010), it appears from the data of this study, that nursing students with mental health concerns seem to experience the workload in an extreme and negative fashion. It would be of value to delve deeper and question if this perception of excessive, unrealistic expectations, that does not prepare nurses for 'real life' nursing is unique to nursing students with mental health concerns or is it common to all nursing students?

Absence of Self-Care Closely related to the stress of workload is the subtheme Absence of Self-Care. The nursing students interviewed clearly understood what they needed to do to maintain their mental health; however, nursing school demands took priority over the time for self-care. A powerful quote by Sasha summarizes the sentiment of several nursing students interviewed, “I knew this going into the program this is what it would be like, but, you know, it’s the program where it’s all about health promotion and stuff, and meanwhile it’s just hammering your health into the ground.”, Sasha, 420-422. Nursing students in this study consistently describe their neglect of personal health because of the demands of the BScN program. They perceived no alternative, and were thus vulnerable to further exacerbations of their mental health concerns,

[D]uring nursing school you are never going to be any unhealthier (...). You do not have time for the gym. You do not have time to eat (...) I do not have time to deal with my mental health issues. I do not have time to do things that I enjoy.
Jane, 571—574

Nursing student with mental health concerns understood that they sacrifice their own mental health during nursing school. They were well aware of what they needed to do to protect their mental well-being but consistently felt the nursing program workload would override their personal health.

I didn't socialize much I think especially when school was really busy like when I had this last semester when I had my complex care placement and like community, I found I didn't have that much time to myself and so there were times when I got really busy that I felt kind of down. Eleanor, 130-134,

The vast majority of nursing students understood what they needed to foster their recovery and, they concluded that nursing school impeded their recovery.

Denying self-care is not limited to the duration of the nursing program. Denying self-care is an expectation of nursing. Nursing students with mental health concerns doubt it will ever be possible to balance self-care needs versus patient care. Somewhere in the nursing school,

experience students come to understand that patient care supersedes self-care. Consequently, students come to see their own recovery as being at odds with the needs of those in their care.

I have worked so hard (...) throughout my recovery to be very self-aware and to take care of yourself. (...) that might be a little bit different in the workplace and even a bit as a nursing student. It's just you have to look after other people so I think it's going to be a bit of a challenge for me to find a balance between still looking out for myself (...) while also taking care of and protecting other people.
Summer, 997-1004

Sacrificing self-care is common nursing students with mental health concerns, "One of the things I found very stressful (...) I don't have time to go to talk therapy. I have to do my homework. So that was a "me-thing"". Mariam, 927-929. The fear of taking time away from studying, could be associated with perfectionism or the belief that self-sacrifice is inherent to *being* a nurse?

Likewise, it seems that they may be a culture of 'just accept how it is' or 'try harder' even if it is perceived as unrealistic amongst nursing students with mental health concerns. At one point in the history of nursing education, this might have been the accepted norm. However, in today's fast-paced world where many people understand that stress makes you *sick*, either physically or mentally, should this attitude of just accepting more unrealistic expectations continue? Is it that course demands have grown to 110% or more? If so, is this counterproductive to teaching nurses what healthy living is or should be? Alternatively, do nursing programs teach that nurses offer care beyond what is humanly possible, beyond perfect, and do 110% or more in the time given them? Do methods of evaluation and reward in nursing school breed perfectionism and self-sacrifice? Does nursing school harm the mental well-*being* of the students in the nursing program by driving perfectionism and self-sacrifice? Does nursing school which is perceived by students with mental health concerns as trying to 'toughen' students up for the real world, much like a 'boot camp' meet today's nursing demands, being that the participants in this study seemed to believe there was a disconnect between what is taught and what is really needed in the

professional arena. For most of the participants in the study, the nursing program is a threat to their recovery by exacerbating their mental health concerns. Students describe living in a vicious cycle,

It is like a vicious cycle because (...) friends are my support system. I don't have any time for friends., (...) where does the me-time kind of fit in there. (...) and they say, you know, make time for yourself, but, yeah, that's... that can't really happen too well when you literally have no time. Sasha, 224-230

Isolation An overwhelming majority, eleven of the twelve participants, mentioned that they experienced isolation in the nursing program and this isolation threatened their recovery and exacerbated their mental health concern. The cause of the isolation stemmed from no time to nurture friendship because of the perceived excessive workload. In the program, it was difficult to make friends in the nursing program and the teaching atmosphere did nothing to facilitate belonging, leaving nursing student with mental health concerns feeling isolated. “The times I experienced it (mental health concern) more I would say was just time that I didn't see or didn't socialize much I think especially when school was really busy”, Eleanor, 129-131. Other student speaks to the classroom environment as breeding isolation “[I] always sit in the back were like oh I don't know anyone you know I just try and listen, but it definitely improved going from big to small [classes]” Andrew 336-337. Others elude to the nursing program atmosphere, as giving them a profound sense of loneliness and isolation that contributes to mental health concerns. When speaking of her nursing program Jessica says, “It was very lonely and I didn't have classmates and I didn't have friends”, Jessica, 341-342. Julie adds “It [the nursing program] made me feel a lot more alone than I was and I'm okay with being alone but *being* lonely is a different sensation, yeah the general atmosphere of the class (...) contributed [to the mental health concern]. Julie, 321-324. Feeling a sense of connection, central to supporting recovery, was near to impossible in nursing classes and overall program,

I do not really feel like there is any personal connection and every time I try to talk to someone in the class (...) everyone seems kind of cold (...) unfriendly, which is unfortunate because you are in university. You are here to make new friends and stuff and it has been kind of difficult for me because of that. Like I want to make new friends but it's hard to when the general environment of the class is very like I'm here to learn I'm here to look at that slide up here that's it and I'm going to leave, Julie, 289-300

The nursing student with mental health concerns describe the class atmosphere as toxic to mental well-being in that it is unfriendly, unwelcoming, and lacks connectedness. The participants in the study seemed disillusioned, particularly in first year, by their university and nursing school experience as they thought they would have met new friends and made new connections. Isolation extends beyond student-to-student relationship to faculty–student relationships as well, “I don't necessarily have a very close relationship with any (one), like my professors or TAs”, Summer, 379-380.

At times students with mental health concerns understood their sense of being isolated not as a by-product of the program or environment but as a reaction to their mental health concerns the result of the reaction of others to their mental health experience, “I went into a pretty bad depression, a lot of anger. I was very dark. People didn't like me so much”. Jane, 303-304. Jessica mentioned that “it [mental health concern] negatively impacted some of my relationships (...) it was difficult for someone who cares about you to watch you go through that”, Jessica, 364-366. Participants felt isolated because their mental health concerns taxed relationships. Some students actively sought out to isolate themselves because of fear of stigmatization “it's just I didn't want anyone to think of me differently (...) I just like I thought to myself the best thing to do was just isolate myself”, Sophie, 358-361. Stigma will be discussed further when the theme *psychiatrized self* is explored.

Isolation also surfaced as a subtheme when nursing students felt others disregarded their situation as a student with a mental health concern. Mary became dismayed as she expected nursing students to reach out to students in their class with mental health concerns, once they learned about the incidence of mental health concerns in their age population in their theory class. Mary felt her classmates disregarded this important fact and she observes no change in the attitudes of her classmates. Unfortunately, Mary believes that classmates even went so far as to deny mental health concerns existed. This dichotomy of learning the fact that mental health concerns affect one in four people, between 18-28 years of age, and then perceiving that classmates denied that people with mental health concerns can be amongst their 140 classmates, lead Mary to an even deeper sense of isolation:

Nurses understand mental health in theory but in practice, I don't think they look for it in their peers. (...) I don't know a lot of people with mental health issues in my program. I don't (...) know anyone actually not a single person, (...) so it's not shared, it's not talked about, it's kind of pushed to the side because once again you have to fit the perfect picture of a nurse and I think there's a lot more focus on (...) patients rather than our selves. Mary, 436-445

Mary's feels isolated, because she comes to believe she is the only student with a mental health concern, albeit knowing intellectually this was highly unlikely. Adding to this sense of isolation is also Mary's perception that she had to be silent about her mental health concern because she had to fit in to what a perfect nurse would be, which she was learning did not include having a mental health concern. This above quote is profound and eludes to the complexity of the lived experience of the nursing student with mental health concerns that benefits from deeper analysis using a critical lens that is sensitive to social realities, such as stigma and professional regulation that may be at play in Mary's experience. Stigmatization and regulation as theme that contribute to the lived experience of nursing student with mental health concerns will be presented, later in this chapter.

Unlike Mary and Sophie who isolate themselves for fear of the repercussions to the nursing studies or career, a few participants did come to realize, for the sake of their own recovery, that sharing their experience with a mental health concern with others would benefit them. Thereby they broke the hold on their isolation and fostered connections, an important concept in a recovery model. Interestingly and not surprisingly based on Mary's experience, nursing peers were not the chosen confident of the participants in this study. The fact that nursing classmates, where not choice connections, that fostered recovery, seemed tragic to the participants in this study. Noting that only two of the twelve participants verbalized taking action to counter their sense of isolation is also significant being that almost all the participants mention feeling isolated.

Amotivation defined as a state of lacking motivation to engage in any activity. The DSM 5 characterized amotivation by a lack of perceived competence (DSM-5, 2013). Almost half of the nursing students interviewed, describe a state of amotivation. Amotivation robbed participants of the competence and capability they typically enjoyed as academically strong students. "How I feel when I'm depressed, very, very unmotivated, very hard to get out of bed, it's difficult for me to attend classes because I feel there's no point, I'm just very down on myself like for example today could be such a beautiful day and I'd still feel like I have no sort of purpose or meaning, Julie, 44-49. The students articulate the consequences of amotivation on academic performance.

[T]here were a lot of days this semester where I just didn't go to class because I was like I can't get out of bed, and it wasn't necessarily (...). I am in like a super deep dark place, but it's kind of... I find my motivation sometimes is like just not there (...). So, I find that has affected my school. Leila, 118-127

Poor performance because of amotivation then leads to poor self-esteem, which further disheartens the student. A participant painfully describes the vicious cycle students experience "so then that just led to a whole cycle of me not being motivated me getting bad marks me being

sad me not being motivated mean getting bad marks me being sad so it's just an endless [cycle], Julie, 581-584. Eleanor equates her student stress that manifests as amotivation, to her not taking the time for self-care. She sees a relationship between the two subthemes absence of self-care and amotivation.

I just wouldn't feel like I had a reason to get up (...) I find that would happen mostly if I didn't have time to myself or enough time to do enjoyable things and I can recognize that now but especially in like in the past it would just be like you know I don't know why I'm doing this. Eleanor, 116-121

The voices of the students with mental health concerns make obvious that they want to offer their best but recognize that some days they cannot function at their best because of their mental health concern. As part of their recovery, the students gain self-awareness regarding how amotivation a symptom of their mental health concern affects their student life and otherwise. Simultaneously students learn that being a responsible nurse means self-awareness, whereby nurses self-assess if they have knowledge, skill and ability to provide needed care. Students with mental health concerns come to understand *ability* as including their *state of mind*. Likewise, students come to understand that faculty would question and may even punish a student who shares that. They have conducted a self-reflection, they are aware that their *state of mind*, and thus their ability, is not at its best, and would need to take care of themselves which might mean being absent from clinical or class is necessary. Being self-aware, seeking the ways and means to have the knowledge, skills and ability to practice is in the best interest of the patients, touts the profession. However, if it is to be practiced by students with mental health concerns, who recognize they need to take the time to take care of themselves in order to provide safe care, it would equate with poor performance or poor professional conduct.

Technology. Technology contributed both positively and negatively to the mental health of nursing students. Some participants stated that technology improved communication between

students and faculty, for example made it possible to view recorded lectures if amotivation prohibited attending, and technological tools like Blackboard assisted students with organization and studying practices, which supported their mental well-being. Email improves communication with professors because face to face encounter are challenging with lived experience with anxiety: “it’s easier to send an email then to talk to someone face to face (...) I feel like I can express more in email then I can just because I’m willing to type out more and there’s less of a guard in front”. Andrew, 764-767. Online quizzes and assignments reduce stress “now we do have an online component where we do little quizzes for its called mastering A&P (...) so definitely no kind of negative impact through technology.” Julie, 432-434. Students with mental health concerns believe that being in a wireless learning environment with access to the internet can also reduce student stress by empowering students: “Computer definitely enhanced [mental health] and you know you could if you didn’t understand something the teacher said you could just use the internet to find out right away”. Jessica, 879-881. Computers sometimes offered a much-needed distraction is stress was unbearable: “Like if I’m going on YouTube, it’s because I’m stressed so I’m going to watch Monty Python sketches for 20 minutes and then I will feel better. “Mariam, 811-812. Although a few students felt that technology provided them with a means to mitigate the consequences of some of the pitfalls of their mental health concern with further analyzing it became apparent that more students spoke to the negative consequences that technology could have on a nursing student with mental health concerns. Participants cite social media, as having a deleterious effect on a nursing student’s mental health concern, “like I’ll go and read like suicidal postings on Tumblr.” Mariam, 804. Summer agrees with Mariam when she says, “I just kind of had to just stay away from the news, stay away from

Tumblr you know just because it would really, (...) get me down”, Summer, 1103-1105. Leila expounds on a similar warning regarding the toxicity of social media.

I had this Twitter account that was like an eating disorder; people would constantly be posting pictures of weight loss or like how little they're eating or their calories of the day and things like this (...) I was doing it too (...) social media was a huge trigger and a huge issue when I was really sick. Leila, 643-649,

Social media expedites access to negative communities that nursing students with mental health concerns felt exacerbated their mental health concern. For example, Leila experienced more anxiety around anorexia, “for me, social media was very harmful (...) it's so accessible (...) a lot of other people who are suffering in the same place are doing the same things. So you're constantly feeding off of each other.” Leila, 653-659. Continuous access to world issues, afforded by technology, also fuel anxiety

It's not the best thing to be always on top of all the bad things that are happening (...) all you had to do was go on Twitter to see what was really happening videos from people and pictures I guess it made me kind of misanthropic in the way that I was, I would get frustrated. Summer, 1156-1170.

Winter further contributes to Leila and Summer's trepidations about technology but also adds that even though she and her friends all know that social media does nothing to enhance their mental well-being, they are 'addicted' to it.

Perfect model of the Victoria's Secret campaign (...) literally that would be my newsfeed which unfortunately (...) it can be addicting (...) first thing in the morning you'll go check all your social media but it's like a dose of a negative in the morning. Winter, 530-539.

Winter returns to the addictive nature of social media and admits to hopeless dependence on the technology despite its negative consequences when she says:

I see it as a very big factor and everyone is doing it. So, you're on it too and no one realizes it, people know it's a problem they know it's bad but you can't really stop doing it which is kind of really weird and it's not going to stop but yeah medias a big thing [hinders her mental well-being]. Winter, 557-561

Technology is the tool that permits social media to act as a power influencing how nursing students with mental health concerns perceive themselves, their *'being'*. This power is much like Foucault's conceptualization of bio power. The students in this study found themselves pushed into a certain direction (Sawicki, 2003, p. 59), promoted by social media, albeit the negative consequences this direction had to the student's mental well-*being*. This power is "right in the depths of society" (Foucault, 1997, p. 27) as the nursing students, as emerging adults, came to experience it.

Technology at the University was continually interrupting students' lives. Technology makes it possible for professors to be in continual contact with students, which means school is constantly on a students' mind. Students speak to being away from school but still getting messages about grades, and assignments. Some students believe they need to turn off school at times for the sake of their mental well-being but fear as long as they are pursuing BScN studies this will not be possible as technology is part of the learning experience and thus mental well-being continues to be taxed.

students are constantly required to be students and technology forces you to do that (...) when you're trying to relax and you get an email (...) technology makes school kind of constantly there, constantly in the back of your mind (...) that element of it is kind of hard. Sasha, 686-692

Technology also erodes on human contact, as less face-to-face communication becomes the norm. "We [are] (...) not as good as interacting face to face because we mostly interact through our phones (...) I think that's a very big thing because it's less human contact you (...) go anywhere for days and you can feel connected to the world where the reality is you're just sitting in your own [world] doing nothing. Winter, 674-680. In this quote, technology gives the illusion of creating connectedness, but in reality, each person is alone, and not enjoying the benefit of relationship, a significant aspect of mental well-*being*.

In conclusion technology can be a tool that is perceived by the nursing students with mental health concerns as beneficial if limited however dangerous if it undermines a nursing students' ability to disconnect with school. It is also dangerous when it substitutes face-to-face connections with superficial connections or facilitates connections to destructive websites identified by the student nurses with mental health concerns as threatening to their mental wellbeing. Technology bombarded them with messages that negatively affected their understanding of *being and* messages that promoted certain norms or standards of what a person should look like, should know, or be part of, in order to belong. Leila warns of this double edge nature of technology and the need to use it wisely to guard mental well-being "Mind you it [technology] could also be helpful, because I've also followed like recovery ones [websites] and things like that. It is kind of an in between. There are definitely both aspects to all of it". Leila, 660-662.

5.1.2 Triggers

A trigger, according to the Merriam-Webster dictionary, is something that initiates a process or reaction. Triggers set a course of action in motion; for example, a trigger can cause symptoms of a mental health concern to begin or to start again in the case of a relapse. The literature on mental health cites traumatic events, or transitions as possible triggers that set mental health concern into motion. Whereas stress is a continuous pressure or tension state, where distinct identified stressors incessantly maintain the state of tension, triggers are distinct external events or circumstances identified by nursing students that produced uncomfortable emotional symptoms or exacerbated their mental health concern. The major category of Triggers had subthemes: Past-trauma, Transition, Being a Number, and Nursing School. The sub-theme of

Nursing School further bifurcated into sub-sub categories: Theory Content, Patient Stories, Faculty Expectations, Faculty Teaching Style, Role Dissonance, and Responsibility.

Past Trauma. Trauma is a trigger for mental illness that is oft-cited (Macfarlane, 2000). Half of the participants spoke to trauma as initiating their experience with a mental health concern. For one student, the trigger was moving to Canada and the culture shock she encountered (Winter, 26-27). She infers that her struggle with an eating disorder began shortly after she arrived in Canada. Another student's stress came when she moved in with one parent after their divorce: "yeah I used to live with my mom but she moved to BC and I think when she moved then my depression was really bad", Sophie, 123. Death of a significant person was the source of trauma for two other participants in the study. Andrew shares that his mental health concern first appeared following the suicide of his best friend: "it started as I began University, about a week before school started in first year my best friend committed suicide", Andrew, 32. Jane believes her anxiety is related to the extensive losses of important people in her life that coincided with her four years of BScN study "I had quite a bit of loss throughout school. I had probably about six significant deaths in the last four years", Jane, 22-24.

Three students divulged that they suffered abuse and this traumatic event triggered their mental health concerns: "I was assaulted when I was 13 twice and that kind of perpetuated the health issues so I think sometimes that can be upsetting, hard, sorry [begins to tear up]", 474-476. Jane reveals, "I don't know if this is pertinent, but you know, like I was sexually abused by my father when I was a child. I was raped, when I was 18, I was highly suicidal in high school. I'm a cutter", Jane, 346-347. Lastly Sasha exposes that she was bullied "I got really severely bullied and it went around the entire school and... that was not a good experience so I kind of... that's always in the back of my mind", Sasha, 392-394. In total, half of the nursing students that

participated in this study had experienced trauma and they understood that their experience of trauma was the trigger for their mental health concern. Part of their recovery was coming to terms with this trauma. Nursing literature speaks to trauma informed care, and the importance of nurses' incorporating trauma informed care into their practice, as trauma is sadly a reality for many people. This study data shows that nursing students are not immune to trauma. Nursing faculty must be cognizant that trauma can be part of their students with mental health concerns experience and their teaching and their programming should use the principles of trauma informed care to mitigate continued traumatisation (Bath, 2008).

Transitions. The definition of transitions relates to how nursing students understand their being at a given point in time, in relation to how it was earlier in time. Some nursing students remarked that the transition from High School to University was difficult; they had perceived themselves as a good student in High school but no longer in university. Andrew describes his academic performance as changing and he equated this to setting off his anxiety “[I have] always been a very high student then. During first year [university], my marks, just plummeted”, Andrew, 165-166. Sophie also found the transition to university challenging and unexpectedly difficult academically.

I guess in high school I didn't really have to try to get good grades it just happened (...) so coming going from that to university you actually really have to try and that was hard because it's like a slap in the face you're like wow I didn't expect that at all so that was really hard. Sophie, 265-270.

Other students spoke to mental well-being challenges arising because of a transition in the level of personal responsibility expected from High school to University.

So much [is] expected of you (...). For first year students is such a change from high school and it's kind of hard to get used to there's so much more independence (...) you to have a lot of self-control because you are now dealing with your own time and I feel like no one really looks out for you except for yourself”, Julie, 131-136.

The seemingly sudden need for personal responsibility brought with it high emotional tension and the lived experience of anxiety. The opposite was experienced by other nursing students who revealed that high school was emotionally tumultuous and that the transition to University brought a welcome relief in anxiety levels and triggered an improvement in their mental status similarly to what Kranke et al, (2013) claimed, “but yeah I think high school is definitely worse than first year”, Sophie, 279. Mariam says, “High School is really bad (...). Like I didn't want to live anymore but first year was just (...) stress and like just being sad so it was like different” Sophie, 273-277. Mariam alludes to the messaging that she heard while in High School about University as causing her undue emotional stress “I think there’s a lot of hype about how horrible university is and then you get there (...) what’s really horrible is not what you were told is horrible”, Mariam, 496-498. This poses a new question: What messaging is in High Schools about the University experience that fosters mental health concerns?

The transition from high school to university also brings with it a sense of grief from leaving good friends behind “in high school you're a very tight knit group and very close relationship, (...) and then in university everyone branches out and everyone goes down their own path”, Andrew, 916-919. The transition from High School to University brings on loneliness. The university environment is isolating despite being with more people there is less opportunity for quality interactions and connections with ‘someone’, “it's a big transition from high school as well but it's a lot less human contact and I get it like there's so many students you can't have that personal contact with someone.” Winter, 516-518. Students appear resigned to being lonely and accept loneliness as part of the University experience. In high school, nursing students knew people and people knew them. In university, they see themselves as nameless, only a number, story-less, and isolated. Jessica comes to realize, during the study interview, that

University was in fact more emotionally taxing than High School although she would never have expected this to be the case. She has come to see herself as insecure, because of her transition to the new university environment. She makes the distinction that this insecurity is not in relation to her external appearance, her 'body' but internally, with regard to her sense of *being*.

I had absolutely no problems in the high school (...) I had friends you know I felt perfectly comfortable with who I was (...) then I got to university and (...) I feel insecure in my well not in my body but in person and it's kind of like I went through all of the high school stuff in university" Jessica 1040-1046

Sophie adds that even when she did make friends in University, she would not feel at ease to share her story of struggling with a mental health concern with them. "Made a couple of friends first year and they were really nice but I wouldn't really discuss this (mental health concern) with them because it's still new and it's more for like a fun friendly friendship and not like open up about my problems and stuff", Sophie, 156-160. As a result, of her transition from high school to university, Sophie has lost a supportive friendship circle and has only a superficial circle of friends

With the transition from high school to university comes another major transition: from youth to an adult service recipient. This youth to adult service transition meant that therapists and counsellors who are involved in the participants' mental health care in High School would change, because of mental health care system regulations. At this pivotal time, when nursing students transition in regard to schools, friendships, roles and responsibilities, they most also face a transition in their therapists as most mental health therapists were designated child or youth specialists. The transition of therapists was identified by Winter as a mental health concern trigger "it was because I was (...) just finishing high school then I stopped seeing my doctor because I used to go there every week and then every two weeks and then every month", Winter,

391-393. Julie tells the interviewer when she started at the university she had a new therapist and this transition triggered her mental health concern:

I was kind of worried with my new therapist (...) I definitely did see a huge difference between their personality and the way they approached the therapy and their way of dealing with the depression because it was cognitive behavioural therapy there's like different methods to deal with therapy and I think they used different methods. Julie, 465-476

The change in therapist also meant a different mode of therapy, precisely when everything in the students' environment was changing. Changing from one *psy* expert to another meant that the student had to begin a new *psy* therapy regime. Student focus was not central to the new *psy* regime. Rather the expertise of the *psy* expert that was available to see the student directed what care the student received. The student explained she had had Cognitive Behavioural Therapy (CBT) while in High School, which the student felt was very beneficial. Unfortunately, CBT ended with her transition to university, as her new therapist could not offer CBT. The nursing student came to understand that the transition of therapist and consequent transition to a new therapeutic modality was a significant trigger for her mental health concern in her first years at University.

The change in physical environment that incurred when a nursing student transitioned from High School to University also triggered mental health concerns. Eleanor shares "I think (...) what I struggled with the most was (...) a change of environment so going from one school that I was so comfortable with to a completely new school", Eleanor 36-39. Eleanor further expounds that this environmental transition entailed, moving from one campus to another, one class to another, one lab to another, or one clinical setting to another exacerbated her mental health concern:

we had so many different placements and environment (...) you would be adjusting to a new environment (...) I just kind of started getting comfortable with it and then it would be over and then you'd have to start a new one (...) same with the labs (...) like it was hard to settle into it sometimes. Eleanor, 217-231,

Students understand transitions as inherent to the nursing program as students are required to shift clinical environments, labs, and classes frequently as part of their learning experience.

Although these transitions foster learning required in a generalist nursing education, the frequent changes, over short periods of time where understood by the participants as a trigger for mental health concerns.

Being a Number. Another significant trigger that aggravates nursing students' mental health concerns is identifying themselves as a body in an auditorium rather than a person belonging to the class. More than half of the participants in the study felt that they were a number, not a person in their baccalaureate of nursing program and this aggravates their mental health concern. Andrew affirms, "You're definitely just a number you're definitely just one out of 500 in the big auditoriums and I find that, that was, that was definitely not good and not beneficial to me", Andrew, 317-319. Julie echoes the same sentiment when she professes "I think that I feel like there is two hundred something people in those classes and the fact that I feel so tiny in such a huge classroom, of a subject that I barely understand or have trouble understanding sort of makes me feel a lot worse", Julie, 283-286. Jessica also has a sense of being "small", and insignificant "I think you always feel so small in such a big institution and you feel small in a big classroom", Jessica, 990-991. Whereas Mariam, in a frustrated tone states "you are dumb little student number 8,632. I don't know what you look like and I barely know your name" describing an encounter with an administration at the university, Mariam, 467-469. Julie believes that professors, like administrators treat students as numbers in the class, as things, not as *beings* and therefore it is easy for professors to have little interaction with the students:

I also feel like you're just another number almost like another student number and that's all they [faculty] know you by, I haven't had a professor who like actually went out of their way to try to remember their students names (...) and there is no like real connection with the professor or anything. Julie, 138-144.

Sasha, like Julie, claims there is little connection and communication between professors and students. Consequently, students are nothing more than a student number, never a name, and never in the context of a story. "Like your profs don't say good job on that exam, because again, you're just a number", Sasha, 652-653. Being a number is a significant trigger for their mental health concern as it denies their *being*, it objectifies the student and this they understanding as threatening to their mental well-being.

Nursing School. Nursing School is a trigger that negatively sparks mental health concerns. Participants shared that their mental health experience exacerbated when course content contained patient stories, which was akin to the nursing student, lived experience with their mental health concern. Teaching styles perceived as aggressive also threaten mental well-being. When what was taught in learning in theory, lab and clinical was discordant with what they saw in real practice also triggered mental health concerns. As well Nursing school brought an overwhelming sense of responsibility for others in their care and some students expressed that this lead to moments of extreme anxiety. The following paragraphs will describe the data that relates to the sub-sub categories of Nursing School: Course Content, Teaching Style, Role Dissonance, and Responsibility.

Course Content. Course content contains two key groupings. One pertains to clinical course content where students heard patients' stories, which seems to ignite mental health concerns if the experiences the patients shared were similar to the students' lived experience. The second grouping related to course content that spoke to the mental health concern that students had personally experienced. The following quote illustrates the first grouping, "hearing

other people's stories like patients or friends going through difficult times people dealing with the loss of a loved one, that always kind of triggers”, Andrew, 148-150. Sasha describes how the patients ‘stories rekindled her mental health concerns:

There is a few cases where (...) wow, that is (...) that was me when I was 16. (...) patients that hit a little too close to home. After that you kind of need to shake it off and be like but I’m past that now so it’s okay. (...) but, you know, you just feel... you feel for them. (...) it is a fine line between being empathetic and like living that experience again. Sasha, 629-633

Participants believe that nursing students resonate with the lived experience of their patients must be careful that their own mental health concern is not triggered. Some nursing students with mental health concerns believe they need to distance themselves from working in psychiatry thinking that the patient stories are too close, “I think that’s what really pushes me away from even wanting to be a mental health nurse. (...) it is too much for me. I got to deal with my own crap. Can’t deal with other people’s”, Jane, 339-341. Mariam, like Jane, found nursing in psychiatry a threat to her well-*being*. Patient stories, her stories, and those of her family members were all too similar and she needed space to maintain her mental well-*being*, “my mental health clinical... I hated every second of it, because it is just like (...) I have mental health issues. All the people, I am related to, have mental health issues. Like I’m dealing with it at home I don’t need to deal with it in my professional life.” Mariam 818-821. Jane explains how a patient’s story triggered her depressive and maladaptive eating behaviours, “I had a highly depressed major depression lady (...) just so much baggage on you, and I remember telling my instructor. (...) I had the worst day ever, when I went home. (...) I am like I can’t be a mental health nurse. I would be huge. Just eat away my problems”. Jane, 328-333. Andrew, who experienced the traumatic event of his best friend’s suicide in grade 12, heard similar stories from patients. Hearing that others experience the same trauma made him feel vulnerable as well as the vulnerability of people in his charge:

you suffered, like a patient suffered, a traumatic event in the late teens (...) oh I did too and I'll start to talk to them and find out even more similarities and they just kind of, you just kind of worried about your own self and you know is anyone really safe? Andrew, 631-637

Although Andrew, Sasha, Mariam, and Jane spoke specifically of how the patient stories in mental health settings triggered their own mental health concerns, Jane also recalls that when on a palliative care unit she also felt her anxiety rise as the experience rekindled her unresolved guilt.

My life experiences this year, palliative lab, end of life lab, was very difficult (...) having an actor act out fear of having cancer and the fact that they are going to die, it is very triggering. Jane 863-866.

Just as patient stories from clinical or lab triggered mental health concerns so did theory content. To illustrate the threat to her mental well-being, Summer discloses that the discussion of sexual assault in a theory class was very difficult for her.

[T]he topic of like sexual assault that kind of thing like I was assaulted when I was 13 twice and that kind of perpetuated the health issues so I think sometimes that can be upsetting, hard, sorry (student tears up). Summer 473-476.

Sasha who has lived experience with obsessive-compulsive behaviour shares that when her professor taught about anxiety disorders and particularly obsessive-compulsive disorder, she became distressed. More importantly Sasha explains what triggered her concern was not the topic per se but that the professor presented the person with obsessive compulsive disorder as a helpless, out of control, 'sick' person. Sasha felt that class content reduced her lived experience with obsessions and compulsions to a list of symptoms. Living with OCD became behaviours that needed to be controlled, number of cases a nurse would expect to come across, and statistics to count. Nowhere was the lived experience of a person with a mental health concern explored, no understanding of what it is like to struggle with OCD was provided. This way of presenting the

mental health content was a threat to Sasha's mental well-being as she felt her lived experience was not valued.

We were learning about obsessive compulsive in one of our courses and (...). It is like these people (...) they cannot control it (...) kind of putting them in the helpless situation. (...) it's kind of a reductionist attitude and I would hate for me to become a number or a statistic or a case study or, you know, something like, Oh, look at this. , Sasha, 333-341

Missing the focus of the person with a mental health concern and the seemingly un-empathetic presentation of the professor of the topic is what upset Sasha and triggered her mental health concern. While some students brought to light how theory content could trigger mental health concerns, others identified how the importance weighted to certain theory topics or course content could also trigger mental health concerns. Students believed the BScN has little mental health content. Participants despairingly interpret this as faculty reinforcing what the profession and society believe, that mental health concerns are unimportant. "It was like two lines and a power point and that just kind of pushes the message home that even in a mental health class when you should be discussing mental health issues it's like barely talked about", Mary, 497-500. As well, the presentation tone posed a threat to mental well-being. "Hearing Profs Talk about people with mental illness (...) they do it in a very objective, (...) with kind of like negative connotation". Sasha repeatedly describes mental health content as presented in a "reductionist" manner. This reductionist perspective leaves Sasha distraught as she feels this kind of teaching perpetuates poor nursing care, as nursing students will leave class having learnt that people struggling with eating disorders "just don't want to eat". The tragedy for some nursing students lies in how professors present the mental health concern not the person. Sasha believes this invalidates the important role of nursing and disaffirms her experience as a person, with mental health concerns, "It's (teaching style) very much, you know, looking at the disease

rather than the patient. Nursing is more about that, which I like, but, you know, when people don't have an understanding of mental illness and they're just trying to teach course material and make a multiple-choice exam, well, it's very reductionist", Sasha, 585-592. The lack of human empathy expressed by her professors isolates Sasha, reduces her experience as a person with a mental health concern to a case, a number and worse, something that Sasha refers to as "that student", the other, the student with a mental health concern, the stigmatized and certainly not one of the nurses:

There's no lived experience element discussed. It's not like, (...) this is why the person does this, but you know, what are they experiencing as they do this and it's such an important element of nursing I feel like it needs to be looked at more (...) So that's been hard listening to profs talk about that. Yeah. I just kind of anxious - I'm anxious about being isolated as... so at the same time, I don't want to be a number. I also don't want to be that student [students raise hands to indicate quotations] you know. It's hard. Sasha, 594-600

Fear of professors identifying her as "that student" and then separating her from the other nursing students if she speaks out about how the lived experience keeps Sasha silent. Self-silencing is a significant aspect of the lived experience of nursing students with mental health concerns that will be discussed as part of self-stigma later in this chapter.

Teaching Style. Just as the nursing program, content can trigger a mental health concern, so can the teaching style that the professor uses to translate knowledge to the nursing students. Many of the participants felt that their mental health concern exacerbated by how some professors taught. When professor or instructors used fear tactics, for example saying students will fail their course, or will never be registered or worse kill someone, as a means to emphasize the importance of certain material or expected nursing behaviour, this was detrimental to mental well-being. "I feel like a lot of professors are trying to scare us almost, either scare us out of the program or like into something else", Julie, 575-577. Nursing students with mental health concerns felt their anxiety rose when interrogated by professors. This happened most often when

medications were being distributed “there’s quite a bit of anxiety involved with giving out medications because they grill you” Jane 129. “There’s a lot of, you must know this or if you don’t know it your patients will die because you are unprepared”. Mariam 89-90. Verbal aggression, from the professor to the student, also exacerbated mental health concerns, “I don't like when teachers get aggressive. I guess because it makes for an unsafe [place] I feel like I don't feel safe in my learning environment”, Mary, 677-679. “[S]he's (...) really intense you go into an exam and she's like no talking in the exam room and she's like yelling and no one is talking, and that makes me stressed just like that can make me feel panicky”, Mary, 666-669. Regrettably a perceived hostile learning environment, where professors are verbally aggressive, also disillusioned students’ image of a professional nurse.

I feel when a professional act unprofessional (...) it makes me scared I guess and I think that's really like I didn't want to go to the class after which is really bad because you know I have to go to class but like I felt like I skipped the next two classes because I'm so anxious. Mary, 673-678

Jessica articulates that the teaching style used by faculty “can make or break your experience for sure”, Jessica 810-811. Eleanor agrees that she has had both positive and negative experience with instructors in nursing school. Eleanor elaborates that her negative experiences came about when she felt perpetually watched and judged by some clinical instructors who could not trust the student.

I think honestly it was just the clinical instructor that (...) made or break a placement so I've had a really great one that were really clear helped you with everything. (...) other ones who just weren't really there for us, (...) some teachers just make you feel like you're always doing something wrong kind of thing and aren't really there to help you but just to point out your mistakes. Eleanor, 407-417.

Alternatively, Sasha shares that she had clinical teachers who were less judgemental and she believes this makes for a positive teaching encounter, which she coins as when the teacher “take the institution out of teaching”,

Like some profs I am comfortable with (...) always the profs that, you know, take the institution out of teaching. So, it's the personalized, like I care... like even though I have a class of, you know, 250 students, I care about each and every one of you and, you know, I've had two profs in particular (...) you feel comfortable because, (...) you feel like they would be receptive and they wouldn't judge you because of that [mental health concern]. Sasha, 481-487

Sasha elaborated on the curious phrase “take the institution out of teaching” and described this teaching style as more personal, one where the teacher focuses on the students' needs rather than institutional directives. Sasha repeatedly expressed her concern regarding how teaching style will trigger nursing students' mental health concerns. She maintains that faculty must be aware that their teaching style will affect mental well-being of students in the class. The onus of responsibility lies with the faculty to use teaching styles that favour a focus on students' needs and an atmosphere of openness to discuss mental health concerns.

Well, I guess as nursing professors (...) it is important for professors to be aware that statistically speaking, they have someone in their class with mental illness. They need to think about how they can, you know, be the kind of prof like (...) that students are comfortable with going to” Sasha, 849-853.

Other students echo the same sentiment and share they had experienced teaching encounters with faculty that demonstrated an openness, allowing for discussion of, and acceptance for mental health concerns. Consequently, their own mental well-being improved: “well there has been Profs that are very excited about the cause [Mental Health] and what they are teaching which makes you excited about it (...). Winter, 429-433. The following quote allude to how clinical instructors and professors demonstrated this openness to mental health concern discussion.

I think at one point we touched on mental health briefly and he [Professor] kind of made a comment, like, Yeah, like I'm not a therapist, but I mean if you guys are struggling in the course or need extra help or whatever. Leila, 536-538.

The teaching style that promoted an openness for discussion about mental health concerns is not the norm. This experience was more unusual although very welcome.

Another aspect of teaching style that contributed to a student's mental health was the type of feedback, being either generous or stingy, they obtained. "The type of instructor and (...) the type of feedback and support you get, varies from instructor to instructor, and that can essentially make or break you [emotionally] as a nursing student", Jane, 155-156. Jessica explains "the clinical teachers who see you practice and they give you positive feedback I mean your mental health is just optimal right vs if you have someone who kind of doesn't have very many comments. [Then] your kind of questioning yourself, and it's hard on your self-esteem", 777-781, Jessica. The same student continues to articulate this important relationship between mental health concerns and receiving teacher feedback illustrating her understanding of the phrase "make or break" a nursing student:

I was always stressed because I had questions. (...) I could never find her and she never praised you if you did something well. You do not need praise but a little bit sometimes as a student when you're insecure is good. (...) I had another teacher who was just another personality (...) she would notice things that you did and she told you you are so good at this. Jessica, 786-790

Mariam adds that she would have appreciated more feedback that is positive and an acknowledgement of how she was progressing in her abilities. She believes this would have advanced her confidence and mental well-being. "I would have like more feedback of yes, more acknowledgement, and validation of, yeah, this is really hard. I know you haven't slept well in five days". Mariam, 654-655. This quote also alludes to teachers acknowledging that they can see students are struggling mentally and trying their best despite their emotional challenges. It seems from the participants responses that feedback is important and needs to be frequent and meaningful to build the students confidence and fosters mental well-being. Participants in this

study understood it was the faculty's role, especially clinical instructors' role, to provide quality feedback. Judgement without suggestions for improvement was not helpful in their development as nurses or to their mental well-being.

Role Dissonance. Another trigger for mental health concern, subsumed under the subcategory of Nursing School, is that of Role Dissonance. Role dissonance is the emotional discomfort, anxiety or hopelessness, that nursing students experience when practice standards they are taught do not reflect what they see in the clinical setting. Although mentioned by only three of the twelve participants, those that spoke of this role dissonance found it troubling to their mental well-being. Jessica spoke to how damaging this misalignment between practice and theory could be to an evolving professional's mental well-being. Burnout, Jessica believes results when nursing students see professional nurses take short cuts, because of the excesses demands and ultimately do not practice as is expected by the profession

I worked at the hospital between 3rd and 4th year and I think that is when the burnout happened (...) I think I got very disappointed in how many corners were being cut and how people do the best they can and like still feel like you did not do enough. Jessica, 241-249.

Role dissonance also came when a nursing student felt they needed to display emotions externally that they did not hold internally in order to mitigate the expression of their mental health concern. Mary felt obliged to put on a brave face, projecting confidence she did not have, to be the nurse she wanted to be. Mary understands this as something she has to do and that over time it may improve her mental well-being,

I definitely try to (...) project confidence even when I'm not confident because I know that's kind of what's really related to my stress (...) or my anxiety I guess because I think lower of myself than I really am so like especially with my depression (...) I see myself as (...) pathetic (...) when in reality I know I can be a strong person. It's just over coming my own self perception of who I am and so in clinical I tried to force myself to be the person I want to be because I know like I can get there I just have to push myself harder. Mary, 96-106.

Responsibility is the final sub-sub category under nursing school that identified by nursing students as a trigger for their mental health concern. Responsibility includes being entrusted with the lives of vulnerable people and having to make decisions and to take actions that could result in life and death consequences. The weight of this responsibility was at times threatening to a nursing student's mental health and well-being. "I was not confident in my nursing abilities and very honestly, I'm responsible for people's lives. I found that extremely overwhelming. I found being in the hospital setting extremely overwhelming because people in hospital are sick" Mariam 13-16. Curiously, only one of the twelve students mentioned responsibility as a trigger. This absence in itself draws attention to the possibility that the vast majority of the nursing students might have been comfortable with the responsibility that nursing entails and did not feel emotionally taxed or threaten with caring for others who might be in very precarious health situations. Perhaps having responsibility for another may be similar to the altruistic qualities that Leamy et al, (2011) claim favour recovery.

5.1.3 Feelings

The third category under the major theme *Concerned-Self*, was feelings. Although the concept 'feelings' is rife with conceptual complexity (Kleinginna and Kleinginna, 1981), feelings in this study were defined as by American Psychologist R.S. Woodworth (1948), as the emotion of the individual's internal state. Exploring this internal state is central to mental health studies and to gaining an understanding of the lived experience of a mental health concern. This theme describes the predominant emotions that nursing students experienced living with their mental health concern. This theme relates to the *Concerned-self* not the *Psychiatrized-Self* or the *Recovering Self*, explored later in this chapter, as feelings are distinctly different under each

theme. The key internal state emotions or feelings expressed as a *Concern-Self* where; frustrated, hopeless, out of control, and alone.

Frustrated. Three of the twelve nursing students spoke to how they felt frustrated because they were incapable of concentrating when their mental health concern peaked. Not being able to concentrate put their academic performance in jeopardy and this was the source of frustration, as they knew they could do better. Mariam says she was

Anxious all the time. I could not concentrate on anything. (...) say you're reading a book but you're also waiting for the bus, so you're always constantly looking up. Is the bus here? Did I miss it? So it's that kind of I can't concentrate because I'm always thinking of something", Mariam, 126-129.

The feeling of frustration was persistent, debilitating, and hindered academic performance and mental well-being as Sophie shares. "I guess (...) studying is really hard you get distracted really easily. You can't concentrate which is really frustrating" Sophie, 177-179. Summer continues in the same vein "I would just wait in the class for it to start, (...) I would get frustrated because I had a really hard time concentrating so I wasn't able to do my work very well and like I said I was always very studious so I got really frustrated with myself", Summer, 132-138. Students recognize that their mental health concern robs them of their ability to concentrate, therefore their ability to study and maintain their high academic standards. This experience leaves them frustrated, which in turn contributes, negatively to their mental health concern.

Hopeless. Two of the twelve nursing students was felt hopelessness when faced with their mental health concern. Mary, who was a university student, but studying in another discipline when she was diagnosed with depression, shared: "my depression got the worst during that year. It was the idea that I had no future; I hated the fact", Mary, 264-265. Studying a major that she had lost passion for and believing she had no prospect for employment upon graduation

wore heavily on Mary, leaving her feeling hopeless. Adding to her already despondent state she was then told by a *psy* expert that she had depression and that it was a chronic illness: “I think accepting the fact that it's a chronic illness has been difficult because I don't want to be this way” Mary 617-619. Having a chronic *psy* label magnified her feeling of hopelessness. Her sense of being was rocked. For Mary, hopelessness was most acute before she came into the nursing program. She was so committed to becoming a nurse and she saw no other meaningful alternative. The fear of not being accepted into the nursing program and not being able to study her passion lead her to the point of extreme hopelessness, to the point of considering suicide. Being accepted into the program was her only hope; “I was really nervous about not getting accepted (...) I couldn't really cope and like I got really suicidal at that time and I would say like that was probably the closest I have ever been to actually killing myself I had a plan I had a date. “ Mary, 543-549. Alternatively, Julie’s lived experience with her mental health concern began in High School however now in University, she feels more overwhelmed with the workload, and this sets the stage for her unrelenting feeling of hopelessness. “I feel like I'm going through emotions not necessarily actually living kind of just surviving sort of thing”. Julie, 91-93. Julie perceives student life in the nursing program as something that robs her of living a meaningful life, of being in the moment. Unlike Mary who found hope when she came to the nursing program, Julie, whilst in the program, was having her hope eroded daily because she understood program expectations to be unrealistic. These are two perspectives on hopelessness and both demonstrate that the feeling of hopelessness can be part of the lived experience of nursing students with mental health concerns.

Out of Control. Some nursing students, four of the twelve interviewed, voice a feeling of losing the reigns of their lives, that things seem to get ‘out of control’ and then their mental

health concern would wreak havoc on their lives. “So, when things get out of my control, (...) I’m going to have a [panic] attack”, Mary, 140-141. Mary recognizes that she has both periods of control and those without control. Other students feel like they are never truly in control, as anxiety can well up at any time to the point of panic. Jane understands herself as damaged, because she does not have control of her *being*: “yeah I’m like a walking nut bag. (...) Like I’m unhinged or, you know, I’m uncontrollable because I have something that could happen at any point.” Jane, 421-423. Summer also articulates that her mental health concern threatens her feeling of *being* in control of her life. She compares how she perceived *being* out of control as different to a typical students’ school stress. “[mental health concern] threatens my ability to be in control, (...) a little bit extra more so because it’s something that I have to plan other things around which sounds horrible and weird but yeah sometimes from that I can feel like I, I (...) don’t have control over something. Summer, 953-961. Sophie, on the other hand, mentions that she has learned to control how she feels through thinking positively. Feeling in control for Sophie is to control her mental health concern, something she believes she can do,

If I'm thinking negative then obviously like my day is not going to go as well as it should. (...) if I think positive I think it starts with me and then little factors influence like your environment the people around you and stuff like that but most of all its me that can control how I feel and how I want to control it and show it. Sophie, 702-707.

Alone is a feeling felt by nursing students at times during their lived experience with mental health concerns. Earlier in this chapter, I presented data that related to the subcategory isolation, perceived as an external stress that exacerbated the nursing students’ experience of their mental health concern. Feeling alone was the overwhelming internal sensation experienced by the participants. The two concepts alone and isolation are clearly dissimilar. Five of the twelve nursing students describe feeling alone when their mental health concern became part of

their lived experience the mental health concern put distance between the students and significant others. Their mental health concern drove them to feel alone and made them want to be alone which further exacerbated their mental well-being. The more alone they were the more their mental health concern festered. The more their mental health concern festered the more alone they felt. “I was very, very lonely I didn't interact with a lot of people, and I would have a lot of friends asking me what's going on are we in a fight (...) and that kind of thing and I would just say no I don't really want to hang out.” Summer, 143-147. Family and friends might have tried to reach out to the nursing student with a mental health concern, but family and friends did not understand that the rebuff they encountered was part of the mental health concern, therefore they walk away from the relationship, leaving the student feeling even more alone. The nursing students believed they drove others away leaving them feeling overwhelming alone. Nursing students felt alone because they had no one to talk to, and no one who understood what they were going through. Some students felt that even those closest to them, family members, could not be counted on maintain connection, the antidote to feeling alone. In particular families’ members that denied that the student had a mental health concern added tremendously to the nursing students’ feeling of being alone. Julie describes how not having her experience with a mental health concern validated by those closest to her, made her feel that much more misunderstood and alone,

they [parents] feel like I don't actually have depression (...) you're just sad or whatever so that kind of upsets me and I definitely think that affect my relationship with my family because it's just frustrating to feel like you already feel so alone when you're depressed and you want to reach out, Julie,177-182

Other students never spoke to family members because they feared sharing their mental health concerns would mean something was wrong with them, and that would be a burden to family “I avoided telling my parents because I knew something was wrong but I didn't want them to be

worried about me”, Mary, 322-324. Jessica echoed the same sentiment “nobody (...) you like even my family didn't know that I was struggling “, Jessica 302. Mary eloquently describes what the feeling of loneliness that a student with a mental health concern experiences.

I've always felt out of place and I remember one time telling my boyfriend I was like everyone has a movie script and we're all part of the movie but I didn't get the script so I just walk around and do whatever I want but everyone is following the script that I can't even comprehend. Mary, 381-385

Although only five of the twelve students describe feeling alone because of their mental health concern previous elaborations on how nursing students as concerned self-described their lived experience with mental health concerns could be understood as variations on being alone, of being disconnected from others physically, emotionally and socially. Later in this chapter, a discussion on stigma and its role in driving a sense of being alone will transpire. As well, the feeling of belonging, as experienced in the third theme to surface in this study, *Recovering Self*, may be the antidote to feeling alone. Belonging, as understood by the nursing students, is a feeling, an internal experience that mitigates the ramifications of mental health concerns. The feeling we will learn later in the chapter, is something that is nourished.

5.2 Theme Two: Psychiatrized Self

In order to gain a deeper understanding of how nursing students with mental health concerns understand their experience, participants explained what it is like to be a student with their mental health concern and how it affect their student life. They were also asked how nursing students with mental health concerns made sense of their experience in light of the psychiatric apparatus that permeates student life? How institutional policies, procedures, and technologies help or hinder nursing student mental wellbeing? The next section of this analysis will expound on the data that surfaced in relation to these questions.

As the nursing students experience their mental health concerns, all twelve participants in this study interacted with the health care system, the *psy complex*, and obtained a *psy* label for their mental health concern. With the *psy* label, nursing students could access *psy* care regimes initiated by *psy* experts. Curiously, although this researcher was careful to use the term mental health concern, the nursing students identified themselves with *psy* labels, for example, depression, anxiety, or obsessive-compulsive disorder. The label appeared to give students a language to begin their discussion of their mental health concern, the *psy* label seemed to justify to the students that they had a reason to speak to the interviewer and the experience central to this study. The *psy* label they believed gave them credibility. Whereas the first theme in this study the *Concerned Self* sought to gain an understanding of the experience of *being* a student with a mental health concern, this second theme, *Psychiatrized Self* speaks to experiences that nursing students spoke to that occurred once they obtained a *psy* diagnosis. This theme further divided into the categories; Consequences, Regulated Self, Stigmatized-Self and associated subcategories.

5.2.1 Consequences. The first category to emerge as the nursing students described their experience as a *Psychiatrized-Self* surrounded the consequences of a *psy* label. The category *Consequences* divided into two subcategories, *Docile Self* and *Resistant Self*. All of the nursing students with mental health concerns contributed to findings associated with these subcategories. The experience of *Docile Self* proceeded *Resistant-Self*.

Docile Self. Being attributed a *psy* label, by a *psy* expert was something that happened to the nursing students. At first the participants in this study acquiescent and accept the *psy* label which initially held very little significance to them although with it they began to compare their lived experience with a mental health concern to the norms dictated by the *psy* disciplines. Their

being was subtly, docilely and ubiquitously subjectified as the students tried to understand their lived experience with a mental health concern through the only knowledge, language, resources available to them, that of the *psy complex*. Nursing student internalized this *psy* language and understanding in an attempt to comprehend the experience they had thus far as a *Concerned-Self* with a mental health concern. The students in this study came to understand their lived experience with a mental health concern and their means of dealing with challenges through the tools of the *psy complex*, namely the labels, dictated treatment plans, medications, talk therapies and hospitalization. This *psy* language and associated treatments disciplined nursing students with mental health concerns, as described by Foucault, into a docile body, termed *Docile-Self* in this study. The lived experience of the nursing student as the *Docile-Self* is one of subjectification where the *psy complex* acted on the nursing students with mental health concerns. The lived experience as a *Docile-Self* divides into four sub-sub categories: Multifaceted, Hospitalization, Medication, and Talk Therapy.

Multifaceted. All twelve nursing students, where given *psy* labels (psychiatric diagnoses) at some point, during their experience with a mental health concern. All, but one student had multiple *psy* labels attributed to their lived experience and consequently they understood their experience to be multifaceted in nature. Andrew explains “I have a little bit of anxiety from time to time those are my two main ones, depression and anxiety” Andrew, 28-29. Eleanor expounds “anxiety and [a] kind of depression” Eleanor 22. Leila speaks to her “anxiety and perfectionism and OCD” Leila, 205. Sasha shares “I had depression, an eating disorder, it was not specified. It was kind of a mix of anorexia and bulimia and I had severe obsessive-compulsive disorder” Sasha, 72-73. Nowhere in the voices of the nursing students was a reaction to the *psy* label articulated. The labels anxiety, depression, eating disorders, obsessive compulsive disorder had

no meaning to the participants when they were first attributed to their lived experience. These labels when first attributed to the students lived experience did not serve any purpose. They were neither negative or positive, helpful or hindering. The language had no meaning and the *psy* label no value. One can even hear in Winter's words a sense of the absurd in that she went to the hospital with one concern, an eating disorder, and then left the hospital with three disorders, "you go into the hospital saying oh you have an eating disorder and then they diagnose you with 3 other things". Winter, 47-48. She finds *psy* labels as generously attributed to people with mental health concerns by *psy* experts, but they do little to help a person understand their experience. Even though she questions the number of *psy* labels given to her as being somewhat excessive, Winter, passively or docilely accepts the labels, without questioning. At this point in her lived experience, the *psy* labels are meaningless words; they carry no value and serve no purpose to her. However later she, and other participants in the study, will share that as she engaged with people representing the university and the nursing profession, she faced stigma because of these *psy* labels and learned that they were powerful and lead to consequences in her lived experience. Later in this chapter, Winter's experience, and that of the majority of the students in this study, as the *Stigmatized-Self*, stigmatized because of the *psy* label will be presented.

Hospitalization. Only three of the twelve nursing students were hospitalized because of their mental health concern, thus hospitalization is not typical to the lived experience of the participants, however for the three nursing students it was another example of what was categorized as the *Docile-Self* experience. All three participants hospitalized came to be so because someone else deemed it necessary, it was not something they choose, wanted or understood as necessary. Hospitalization did not occur because of their volition.

it wasn't me that knew that I had an eating disorder or whatever it was my parents who I guess my health got so bad they had to take me to the hospital so I

guess it wasn't me that said Oh I have a mental health problem because I didn't even know what mental health problems were, Winter 29-31

The incomprehensible nature of the mental health concern when it first appeared in the life of the student is apparent in Winter's words. She has no previous experience and thus "didn't even know what mental health problems were". She does not have the words or understanding to make sense of her experience, without words or experience she trust her parents who in turn trusted or perhaps succumbed to the words and the advice of the *psy* experts.

Leila and Sasha experienced repeated hospitalization before and while pursuing post-secondary studies. "I've been in treatment [hospitalized]...for an eating disorder, both during high school and last year actually", Leila, 39-40. Sasha shares her experience of repeated hospitalizations for multiple *psy* labels "I've been in treatment [hospitalized] for both kind of [mental health concerns] ... or for the three things kind of on and off really since high school," Sasha, 75-76. Although hospitalized, Leila and Sasha do not elaborate on the experience. However, Leila does voice that she saw no benefit from her hospitalization, because at that point in time, it was something she did for others, not herself. She states "I mean I did [names the hospital] to kind of please other people (...) nothing really improved. I mean the symptoms subsided while I was in the program and then after that I kind of just bounced right back". Leila 63-65. This illuminates the quintessence of the *Docile-Self*, how when hospitalized the *psy complex* acts on the person, they are subjected and improved, as Rose (1996) would contend, however hospitalization does not benefit the nursing student in any fundamental manner. Winter, Leila and Sasha, were minor when first hospitalized. Being a minor might have contributed to the *Docile-Self* experience. However, Leila and Sasha faced re-hospitalized while in University and despite sensing that the hospitalization would bear little sustainable benefit they once again submitted to the advice of *psy* experts.

Medication. The majority of the students, eight of the twelve participants, spoke of their experience with prescribed medications. The nursing students explained they reluctantly accepted to take the medication and felt coerced to do so because their *psy* expert urged them and offered little more to help them with their lived experience with a mental health concern. This ‘help’ that the medication would offer was explained to the students by their *psy* expert as a means of correcting or improving some biological imbalance, an imperfection that the student had as a result of their mental health concern. Mariam tells the interviewer that her *psy* expert instructed her that medication would help her by fixing her flaw, by ‘resetting’ her to a “normal level of functioning” inferring that as a student with a mental health concerns she was abnormal, and did not meet the norms of normalcy set by the *psy complex*:

The theory behind (...) medication (...) it would reset myself to a normal level of functioning. (...) I am unable to function. I am having trouble doing day-to-day stuff. (...) the idea was to be on the medication for a few years to reset. Mariam
63-67

Mariam’s tone, body language, and choice of words “the idea was” appeared to question the claim that the medication would benefit her yet she felt obliged to take the medication. Leila was also told by her health care provider to take medication to help with “some sort of imbalance”, inferring that she was flawed and needed to be improved. Leila believed the medication helped her but waived on if the medication is good for everyone. She reasoned that her success with her medication relates to what her *psy* provider believed and promoted, not what she believed. Leila inferred that she accepted she had an ‘imbalance’ that could be restored to normalcy with a pharmaceutical intervention. In hope of correction or improvement, Leila took the medication prescribed. She followed her *psy* expert’s advice although not convinced medication is required to restore mental well-being, which could be an example of how the student’s personal values and beliefs were subjugated as the *Docile-Self*.

I mean I guess it depends on the professional using them and promoting them, but for the most part (...) is [medication] benefiting patients? Absolutely, because I think medication is a big part of treatment nowadays. Not to say that it can't be done without, but I think it is a huge thing, especially if it's some sort of imbalance. Leila, 820-824

Jane articulates she is a “firm believer in psychopharmacology” after having been prescribed and taken medication to manage her anxiety. Jane emphasizes that medication was invaluable to her care, but emphasizes that it was only a short-term intervention to control her thoughts and behaviours.

I am a firm believer in psychopharmacology. I used it. It was a necessary treatment for me to get my anxiety under control to a point where I no longer need it. I have, you know, my clonazepam. I no longer have to be on Cipralex for the rest of my life. Short-term treatment, to get it under control. Jane 1061-1062.

Jane accepted to take the medication because her anxiety was beyond her control and hindered her experience of being. For all three students, at a certain point in their progression with the lived experience with their mental health concern, anxious symptoms robbed them of being in control. The promise of being in control, led Jane to accept a pharmaceutical intervention. If the medication did as the *psy* expert claimed it would, and restored a sense of control this was a positive force in the students' lives. Curiously, medication was not always a benefit; for example, Jane spoke of having success with anti-anxiety agents, whereby with the medication she felt in control, yet extreme frustration and pain when her *psy* expert prescribed medication to reduce her depressive symptoms that in fact drove her into deeper despair. Jane articulates that not having the same success with anti-depressants was a dispiriting experience. Several medications were prescribed by her *psy* expert and all failed to reduce her depressive symptoms. With each new prescription, and no subsequent relief, Jane felt more hopelessness. It also appears that with each failed attempt Jane's confidence in her *psy* expert and in pharmacological interventions erodes, and she becomes more discouraged. She alludes to being a victim of a

process where medications are ‘tried on her’ without any rhyme or reason. She has no control or no assurance from her *psy* expert they will help. Subjected to futile interventions, she becomes discouraged and her mental health concern exacerbates..

I have never had success with depression medication (...) unfortunately, with mental health and medications; they are very discouraging, because it’s always try this medication. It takes a month to two months for you to feel the effects. Oh, it doesn’t work. Okay, let us taper you off that one and try you on a different one. You know, it is a lot of trial and error and (...) it is very discouraging. Jane, 1064-1071.

Jane inferred that her *psy* expert is unsure of what to prescribe in her case, and offers nothing else, leaving her feel very vulnerable and hopeless. Despite her lack of confidence that her situation will change with yet another pharmaceutical intervention, she is coerced and succumbs as her *Docile-Self*, to the *psy* expert advice to take another medication, buying into the dominate discourse that she is damaged and needs to be improved as she is flawed.

Unlike Jane’s situation of never finding the right medication, Mary found relief with the first prescription given to her by her *psy* expert. However over time the medication lost its effectiveness and thereby Mary became discouraged with the *psy* complex, namely the medications and expert advice. Once Mary realized her medication no longer alleviated her depressive symptoms she requested another medication but her *psy* expert was unwilling to prescribe another pharmaceutical intervention claiming that changing the medication while in school might make matters worse. Mary did not understand how things could be worse yet the *psy* expert convinced Mary, by means of instilling trepidation that Mary will regret changing her medication should her symptoms worsen. Curiously, Mary’s words describe a paradox in *psy* interpretation of the lived experience with mental health concerns. Interestingly, the ability to change the medication and improve her lived experience lies with the *psy* expert, but the choice to make her situation worse by changing her medication lies with Mary. Mary has no option that

would improve her state of being as her *psy* expert offers her medication that does not work. At this point, Mary is a victim, manipulated by fear to take a medication that does not help her and offered no succour.

It was the first medication I ever tried and it worked luckily right away. I do not find it works as well now but because I am in school, my doctor is not certain about changing it. I talked to her about it last semester but yeah she does not want to change it just because if things go wrong and I am in the middle of my schooling and I will regret that. Mary 37-42

Mary also highlights her inability to effect any change regarding her care and mental health *well-being*. Her *psy* expert dictates what is best for her, and holds her by means of fear to following his/her advice.

Eleanor, like Mary, also requested a change in her medication regime and she too did not have her wishes heard. Years ago, Eleanor's lived experience was attributed the *psy* label of anxiety. At the time of the interview, she was symptom free and wanted to wean herself off the medication prescribed by her *psy* expert. Eleanor described how her *psy* expert convinced her, by means of instilling fear, to continue with the medication while in school because school is stressful and runs the risk of exacerbating her symptoms of anxiety. Here again no other option of *psy* care was suggested to the student. Taking medication, was the only option offered, albeit it being ineffective or not needed as per the students in this study.

the only reason I think I'm still... on it [medication] is just because I haven't really had a chance (...) I've brought it up to my doctor before but since she said you know I'm still in school and there's going to be a lot of changes in my life she wants me to stay on it. Eleanor, 48-53

Eleanor and Mary felt powerless and continued to take the medication prescribed for them, because of their *psy* expert has informed them that stopping runs the risk of further thwarting their mental health. They do not believe the claims of their *psy* expert yet fear effectively coerces them to maintain the ineffective status quo. Continuing with the ineffective status quo

medication regime satisfies the conditions of a relationship with their *psy* expert but is by no means a beneficial intervention. The students are powerless in their ability to help themselves, which further foils the students' mental health and well-being. The nursing students with mental health concerns as *Docile Selves* have been subjectified as the 'mentally ill' never to recover being.

The *Docile-self* as experienced by nursing students with mental health concerns manifests when nursing students spoke of taking medications despite the debilitating adverse side effects they incurred. Although the side effects of pharmacological interventions made the students feel worse, having no other options or understanding of their state of being, they continue to heed the advice of their *psy* expert and obediently consume the *psy* medication. Other students who took action and stopped their medication, because of the adverse side effect, were driven to resumed their medication regime because in their experience the deleterious effects of withdrawal were far worse than the adverse side effects of the *psy* pharmacological intervention. Either situation rendered the nursing students powerless, unable to act for themselves, left dependent on something outside themselves; all the while doubting that medication improved their state of being. Winter's quote explains this perceived as upsetting situation. She was reluctant to take antidepressants because of how they made her feel physically and how the act of taking the medication where contrary to her values and beliefs. However, despite verbalizing her disinclination, Winter submits to her *psy* expert's advice to take the medication for what she considers a lengthy period whilst experiencing continuous mentally debilitating negative effects.

I took Prozac for a while but I really did not like it. (...) I am never for the idea of taking medications to alter my brain chemistry to treat something. I do not know it is kind of a way of thinking I guess that's the way I see it now, but at that time (...) it made me more of a zombie. I guess I did not really like it but I was on it for about a good year. Winter77-83

The continuous personal internal tension of wanting to stop taking medication because of deleterious effects, fear of doing harm to oneself (altering the brain), yet feeling obliged to continue because of the *psy* experts advice was also experienced by Eleanor and Jane. As shared in an earlier quote both students felt that their medication no longer served a benefit and against medical advice they tried to discontinue their medication regime. When they stopped the *psy* pharmacological intervention, they encountered substantial withdrawal symptoms. The symptoms were so harsh they felt they had no alternative but to return to taking the prescribed medications. The *psy* pharmaceutical intervention became the force of coercion on the *Docile-Self*. The following two quotes illustrate the consequences of being medicated, and the inability to act against the effects of the pharmaceutical agents even if the nursing student with a mental health concern desires otherwise.

I have tried to get off it [medication] myself. (...) I feel awful like flu like symptoms (...) anytime I have tried to taper down. I've told her [psy expert] obviously she can't stop me from doing it but like the symptoms were just too much to take.(...) I'm hoping it won't be too difficult when I do try to get off it especially because I don't have I don't have benefits and it's expensive .Eleanor 55-62

Attempts to stop taking the medication met with significant discomfort that drove students back to taking *psy* medications. Being back on the medication was disappointing to the students; they were disappointed in themselves for not being able to overcome the side effects. Not being able to wean themselves from the medication, left them disillusioned in themselves and feeling weak and not in control of their being. They understand themselves as without ability or choice; they passively accept their situation in which they are physically, emotionally and cognitively at odds with the *psy* pharmaceutical interventions and what they desired for themselves. Furthermore,

because the medications is ineffective and costly, this adds yet more mental strain to their lived experience.

Continuing to gain more of an understanding of how medications contribute to the Docile-Self, two more nursing students, Mariam and Summer, spoke of their experience with medication coupled with talk therapy. This combination of interventions fostered mental well-being. Mariam spoke positively of her use of prescribed medication and proclaimed that talk therapy alongside the medication helped her to reap long-term benefits. Medication without talk therapy, she cautioned, serves little value:

I think it is wrong to say only drugs. I think if you're on medication you need to have some kind of talk therapy. (...) because like the drugs are treating a symptom and they [medication] can help you get over that, (...) But with mental health, it's more complicated because it's all these thought processes, so you can't just be on medication. Mariam 876-883

Summer understands that in her lived experience medication helped her be calm enough to be able to learn the important coping strategies for dealing with life stresses, whereas through talk therapy she acquired and refined the coping strategies she needed to engage with whatever life brought her. The coping strategies were paramount to being an engaged, self-actualizing nursing student. The medication assisted her to be in the frame of mind to be able to learn the strategies. One intervention without the other is ineffective for Summer. She needed both to move towards a state of recovering.

I think it [medication] definitely helped. (...) I was not very receptive and I was having a hard time (...) understanding [talk therapy] because of the state of mind. (...) taking the medication really brought me out of that ditch and to a place where I was able to understand what she [therapist] was saying and receive it [talk therapy] and actually practice you know the coping mechanisms, Summer,865-871

Like Mariam, Summer was offered medication and Talk therapy, and found that together her state of mental wellbeing improved. Unfortunately, of the eight students prescribed medication

by their *psy* expert, only Mariam and Summer were offered *psy* medication and talk therapy, namely, two *psy* interventions simultaneously. This omission by *psy* experts, to offer the two *psy* therapies simultaneously was understood as tragic by the two participants that received the full complement of care. These two nursing students understood that to promote recovery *psy* experts needed to provide both therapeutic interventions, *psy* medications and talk therapy; otherwise, little in way of recovery is accomplished. This analysis has exhausted what nursing students said about *psy* medication, analysis now turns to explain findings as they relate to talk therapy.

Talk Therapy with medication and alone was offered to half of the participants in the study. These six nursing students, spoke to the benefits they experienced by engaging in talk therapy with *psy* experts. Having experienced both, Mariam confessed that the benefit of talk therapy far outweighed *psy* medication and therefore, she believes, all students struggling with mental health concerns should have access to talk therapy. “I think it's like when it comes to the therapies that we offer it [talk therapy] definitely has a lot more potential [then medications] I guess because it's trying to change the way you think and act and that's a (...) better goal,” Mariam 868-871. Mariam comes to believe that recovering from her mental health concern required a change of thinking, not addressing an imbalance in her physical body. Her changed way of thinking about how she engaged with life, with *being* in the world, was what benefited Mariam and ultimately her sense of recovery. Mariam believes medication should be a last resort if talk therapy does not suffice. She detests the current practice by *psy* experts that offer *psy* medication and no or limited talk therapy, “if it was a perfect world, I think everyone would have talk therapy, and if that did not work, or if a professional said you will need medication as well, then you will do that” Mariam 884-886. Andrew also found talk therapy helpful, however he cautioned that it only works if the *psy* expert is competent, and this, based on Andrew's

experience, was not always the case at the university counselling centres. Andrew makes the point of stressing to the researcher that talk therapy is not the same as simply talking to someone.

The two experiences are fundamentally different according to Andrew.

The student counsellors [at the university] (...) are just like a friend to talk to kind of thing but not really too professionally. (...) they don't have (...) professional training (...) there kind of just a helping hand which is definitely a good thing and it's necessary and its needed but I definitely think the psychiatrist would be like the ultimate, support aid. Andrew 686-694

Overall, the experience of undergoing talk therapy was favourable for the nursing students with mental health concerns and eclipsed medication alone. By digging deeper into the data, it became clear that talk therapy, albeit its benefits, was seldom offered to nursing students who claim they would have wanted it. Their accesses to talk therapy was arrested because of the limits set by university rules regulating what services are offered through student services or by insurance policy rules that decree what services are reimbursable and to what monetary level. Unbeknownst to most of the nursing students, university and insurance rules dictated their therapy options. This lived experience will be explained when the sub category regulated Self is discussed.

Resistant Self as a sub category came to be understood, by the nursing students with mental health concerns, as how they see themselves as being able to take charge of their situation. This new state of *being* began when a person initiated taking action to address their mental health concern. This *Resistant-Self* chose to exercise, talk with others who were not part of their *psy* treatment team and refused their prescribed medications. All twelve nursing students that participated in this study at some point in the interview made mention a point where their understanding of themselves in relation to their experience with a mental health concern shifted from what was previously described as the *Docile-Self* to a *Resistant-Self*. The following sub-

subthemes: exercise, talking and refusing medications, will elucidate the meaning of this significant shift in the nursing students' experience of living with a mental health concern,

Exercise. Seven of the twelve nursing students with mental health concerns discovered, on their own, that exercise helped mitigate the negative symptoms they associated with their mental health concern. "I found going for a walk helps" Mariam, 169. Sophie speaks to how she recalls consciously making a decision to change her actions from her *psy* expert's advice to her own choice of action. "I've been like going to the gym instead, you know when I feel sad now, I (...) go to the gym" Sophie, 44-46. Summer tells the interviewer she had to relearn that exercise helps her deal with life's stresses. She came to this realization herself not because of her *psy* expert. Somehow, she had lost this important understanding through her encounter with her mental health concern and *psy* experts. She claims that she now exercises and reaps great benefit.

I almost had to relearn how to deal with stress.(...) it was like a lot of it was going for walks (...) maybe even be by myself (...), like being active really (...) helped, like exercising and working out. Summer, 892-901

Students speak to the important role of exercise in mitigating their mental health concerns. At first they benefit emotionally and physically, but over time nursing students learn that exercise teaches them that they can do something to improve their well-being, they can do something themselves and this helps them find hope and resilience. "Actually, running made me feel really happy it was really good (...) I try to be happy by myself, not to depend on other people", Andrew, 171-173. Exercise nurtures a sense of self-accomplishment, independence, and self-reliance. Furthermore, exercise, helps students burn off destructive emotions that, if left to fester, exacerbate their mental health concerns:

Just something about running, if I was stressed (...). If I ran, it kind of burnt off those hormones and whatever it was a (...) great source for me. Jessica, 60-66

I know the routine is very important for me just making sure I exercise (...) I've decided to start exercising regularly and regularly going to the gym and that's

been the best way to handle any issue, (...) I can just go sweat it out or go you know do something get some fresh air go for a walk exercise, Andrew 99-105

Mariam and Winter expound that exercise is the tool they need to get through their nursing classes and clinical. When Mariam feels her anxiety rising, she exercises. “We have a 15-minute break in this three hour lecture. Excellent, I’m going to run around outside”, Mariam, 789-790. Winter’s exercise makes getting through her nursing school day possible, which would not happen otherwise. “I’ll feel like shit at the end of the day, you know usually, I’ll try to go for a run whenever and then things just happen you know I go for a run and then I cook something and then the day happens.” Winter 193-194.

All of the nursing students in this study came to understand that exercise was an intervention that improved their state of being. Importantly they see exercise as something they discovered, and not prescribed by their *psy* expert. Exercise gave them a sense of control over their mental health situation. Nursing students perceived they could run off deleterious emotions. They did something for themselves; they were not dependent on something external to themselves as is the case with medication or needing to wait to talk to *psy* therapist. The nursing students began to see themselves as a person with unique capacities, as someone who could take care of their own issues, not dependent on the *psy* discipline or on *psy* norms to define what is normal. Andrew attests: “Exercise, and diet and support groups and family and friends were definitely the best cure.” Andrew 71-72. He was empowered by his discovery of how to help himself. This sense of self-empowerment was foundational in his recovering experience, which will be discussed later in this chapter when the third theme, *Recovery- Self*.

Talking in this study came to be a verbal interaction initiated by the nursing student that takes place with someone of his or her choice and is not a conversation with a member of his or her *psy* team. *Talking* in this context is not *Talk Therapy*, which was a sub-sub category under

Docile-Self, prescribed by the *psy* expert. Rather the sub-sub category *talking*, under the *Resistant-Self*, is an intervention that the nursing student with mental health concerns initiates on their own to help restore their sense of mental well-being. *Talking* is, for nine of the twelve nursing students, a significant sub-sub category under the *Resistant-Self*. Talking to peers and family was beneficial in dealing with negative emotions and often mentioned by the participants. Sophie tells the interviewer: “I have some close friends that I can talk to you”, Sophie, 137. She goes on to explain that talking to these friends maintains and improves her mental well-being. Summer came to the self-realization, that talking to others, not *psy* experts, and being open about her lived experience, contributed to her recovering:

Keeping the conversation open has been what has prevented me from continuing to do those behaviours (...) keeping it very open and not being ashamed of what I was going through. Summer, 440-447

Choosing to, not hide emotions and behaviours, but openly sharing and talking with friends family and others, contributes positively to mental well-being. “When I feel sad now I know to (...), talk to someone and it's okay and I've been more open towards people about my depression it's just helped a lot I'm not hiding from it” Sophie, 45-48. Talking to others, is freeing and this is beneficial to nursing students with mental health concerns. Summer says “[having] an open conversation (...) it's easy. To talk to people about depression and even if they don't understand they tried to, and it's good yeah” Summer, 365-367. This quote brings to light that talking needs to be reciprocal in nature, that the student opens up to others by sharing their story, and that the student needs to sense that the other is willing to hear what they have to say. The act of talking does not need to provide answers or give the nursing students directions as to what they should do. Rather talking makes for a space, in time, and acknowledges that their story is worth speaking. Talking also requires commitment from the other to hear the nursing student's story,

their experience with mental health concerns. Sophie alludes to the deleterious effect that not talking had on her mental well-being. For the sake of her own recovery, she chose to talk to others, even if it was difficult. “I've been through so much like family-wise and stuff so I would always keep it inside and they're like you really need to talk to someone if not like its you're going down a rough path and ever since then I've been slowly trying to talk to people” Sophie 61-65. Three quarters of the nursing students interviewed realized that they benefited if they chose to talk to others about their mental health concerns and no longer hide their lived experience and related emotions. Curiously, qualitatively the nature of these important frank, open, and ultimately therapeutic conversations was different than conversation that transpired between nursing students and *psy* experts. Talking with friends and family members was less judgemental and provided more accepting, something that was important to their sense of recovering.

Two students spoke to the benefit of talking to others online rather than face-to-face. These students believed that the virtual world allowed them to be speak when they needed. This online talking was safer emotionally. These two students felt they could tackle issues that they could not entertain in person with close friends, family, and members of their *psy* team.

I had made a lot of online friends in my high school years and so I would communicate with them. But not with my close friends, (...) I realized I needed people to talk to, like I couldn't keep all of these thoughts in my head because like they were bringing me down (...) especially all of my suicidal thoughts and stuff it's really hard especially when I was in the depths of my depression, Mary 955-964.

Again, the students share their understanding that talking allows for a release of emotions or negative thoughts and thereby promotes recovering. “I realized I needed” substantiates that the discovery that talking is beneficial stems from the nursing student. Leila shares that online conversations gave physical distance, which gave her a means to regulate what she said. This

was an important tool for her and enabled her to have difficult open conversations when she is experiencing mental health concerns. Even texting, communication of only the written word, served to be beneficial as it connected the students with mental health concerns with others with a level of clarity in communication, a filtering, of words from emotions. On-line communication permits modulation or control of the amount of talking, the depth of what is shared the emotions, and difficult non-verbal communication, all of which allows connection in a safer environment.

There are days where it gets a little bit darker, but I do not usually try to reach out and actually like see people in person, (...) I just want to lie in my bed in the dark and cry by myself. But I will like talk to them (online) or text them or just sort of have some connection, but a little bit less personal, I guess, and less in my face.

Leila, 176-180

Technology allows Leila to choose how much she will open up and share about her experience. Even though she does not want to be in the presence of others, she does believe that being connected and talking via texting keeps her safe from personal harm and improves her mental-being. The student controls this connectedness, it is not a constant connectedness but an as needed connectednesses.

For many of the students in this study talking to others was important. Whom the student chose to talk to was less important than, if the person was receptive to hearing their experience with a mental health concern. Three students identified that talking to someone who themselves had encountered a mental health concern brought substantially more succour than someone who had no lived experience with a mental health concern. This person could have been a friend; acquaintance of even a stranger, the qualifier was that they had personal experience of living with a mental health concern. Having personal experience with a mental health concern elevated the person to someone worthier of giving advice: “So part of it’s just being able to talk it out with someone who’s been there, done that. You can talk with a friend but talking with someone who’s been in the same situation is a big help’, Mariam, 258-261, where help was understood as

providing guidance. Sophie describes that people with lived experience can be trusted to provide better advice and could be trusted. This trust between two people who have both experience mental health concerns encourages more openness and connection, which fosters recovering,

She dealt with depression too and anxiety (...) I always have her to talk to which is great. Honestly I can just give her a call anytime and she like she'll calm me down if I'm sad or if I just want to talk to her about something a little she's there for me . I think that's a huge support and I trust her so that's a huge thing right to have someone you trust and able to talk to, Sophie 137-145

Winter finds support in talking to her friends in the nursing program who have personally dealt with mental health concerns. She claims these friends understand her best, accept her, and see mental health threats and concerns as commonplace. Winter is not different or odd when she talks to these friends. Being part of a friend circle that sees mental health concerns as common, not as abnormal supports recovering,

My friends and the nursing community is very informed. Definitely, in my generation because I think they deal with it firsthand every day. I mean pretty much a lot a lot of people and most definitely a lot of girls deal with mental health problems, Winter 342-345

Sophie choose to talk to fellow nursing students because they are mindful of mental health concerns. “I think nursing students are more aware of it [mental health concerns] too and maybe deal with it more I don't know or more open to it so that's why I notice more nursing students are more open to talk about it than other people” Sophie, 395-399. However, being mindful of mental health concerns was a double-edged sword. Mary cautioned that nursing students might talk more about mental health concerns but their motives for talking may be more about their own learning, rather than being a supportive person who is listening and cares about a fellow student with a mental health concern. Mary feels more like a patient when talking to nursing

peers and therefore avoids opening up and talking to her nursing peers. She fears that clinical judgement gets in the way of genuine supportive talking.

Because they're trying (...) to understand it [mental health concern] so that they can become better nurses. I don't want to be the patient when I am their friend. (...) I don't share with them because I don't want them to look at me from a nursing point of view. (...) I'm not their patient they are my friends. (...) with other people [not nursing peers], I don't mind sharing as much with them because I know that they are viewing me as their friend. (...) they don't have that clinical picture. They are not seeing the signs; they are not like oh how can I help you. They're just listening and they just care, Mary, 308-317

There is a distinction between 'being heard' and 'being counselled'. In analyzing the data it was apparent that all the students articulated that they could not talk to faculty, only Andrew, shared that he benefited by talking to certain clinical instructors of campus. He felt that the unique relationship between him and certain clinical instructors provided a safe place where he could talk openly about his mental health concern and felt understood not judged or condemned. He did not feel he could talk to faculty, administrators, or counsellors on campus in the same way.

You can confide in certain clinical instructors (...) they definitely understand working in healthcare dealing with students (...) they can relate and understand and you can tell them things you can't really tell other people there's a certain confidentiality between you and [them], Andrew 274-280.

Andrew laments that it was only the occasional clinical instructor that he could talk to about his mental health concern, but when it was possible it validated that he could have his experience with a mental health concern and still be a nursing student. Openness to talk was dependent upon feeling safe, that Andrew's story was confidential. Certain clinical instructors could maintain confidentiality and Andrew feels he gained from talking to them. What is unclear from the interview was why Andrew felt the need to share his story. Perhaps this goes back to a need to process clinical experience, which may trigger mental health concerns.

For one of the twelve students talking had less to do with sharing her story than with verbalizing her experience with a mental health concern and thus coming to accept it as part of her own life. According to Mary, once she verbalized her experience with mental health concerns to someone trustworthy she came to acknowledge that it existed in her life, and then with her acceptance her recovering began. “I think what really happened was I was accepting of my situation because this is what I was used to and talking to other people made me realize do you know things don't have to be this way” Mary, 967-970. Sophie is a firm believer in the benefit of talking to others about mental health concerns. Sophie offers the following suggestion to help nursing students with mental health concerns,

I feel like it's more common (...) I think that helps but I feel like there should be groups or something that you can go to and like talk to people with the same like mental health issue and I think that would be really cool. Sophie, 217-221

Finding others who have had a lived experience with mental health concerns fosters connectedness, and validates being/identity. The nursing student comes to understand that they can be a nursing student and have a mental health concern; one aspect of their being does not negate the other. Later in this chapter, when the theme *Recovering –Self* is analyzed, it becomes apparent that nursing students come to understand themselves as gifted nurses because of their experience with mental health concerns and this giftedness empowers the nursing student.

Refusing Medication. The majority of nursing students with mental health concerns came to a point in their experience as a *Psychiatrized- Self* where they no longer wanted to take their prescribed medications. Nine of the twelve students outright refused to take their medications, despite the counsel of their *psy* expert. Refusal was manifested either when nursing students chose not to fill their prescription or when they choose, against *psy* expert advice, to stop taking their prescribed medication. Sophie illustrates the first scenario “yes [*psy*

expert] suggested medications but I really I really didn't want to so she told me ok for now but if things get worse I have to”, Sophie 84-85. Although Sophie did not take the medication, the *psy* expert left Sophie with the responsibility of monitoring her own mental health. Jessica divulges that she refused to start psychiatric medication because she feared it would make her mental health experience worse by, exacerbating negative symptoms and adding stigma to her life. Jessica understands that if she succumbed to taking the medication she would have a *psy* disorder, she maintains her mental health concern would be “official”, part of her being and this made Jessica very uncomfortable. “I didn't want to like try something [medication] that would maybe make things worse (...) and also I think the medication would also make things more official”. Jessica 899-902. Andrew also dreaded the consequences of taking psychiatric medication and thus refused to fill his prescription. Andrew was adamant that *psy* medication was dangerous citing the suicide of his best friend as his proof in point. Andrew implies that the medication did nothing to protect his friend from killing himself, therefore, why should he take something that serves no purpose and possibly harms. Andrew wants to take “a clear path” which he equates with not taking and psycho-pharmacological agents, inferring that this medication fogs or confuses the mind, something he feels makes talking through your problems, more difficult. Andrew believes medication would hinder his healing and worse compound his mental health concern. Andrew surmises that psychiatric medication robbed his best friend of clarity of mind and thus contributed to his decision to commit suicide:

I decided not to [take medications]. I decided I might as well just keep that out of my head, I can just work through cognitive behavioural stuff. (...) I just wanted to steer clear of it [medication]. My friend who committed suicide was on antidepressants and that kind of just left me with a bad, a bad taste about those types of interventions (...) I feel like I just might as well go down, you know a clear path, I felt, I just felt it would be better. Andrew, 61-68.

Sophie, like Andrew, also chose to refuse to take the medications prescribed by the *psy* expert. Sophie shares that she learned from a friend experience that *psy* medications have numerous negative side effects that compound mental health concern. Importantly, by refusing to fill the prescription, Sophie feels she has to take charge of her situation and do something else to deal with her mental health concern, as to not take medications and not do something else would be irresponsible. Sophie becomes empowered to take other actions to alleviate the symptom associated with her mental health concern. Paradoxically, by refusing to take the *psy* medication, Sophie proved to herself, she is capable of helping herself and ultimately managed her mental health concern.

I don't want to like depend on meds to be happy and my friend (...) she took something [medication] and she told me like she had a really bad experience (...) it made it worse for her. (...) that kind of scared me and I do not want that to happen. (...) I told myself I can deal with this on my own I do not need medication (...). I proved to myself that I can, just by being physically active and like finding good relationships with different people and talking (...) that is my medication. Sophie 587-596

Sophie does not deny her mental health concern exists; she takes responsibility of herself and how she will address her mental health concern and this supports her mental well-being.

The choice to *refuse medications* was not easy for the nursing students that participated in the study. Despite Summer's desire to not take a *psy* medication, she felt pressured from her parents. She describes her parents as "trigger-happy"; meaning that they were quick in wanting her to take a pill believing it would get rid of her mental health concern. While experiencing negative symptoms of her mental health concern; Summer somehow concludes that medication will not fix her; she needed to help herself,

My parents were really kind of trigger-happy. They were like, (...) I will find you a medication and it will help you feel better. I had to explain to them that it's not necessarily going to fix anything, and that it has to go along with counselling or it

can be catastrophic. It can be really dangerous (...) they were kind of really pushing medication. They really wanted to start me on medication. Summer 788-792

Summer resisted the quick fix her parents believed would help her, maintaining that medication alone would be ineffective and could be detrimental to her mental well-being. Summer, came to understand that she needed talk therapy where she could learn strategies to cope with life's issues "because even if you go on medication, like I still had those bad coping mechanisms and I still didn't know how to cope (...) I was struggling" Summer, 828-831. Learning to cope with life is the crux of what supports a student with mental health concerns. Summer's quotes illustrate the tension of the *Psychiatrized-Self* and the emerging *Resistant-Self*. Mary, on the other hand, grudgingly takes her prescribed *psy* medication, as she claims her *psy* expert afforded her no other options. Mary, like Summer, that despite grave consequences *psy* medication is pushed on people.

Definitely I don't agree with the way we approach mental health care because I hate [that] medication is our primary mode of care because you're permanently changing a person's brain for the rest of their life sometimes and not only that it's like sometimes the symptoms are unbearable, Mary 822-826

Her *psy* expert, under the guise of correcting some imbalance in her, coerces Mary to take *psy* medication. She is 'abnormal', her brain needs repair, and therefore she succumbs to her *psy* expert's advice, despite experiencing debilitating side effects and her fear of lasting neurological changes. This experience is similar to what Foucault would describe as, *bio-power*. A force that drives her to be 'normalized' even if this entails permanently changing her brain. Mary begins to oppose the *psy complex* and questions the poverty of *psy* options she is offered. With questioning the first glimmer of the *Resistant-Self* emerges, the second category under the *Psychiatrized-*

Self. Mary describes her experience with *psy* medication as limiting her quality of life and inhibiting her ability to address her mental health concerns and her recovery,

Sedating someone or making them like a zombie, although [medication] hides their mental health illness, [it] does not necessarily allow them to have a better quality of life Mary, 832-834

Despite Mary's strong opposition to taking *psy* medication she perceives herself as powerless, once again illustrating this conceptualization of *bio power*, "I would like to reduce it but I don't see that happening anytime soon unfortunately" Mary, 34-35. It is unclear if her symptoms or her *psy* expert is at the root of her inability to change her situation. Unlike Mary, Eleanor attempted to reduce her medication, as the cost was great and the effectiveness poor. However, each time Eleanor attempted to reduce her *psy* medication intense unpleasant withdrawal symptoms drove her back to reinstating the prescription.

Anytime I've tried to taper down like I've told her [*psy* expert] about it obviously she can't stop me from doing it [stopping the medication] but like the symptoms were just too much to take at the moment or at the time (...) especially because I don't have (...) benefits soon and it's expensive. Eleanor 55-62

Eleanor harboured frustration and disappointment because she is powerless to stop taking the *psy* medication. Her powerlessness substantiates personal weakness and failure. These negative characteristics further erodes on her self-worth, and sense of being. Cognitively she wants to stop the medication, physically she cannot. Trying to live daily with this dichotomy adds to her mental health concern. Although, her *psy* expert prescribes the *psy* medication, the deleterious side effects, and the economic consequences, is not the responsibility of *psy* expert. Eleanor understands this dichotomy and associated struggles as her own problems. She believed that the status quo will remain until her insurance benefits run out, only then will the *psy* expert entertain other options. Eleanor's lived experience is not unique; Sophie also wishes she could resist her

psy regime by refusing her medications. She sees medication as something that brings about inauthentic emotion, and inauthentic living: “I really don't want to depend on the meds to be happy”, Sophie 91-92. She sees recovery as having genuine emotions; genuine emotions as part of being. Taking *psy* medication denies authentic emotion thus has consequences on *being*.

Refusing *psy* medication, once coerced to take them, meant contending with withdrawal symptoms. Participants described their symptoms of withdrawal from *psy* medication withdrawal as worse than their original mental health concerns. Withdrawal symptoms even if, gingerly tapered down, added pain, fear, anxiety, and panic attacks, to a student's lived experience of a mental health concern. These symptoms were extremely debilitating yet despite them nursing students stopped taking *psy* medications. The participants determined that the withdrawal symptoms would abate after some time however, this time would be very difficult to live through. The *psy* expert did not provide support during this painful withdrawal period, as the *psy* expert provided no alternative except to re-establish the medication regime.

I have a couple of bad days like 2 or 3 times a month. (...) I remember the first week I came off you know you have the physical symptoms. (...) headache, you're nauseous that kind of thing for like a week and then a couple of weeks. I've actually had panic attacks, and I've never had anxiety in my life. I've never experienced abnormal stress or abnormal anxiety but because of the medication I was coming off, Summer 276-285

Over time, fear, pain, anxiety and panic attacks subsided and a new state of normal, of living with mental health concerns came into being. A normal where the nursing student accepted that life brought good days and a few bad days. A new sense of freedom from *psy* medication was more valuable than the elusive promise of the *psy* expert that *psy* medication would erase a bad day from the nursing students lived experience.

Although *psy* medication withdrawal was far more difficult than anticipated, Summer did see value in having taken *psy* medication. She believed *psy* medication had a place in her

recovering; however, *psy* medication alone would never have been sufficient to restore her mental well-being. Summer says talk therapy was the secret to her recovery, and alludes “I think that it [medication] definitely helped but I’m really glad that I didn’t go straight to medication and just tried to do it on my own I think that the talk therapy was absolutely the most valuable thing that I did” Summer, 872-875. Summer equates only medication as something she would do in solitude, which she understands as potentially destructive, whereas talk therapy is something she does with someone else. Connecting with another, sharing her story, finding commonness was significant to her recovering.

In summarizing the nursing student as the *Concerned-Self* recognizes that something has changed in their being. The change in their experience leads them to encounter the *psy* expert, typically at the request of a family member. The *psy* expert defines their lived experience by *psy* labels linked to *psy* interventions that correct imperfection in their *being*. At first, the nursing students were *Docile-Selves*, and accepted their *psy* labels. They accepted what the *psy* expert offered as a means to correct their lived experience. As the *Docile-Self*, they submit to the *psy* interventions, mostly *psy* medications. The majority of students had multiple *psy* labels, as one *psy* label did not describe the complexity of the experience of being students with mental health concerns. The labels did little to help the nursing students in understanding their lived experience. Society interpreted multiple labels as being more ill and not the students. The nursing students became subjects of power, the subject-function of being ill, as defined by the *psy* label, a product of the *psy complex*, became part of their lived experience. As *Docile-Selves*, they experienced hospitalization, and claimed that hospitalization served no benefit. The nursing students with mental health concerns acquiesced to *psy* medications, as they felt they had no alternative. Few nursing students who agree to *psy* medications obtained relief and some students

suffered more from the adverse effects of the medications than they did from their original mental health concerns. The nursing student with a mental health concern as the *Docile-Self* took *psy* medications despite wanting to stop, however once they realized the *psy* medication had no benefit, they attempted to stop. Stopping was far more difficult than they anticipated as withdrawal symptoms were debilitating. The *psy* medications over time served little or no purpose, carried a financial burden, left students with physical dependencies, made nursing students feel less confident about themselves and their abilities. *Psy* medication negatively affected their sense of being. Alternatively, *Talk Therapy*, either with or without *psy* medication was understood by nursing students to positively influence recovering. Unfortunately, only a few nursing students had access to talk therapy. Finally, ineffectiveness of the *psy* medication led most nursing students to resist the *psy* expert advice and stop taking or outright refuse the *psy* medications from the onset. Resistance or becoming a *Resistant-Self* meant no longer succumbing to the *psy* expert advice but rather exploring other options that fostered mental well-being such as, exercise, talking to others and refusing their medication regime. Data analysis will now turn to the experience of the Regulated –Self, the second category under the *Psychiatrized-Self*.

5.2.2 Regulated-Self speaks to how nursing students with a mental health concern experienced the rules and regulations set by diverse institutions that influence the lived experience of being a nursing student with a mental health concern. These institutions have rules and regulations that play out in policies and procedures that impact the students in the following ways: how and to what end students are educated; what student services are available and who can access these services and; how and what deems a nurse as competent. These governing forces are continuously present yet students were unaware of the influence of

regulation on their lived experience as a nursing student with a mental health concern. It is only when their needs as a student with a mental health care concern diverge from the tenants of institutional regulations that students experience tension, difficulty, or sadly, even exile as they tried to navigate the education and health care system. The following pages will describe how the nursing student with mental health concerns experience being a *Regulated Self* by means of the following sub-categories: University, Insurance, and Nursing rules.

University Rules. The sub-theme of University Rules speaks to the power structures that regulate and thus influence the lived experience of the student while they are on campus.

University rules drive what, when, and how students access services and programs on campus. Nursing Students with mental health concerns are not conscious of how university rules affect their lived experience by means of policies and processes. Only when they encounter rules or regulations that restricts or stifles their *being* do they become conscious of their impact on their being. Nursing students with mental health concerns spoke to university rules that hindered their lived experience. For example, Jane found herself making poor decisions in exam situations because of exam policies and rules that dictate once a student begins an exam they must finish it in that same sitting. Jane was forced to continue to write an exam while experiencing an anxiety attack, which robbed her of any cognitive clarity. Jane believed there was no use challenging this policy.

[O]nce you start writing an exam, that is it. You do not finish it, you fail it. I think unfortunately (...) that is an awful policy (...) No makeup (...) and that idea always stuck in the back of my mind. Like you can't freak out because even if you told them, like I'm about to have an anxiety attack. I need to leave this facility. It is still a fail, Jane, 989-998

Nursing students with mental health concerns did not believe that the institution and its representatives, the professors, could do anything other than enforce the institutional policy. Rules enforced at all cost, with no exceptions, had negative consequences on students with a

mental health concern. Sasha spoke of blind, mindless, heartless, enforcement of university rules that compromised her mental well-*being*. Professors, staff, and administrators enforced rules.

However, the ‘university’ made the rules, and was a force unto itself, uncompromising, unchanging, unrealistic, and inhuman, therefore impossible to negotiate or reason with:

I feel like this university is just so, (...) by the book and by the rules and if you want something changed, you have to go to this level, and then this level says you have to go to this level and this level says you have to go back down to the lower level. There is no like human I actually care about your element to it, and that (...) has not been a good experience for me. Sasha 172-176

University rules are a force that affects students with mental health concerns. However, it is inanimate in nature. A student cannot negotiate with something that is intangible and this sets the stage for a profound sense of helplessness among nursing students with mental health concerns trying to argue the injustice of some university rules in relation to the lived experience of mental health concerns. The university rules drive standardization and efficiency, two sub-sub themes that arouse from the data, which more often than not, leave little room, according to the nursing students, for meaningful accommodation, sensible learning environments, or meaningful human encounters all of which would have supported student mental-well-*being*. Ultimately, university rules support the institution, not the students

Standardized. Standardization is a process whereby things are to be similar and consistent to facilitate the enforcement of rules laid out by the institution. In post-secondary institutions, rules direct everything, admissions, advancement, and graduation. Post-secondary authorities, people put into positions to enforce university policy, aspire to the priority of treating all students fairly, which equates to a consistent application of the rules to all students. The nursing students in this study question this university mantra of equating uniformity of rule (policy) implementation with fairness. Adherence to established rules designed to speak to the expected norms and standards determine university accreditation. Deviation from norms and standards

would pose questions from accrediting bodies. Furthermore, different departments in the university are accountable to these overarching rules to assure the priority of standardization throughout the institution. In the modern university, standardization of rules trumps best teaching practices that may question the implementation of standardization. Deviation from university rules equates with poor educational quality and is unacceptable to those in positions of power, university authorities and outside accreditation authorities. Students within a given post-secondary institution whose lived experience does not contradict the norms and standards and rules encounter no difficulties and are likely to remain invisible to the authorities. However, if a student, perhaps because of a mental health concern, is unable to meet rule expectations, they do not fit the expected norms; they will likely experience the force of the process of standardization, impelling them to conform to university rules. Sasha is the first to speak of how she experiences standardization: “University (...) is a so like by the book, rules, institution. (...) it has to be done this way, even course outlines, like literally it says unless, (...) someone in your immediate family died or you were in the hospital and can provide that doctor’s note, you will fail if you miss this exam” Sasha, 664-665. Sasha believes that rules supersede needs of the students at the university. Sasha goes on to explain how strict adherence to rules affected her decision to write an exam while suffering a panic attack, just as Jane had shared earlier;

They are (...) really stringent ... you have to be on your death bed if you miss this exam. Well, okay. I was not on a deathbed, but I was, you know, I was kind of convulsing in a parking lot. (...) do you have a doctor’s note for that? No. No one was there. So one time I had to (...) write exam while I was having a panic attack.
Sasha, 656-660

Sasha chose to remain silent and not argue against the university rule. Jane, on the other hand attempted to explain her situation to administrators, to no avail, “felt the pressure from the administration (...)” Jane, 532. Jane in the end also felt forced to conform and wrote her exam

although she knew her mental health concern was causing her difficulty and could impair her academic performance.

Standardized enforcement of university rules included fear of stigmatization, fear of identification as a difficult student, a student that did not fit into the norms or standards set by the university. The fear of stigmatization was a force that led Sasha to go out of her way to conform to university rules even to the detriment of her mental well-being. The emotional tension that arose from belabouring to conform to these university rules, and the added perception of the lack of understanding by the agents of authority at the university, exacerbated Sasha's lived experience with her mental health concern.

[the university is] not very accommodating at all to people with mental health issues, like at all. (...) I am a really good student. I do not use it [mental health concern] as an excuse. I fought really hard to be where [I am]. (...) [Now] I'm just "one of those people", (...) I'm just someone that's anxious. Sasha, 179-184.

Unfortunately, Sasha was not valued as an academically strong student but rather she was judge based on her mental health concern. The consequences of Sasha not having her lived experience with mental health concerns understood by the administrative staff, coupled with the inattentive standardized fashion of addressing students' needs, meant that Sasha lost a substantial scholarship that she had earned for outstanding academic performance. University rules dictated the conditions of her awarded scholarship. She needed to be a full-time student, which she recognized, would not be realistic given her mental health concern. Standardized enforcement of university rules made no accommodation for Sasha's situation. She was forced to choose between part time studies that she understood would maintain her recovery, and losing a substantial scholarship that would add significant financial stress to her life. Sasha then carried a financial burden, felt devalued academically, and 'demoralized' by divulging her lived experience with a mental health concern. This invalidating, fruitless encounter with university

rules contributed negatively to her lived experience mental health concern and threatened recovering.

I got free tuition because of my grades and I had to drop down to part-time. I lost all my scholarships and, you know, having to write the letters for that was hard (...) I was (...) demoralized sort of and embarrassed that when I had to drop down to part-time for a second semester; I did not want to go through the process again of saying, “No, I’m serious. I’m actually sick [but felt the university did not believe her].” Sasha, 164-170

Sasha’s experience brings to the forefront, the need to question the purpose of the rules in a university. Are they there to set a framework for student support from admission to graduation, or a force that punishes the deviant, those that do not conform to the standards or norms set by the university?

Jane shares a similar painful experience where she, because of financial strain, applied to a bursary that invited university for students who had experienced the loss of someone significant to apply. Jane identified with this topic as she was grieving the loss of several members of her family and believed her grief contributed to her lived experience of depression. She explained that the university rules that dictated the conditions for the bursary was very ill conceived and reignited her mental health concern,

I applied for one [bursary] that was for grief. (...). You get five hundred bucks. Worst idea known to man because you got to write a whole essay about it. It is awful (...) and then I didn’t even get it. So, you suffer through this essay writing of the most probably horrific thing that’s ever happened to you, and then you don’t even get anything out of it. Jane, 100-104

The university rule that obliges a student struggling with a mental health concern, to write details of her experience in order to judge if their experience is worthy of financial support, requires a student to put into writing why they need special consideration are based on little understanding of the lived experience with mental health concerns. Such ill-conceived policies/ rules are extremely detrimental to student’s mental well-being. They are especially harmful when these

soul bearing, vulnerable exercises, are than judged by those in authority as less significant or paltry. Such policies leave students more mentally and emotionally battered and no closer to resolving their issues. Clearly ill-conceived University Rules and subsequent policies that lack of understanding of the lived experience of a student with mental health concerns negatively affect the lived experience of nursing students with mental health concerns.

Unfortunately, matters of policy or rules are no better at the school of nursing level. Nursing students with mental health concerns communicated that the inconsiderate, standardized implementation of nursing school rules added undue stress and contributing negatively to their mental health concern. Agents of authority, who enforce the rules at this level, where administrators of the school of nursing, and faculty, who were either theory professors or clinical instructors. The rules of primary interest to the students were policies that addressed grades, failures, and absenteeism.

As per nursing school policy, nursing students must maintain a C+ cumulative grade point average in order to progress in the nursing program. Nursing students understand this to be important as they equate the minimum of a C+ with demonstrating the minimal amount of knowledge to be safe in caring for those in their care; however, a rule that a certain grade is required brings added stress as the fear of not performing adequately festers

Yeah the C + is a big stress but you need it there because in nursing there is a lot of knowledge and you need it so that is not something that I could argue I guess.
Jessica 847-849.

Besides the CGPA requirement there is also a policy that states a student cannot fail more than two nursing courses otherwise they cannot continue in the BScN. Sophie shares how this policy instills fear into the students from day one of the program. She worries constantly that she may fail:

There was a young guy [student rep] (...) he came into one of our classes in first year and told us, [and] he gave like a little piece of paper and said you can't fail these classes Sophie, 530-532

Julie, who struggled academically, voiced how this policy was always on her mind as well.

I'm like right on the fence, it's a [concern] because I don't want to be kicked out, this is very important to me and I want to be able to help people so, yeah that specific situation or that policy that they have it definitely contributed to my depression Julie, 391-395

The students understand the requirement for academic standards to assure patient safety, but the two strikes and you are out of the nursing program consequence of the policy meant that fear of failure and worse, the fear of having their dream of being a nurse destroyed, gnawed at the students with mental health concerns constantly. This perpetual state of worry induced by the policy exacerbated nursing students experience with their mental health concern.

Another rule enshrined in a policy at the nursing school level that aggravated mental health concerns in nursing students addressed clinical absenteeism. Nursing students understood the expectation to be present each day of their assigned clinical practicum. Nursing school policy at the institution where the study took place disallowed clinical and lab absenteeism. If the student was ill and could not be present at their clinical, the school required a physician's note to validate the need for their absence and to confirm that they were ill. This obligation to justify an absence with a physician's note made sense for physical illnesses; however, it did not reflect the reality of the lived experience of nursing students with a mental health concern. The participants in this study explained they readily recognized when they needed a day to refuel themselves emotionally in order to protect their recovery. They knew when their stress was getting out of control, and they knew what they needed to do, however this need to step back and take care of one's own being does not require a visit to a physician. It requires knowing oneself and taking responsibility for oneself, making self-care a priority. Nursing school policy in its current form

leaves no room for validating the important role of self-awareness a premise of recovery.

Furthermore, nursing students with mental health concerns recognize when their state of being, could challenge the quality of their clinical practice however the policy stifles the nursing students' ability to fulfill what she or he perceives as professional responsibility, stepping away from practice if not in a good frame of mind.

You can't be sick for clinical. (...) having a mental health issues, you can't really get a doctor's note for. (...) you can't just be like oh I had a bad day you know like everyone has bad days you still have to go and that can be hard because I'm not focusing on patients. I'm somewhere else you know and I've had days like that where I shouldn't be here [in clinical] but I am. Mary, 197-203

This quote highlights that nursing school policy sets up an ethical dilemma for students with mental health concerns. Students with mental health concern know that their lived experience includes days where they cannot offer their best to their patients; however, removing them-selves from clinical is not possible because of nursing rules. In the end, the threat of failing a clinical rotation has to supersede the nursing students evolving professional responsibility. The following quote further illustrates this ethical tension:

You cannot miss a day of clinical right so especially when my anxiety gets really bad like last semester of first semester of third year everyone knows it's one of the harder ones. (...) we had a lot of exams a lot of final projects due and I just started panicking total stress ahead, tons of panic attacks I think I had 5 in a week
Mary, 174-182

Despite Mary's assessment of her grave situation, despite her ability to recognize that her stress was out of control, despite her understanding of her need to step back to gain control, she did not do what was in her and her patients' best interest. Rather, her actions were compelled by nursing school policy. Nursing school rules in this case are a force that thwarted her evolving professionalism and recovery.

Nursing students are aware of how nursing rules drive detrimental conduct. Mariam ponders why university and the school of nursing rules are not adapted to take into account the

unique situations of students with mental health concerns. Mariam understands that blind enforcement of nursing school rules and standardization of what is to be the expected students' experience is a by-product of the ever-increasing number of students at the university. This becomes a question of quantity at the expense of quality in education. The university uses policy to drive efficiency, leaving little room for considering the unique needs of students with mental health concerns. Efficiency, as is shared latter in this chapter, sets the stage for stigmatization of student with a mental health concern.

I find the admin staff unhelpful. Again, I think it's we [university] have too many students and we (...) cannot make any accommodations whatsoever (...) it was frustrating, Mariam 453 455

This quote illustrates how students with mental health concerns see themselves as victims of university rules. The rules hold power and discipline students by means of disciplinary agents, administrators, who themselves appear powerless to accommodate the needs of students with mental health concerns. The university, by means of rules, enforces standardization, which leaves little room for understanding of the lived experience of nursing students with mental health concern.

Efficiency Whereas standardization is defined as a process whereby things are made to be similar and consistent with rules or policies within the institution, efficiency is a state or quality of being whereby those performing duties or functions are claiming to be doing so in the best possible manner with the least waste of time and effort. Efficiency and quality play an important role in post-secondary education for both students and the overall economic standing of the institution although some would argue that efficiency can at times be at odds with quality (Levinson and McKinney, 2013). In this study, several students expounded on how they felt that the university put more emphasis on efficiency and thus limited the quality of service and support students with mental health concerns received. Efficiency appeared to direct what, where

and how services for mental health concerns were provided on campus, and consequently influenced the lived experience of the nursing students in this study.

Eight of the students interviewed spoke to efficiency when they described how they perceived availability and accessibility of mental health services at the university. Although some students knew they could speak to someone at student services for no cost, they felt the counsellors were not qualified, to address their needs. “I could see someone through the university, which is free, but I’m dealing with a student, so they may, depending on the case, they may or may not be able to help me”. Mariam, 911-913. The students inferred that the university was being financially efficient by using students from the counselling department and not providing access to qualified *psy* experts.

I had seen a psychiatrist a few times, during first year then I just switched over to general counselling (...) and saw a couple student counsellors, I did not find the help as much as a psychiatrist Andrew 46-48

Clearly, to the nursing students with mental health concerns using students as counsellors is efficient, or more precisely frugal or even cheap, and more important than providing the best care to students in a crisis. Julie explains that after she had accessed university services she was dissatisfied and sought help off campus, as the inexperienced, unqualified counselling students did not meet her needs.

I had to seek help from a therapist outside of school (...) I couldn't find someone who specializes in depression specifically (...) or in self-harm, (...) I'm not exactly sure if they're actually registered social workers or if they have any licensing in counselling but to be a university student with a mental health concern is, it's difficult Julie, 122-127

There exists a tension between efficiency and quality and the nursing students with mental health concerns feel it acutely. Julie understands what she needs as a person with a mental health concern and she perceives that the university is not serving her needs. She also believes the

university has far too many students and that counselling services are overwhelmed. She perceives that counselling services may have good intentions; however, the claim of serving students with mental health concerns is inauthentic, as in reality counselling services only address stress related to academics, which is only a part of what would benefit students with mental health concerns. Counselling services burdened with a huge volume of students, have no time to create meaningful mental health services. Counselling service driven by efficiency, allot a token amount of time to each student and focus on stress reduction not therapy for mental health concerns. Julie contends that mental health services most go beyond stress management strategies.

I think the university is just really busy (...). [Student counselling] have a lot of people to deal with in the first place because a lot of people are struggling academically. (...) that is like their main focus (...). The sheer number of people that they have to deal with stops them from maybe creating another program that focuses specifically on mental health concerns or maybe just a lack of funds Julie, 238-244

Summer, unlike Julie appreciated the efficiency of the counselling services and her quick and directed service encounter was beneficial:

they [counselling services] were there definitely didn't hinder [mental health concern] (...) gave me an appointment right away and psychologist was really nice she took me through I guess a questionnaire and then you know directed me to someone that could help me. Summer 468-472

In order to support efficiency in mental health service on campus, the first step would be to make sure that students are aware of what services are available to them. The comments of five students support the perception that awareness or notification regarding the availability of mental health services on campus is lacking.

There was not really any advertising. I know because I worked for the university in second year and I know that there are services but maybe they're not advertised as well because it never occurred to me to go and talk to someone at school I

know that they have counsellors and stuff like that too but it wasn't advertised very well Jessica 604-609

Institutional wise, I think specifically at [name of institution] there's a bit of a lack of mental health awareness, (...) maybe it's just not advertised as well here (...) for me to be able to go and find, Andrew 711-717

Not being aware of the services, particularly in the critical first year of the nursing program was noted as especially troubling for the students and caused undue emotional difficulty at a critical transitional time in the nursing students lives.

I just didn't know about that program [mental health services] at all in my first year. I didn't even know we had mental health services so I never really knew. Had I known about that I probably could have gotten help a lot earlier in that year and I probably wouldn't have ended up where I was you know in May, Mary 573-576

Sophie cautions that words do not make for action, although she had noticed more discussion regarding mental health on campus, she has not come across services that address mental health concerns. In her opinion, the university talks about mental health services but lacks in providing services for students with mental health concerns.

I feel like on campus like nothing is really being done about mental illness. It is more talked about now but like nothing is being done so I feel like yeah the campus should do something about that, Sophie 741-744

No services, is problematic for nursing students with mental health concerns as is, not having access to the appropriate service on campus. Services that address academic success are not mental health services, or at least this is what nursing students with mental health concerns believe. Such services may even further exacerbate student stress levels, as their implicit messaging is that academic grades matter. The following quote from Julie speaks eloquently to the inefficiency of services she experienced at the university:

I wish I could say that the university really tries to help students with their mental health but I feel like they don't. I know that there's student academic success services which helps you (...) but I feel like it's not advertised enough. (...) I

know people who have gone and it took them awhile to actually talk to someone because (...) there's so many people [students] there. Julie 110-116.

Being proactive, Julie does not merely criticize the services for students with mental health concerns at the university; she offers a solution:

If I knew that there was a place, a comfortable safe place to go on campus where I could talk to someone about how I'm feeling like in the moment that would certainly make things a lot easier for me I think because I know someone is there to support me Julie, 262-266

Students seek places that permits open, timely, free from cost and judgement conversation about mental health and living with a mental health concerns. No mention of the need for *psy* expertise only the need for an open conversation. Students seek a space where they can process student life and student stress. They want to learn how to balance student life and cope with mental health concerns. "I know that's a lot of students feel the pressure of university they feel the pressure of doing well and having good marks or even paying for tuition and it's I feel like there could be more support for students with mental health concerns then there is currently, so it's very stressful", Julie 117-121

Efficiency in business is describes as a process that uses the lowest amount of inputs to create the greatest amount of outputs. This would include how an institution sets up mental health services, to minimize overhead costs whilst trying to maximize student accessibility. With the goal of being efficient, the university centralized mental health services on the main campus and offered no services on satellite sites. The overall number of students at the university is in excess 40, 000. On the satellite campus where nursing studies, rehabilitation and medicine are situated there are just shy of 6,000 students. The students on the satellite campus represent one in seven of the total population at the university. If the Canadian Mental Health Commission estimation that 20-25% of Canadians struggle with mental health concerns is extrapolated to the

population of students on the satellite campus, those planning mental health services at the university, could estimate that as many as 1500 students on the satellite campus struggle with mental health services. These students have no access to convenient mental health services. The university expects these students, in their vulnerable state, and within their taxing schedule, with theory, lab, and clinical expectations, to make their way to the main campus to access needed mental health services. The following quotes exemplify how nursing students in this study perceive this as unrealistic. These students feel that efficiency trumps offering students' quality care. "There's definitely a lot of support systems that I could have accessed through the university, but that I didn't because of the disconnect between the campuses", Jane, 1231-1232. Needing to access service on another campus was a serious deterrent to getting needed help

we had our like the campus the main campus and then ours was we had our own campus at the hospital (...) all the services were at the main campus so maybe that I think there's no advertising because the services weren't at that campus, Jessica 609-618

Not being able to access service conveniently is a problem for students at the university but nursing students are also required to juggle classes and clinicals, on several campuses and at several hospitals. The need, in a single day, to attend classes, clinical and meet their program requirements, at different locations was viewed as terribly stressful and contributed to the lived experience of a student mental health concern. Some exhorted that they felt that efficiency drove their scheduling and left them taxed beyond what they felt was reasonable to expect of any student.

I find [the University] is disorganized. Like in second year you will have classes on three campuses in a week. So that's two campuses in one day, plus you're doing clinical (..) you're in four different places in the week any time of day up to late in the evening and that's extremely stressful, Mariam 74-78

When students complained, to those in authority at the school of nursing, they hear that they are powerless to influence scheduling. The nursing school is in fact a victim of the ever-increasing

cry for efficiency dictated by university rules. University rules dictate space and time allotment, not the school of nursing “Like having class (...) on three campuses plus the clinical, (...) the School of Nursing admits that’s a problem, but their supervisors in the great admin are in charge, and the school can’t do anything about it. Mariam 756-759.

Nursing Students with mental health concerns had their conduct and lived experience as students sculpted or disciplined by university rules. They recognized what rules are important for patient care and see value in these rules. As nursing students with mental health concerns, they had experienced times when they deviated from the expected standards or norms as dictated by the university rule. From this place of deviancy, they did not meet compassion or understanding for their lived experience. Rather they experience the threat of exile from the program. Just as, university rules contribute to the lived experience of nursing students with mental health concern so do insurance rules. The analysis will now turn to the second sub category under *Psychiatrized–Self*, Insurance Rules, another subjectifying force in the nursing student lived experience of mental health concerns.

Insurance Rules. The second driver, alongside university rules that dictated what mental health services a nursing student can access, and influenced the lived experience, was insurance rules. Insurance rules included how publically funded health care insurance or private health insurance policies funded and reimbursed mental health services. Eleven of the twelve students interviewed had access to private insurance coverage and therefore the vast majority had experience with both public funded mental health services and privately funded services. Private insurance was possible through their parent’s workplace benefit policy and students recognized the privilege afforded them access to more mental health services then others without private insurance.

The most common private mental health services sought after by the students were talk therapies, and particularly CBT, were nursing students were taught coping strategies. Summer shares: “a psychologist, (...) was covered under our insurance, so we went to see her like privately and like I really believe that’s what helped” Summer, 821-823. On the other hand, Mary who is the one student without access to private insurance confesses “it just always bugs me I think because I (...) always wanted to get help but where do you get help how do you afford [mental] health” Mary, 869-871. The same student explained that because she did not have private insurance or the financial means to pay for private mental health service she did not get the therapy she believes would have helped her. She believed that Ontarians had access to publically funded talk therapy; however, it was so limited and rationed for the very ill in hospital. Students with mental health concerns would likely never obtain such a service on the public coffer.

[Talk therapy] not part of our health care [public health insurance]. I looked into cognitive behavioural therapy like I would love to participate in a program (...) but how do I even get to because unless you are part of like [two areas hospitals are named] those are people who get priority. The general population who is living with mental illness, you have to cope along and especially with lower incomes you can't, you get the medication that's the basis of treatment and you don't get anything else Mary, 850-858

It is the nursing students with mental health concerns perception that student with mental health concerns without private insurance will have little more offered by their *psy* expert than *psy* medication. The previous quote and the following voiced the frustration nursing students’ harbour as they realized that their health options were determined by forces beyond them, namely insurance rules that dictated what mental health service would be funded rather than their own understanding of their personal need. Andrew echoes Mary’s dismay as he saw that students with no private insurance only had access to medication and consequently an inferior mental

health support. Only because Andrew could access private insurance, did he have talk therapy and therefore he could choose to refuse medication.

[Y]ou know a healthcare provider just prescribe this [medication]. You know [it] is just a quick fix. (...) are we actually treating the source of the problem? You look at things that are not like that, like CBT or different kinds of therapy that (...) have shown to help people Andrew, 883-888

Most of the student's in the study felt that talk therapy was more beneficial than medication and pinned for talk therapy as a first line therapy rather than the current practice of medication.

However even medications come at a cost and the nursing students voiced that without private insurance they would not have been able to pay for the *psy* medications. Interestingly some students also felt compelled to take the medication because it was reimbursable, and believed that they would not have taken them so readily if the insurance rules were otherwise.

If I didn't have a drug plan I probably wouldn't be taking it [medication] because I found out it was \$130 for my medication every (...) three months so it's not the cheapest thing (...), economics goes hand in hand Eleanor 562-565

Eleanor recognized the economic realities at play in her choice of therapies. Mary was also astute and understood that socio-political and economic realities, influenced her lived experience with a mental health concerns was influenced. She perceived no societal or political readiness to support any change in how or what services would be reimbursable for those with mental health concerns. Mary believes only the acutely ill, inferring the medically ill, are deemed a priority for service. Mary is powerless in face of the political and economic realities.

Economically you can't afford it and politically to make it unavailable and we have less money in our health institutions in general. (...) that obviously effects all of the mental health care we provide. (...) obviously, our priorities are going to be acute because these people are dying. Mental health patients are not dying and I can understand. (...) we are not getting enough mental health focus there is no money to put into the system and that comes down to politics and even our economic system Mary, 913-921

As social realities reflect societal values and beliefs Mary's comment, that mental illness, as a problem that warrants attention, is not acknowledged or valued to the same degree as medical issues, illustrates that she has succumbed to societal values and believes this to be true even if it means her needs are of less importance. Political realities derived from societal values and beliefs drive policies that deem society's priorities and what will be eligible for support. Economic realities determine what services are available by virtue of funding chosen services. Within this socio-political and economic reality, insurance rules are established which favour certain interventions and determine how long services will be provided, and who is eligible. Mental health services, according to the participants in this study, are governed by insurance rules not by what a person with a mental health concern, their family or even *psy* expert, might deem as best. Consequently, students come to see themselves as *regulated beings*, forced to access mental health services that are reimbursable, not their choice. Consequently, their conduct is coerced, their lived experience affected. The following quotes illustrate how socio-political and economic realities shape the nursing students with mental health concerns lived experience. These realities subjectify the nursing students being in the world:

I was seeing a psychologist at the time. (...) the problem is that it's very expensive and my parents weren't able to afford it anymore. I think I think that was really hard. (...) I had to go write in my bio exam and I was really nervous about not getting accepted and it was just like a whirlwind of things going on. I felt like I couldn't really cope and like I got really suicidal at that time and I would say like that was probably the closest I have ever been to actually killing myself, Mary, 541-548

Just as not having access to quality services because of insurance rules made for worry in the nursing students so did the fear of having a relapse and not having the insurance, or having exhausted the limit for reimbursable services. Summer knew that she had incurred financial burden for mental health services she had received and although at the time of the interview she was feeling well and did not need mental health services, she carried a fear that one day she may

relapse and require costly private mental health services again. Her fear magnifies when she considered the reality that she may not have insurance to cover the cost at another point in her life, as she will no longer be a dependent of her parents. As someone recovering from a mental health concern, she understands that relapse is possible. Summer accepts relapse as part of being a person with a mental health concern however, the fear of not having the financial resources or access to insurance to cover the cost of mental health care is far more troubling than the potential of a relapse.

Economically as a student with mental health concern, it's always a little bit. (...) scary to think that you know relapse (...) might not necessarily be an option. (...) you might not really have the means to go through a relapse. If I went back and I got to where I was before really bad depression very down and not very productive like the self-injury it's like can I afford to do that you know? (...) am I going to be able to afford medication, counseling, or that kind of thing? You know right now as a student I am still covered under my parents' insurance, which is great, but in the future, it's kind of a little bit daunting. Summer, 1005-1019

Students understood they could not readily separate their lived experience from socio, political and economic realities. University and insurance rules dictate what mental health services are available and reimbursed. As the interview continued, several nursing students also described another force that regulated their conduct and thereby contributed to their lived experience as nursing students with mental health concerns. This regulatory force, *nursing rules*, originated from the nursing profession and this regulative force also contributed the nursing students lived experience with a mental health concern.

Nursing Rules. This subcategory surfaced in more than half of the interviews with nursing students with mental health concerns. Nursing Rules were the professional competencies required for nursing practice. In their BScN program, students learnt that the nursing regulatory is accountable for public protection. The nursing regulatory body ensure nurses are competent

and ethical practitioners. Competency, as defined by the regulatory body in the jurisdictions that the student studied, is the knowledge, skill, ability and judgement nurses require for practice (CNO, 2014). Competency equates to something that the regulatory body claims it can evaluate and measure in a national competency examination (CNO, 2014). Central to nursing curricula are the expectation that nursing competencies will be met. Success in a nursing program means a student has demonstrated the knowledge, skill, abilities, and judgement required of the profession. To prove one has the competencies required, students are continuously evaluated. Based on the competencies high stakes evaluation is emotionally demanding, however, accepted as a fundamental characteristic of nursing school.

It does make sense in nursing to be strict because it makes sense that they want to weed out people who either don't want to do it or who are unable to handle the rigour of being a nurse in whatever capacity, because you are dealing with people's lives. It makes sense that you must be prepared and you must meet a certain standard. Mariam 201-210

In nursing school, indoctrination into the culture of competency and evaluation begins but not without difficulty.

I heard from her [a nurse mentor], you got to make sure you can handle it, and I have a bunch of friends that graduated that are like, who, good luck. (...) it is like a rite of passage for nursing. Nursing school is tough. It always has been, probably always will be. Sasha, 435-439

A subtle inference in the above quote and one that is more apparent in the following is that during nursing school as students prove themselves competent, they will feel emotionally battered, even abused at the hands of other practicing nurses who will be testing them. Nursing student accept this emotional abuse as something inherent to nursing school, part of the rite of passage to becoming a nurse. Nursing students believe this to be part of nursing culture.

There has always been this philosophy. I think with nursing where nurses kind of went through a hard time when they were in school, so... oh, it was so tough

when I was in school. We got to show these kids what it's like too. Sasha, 868-870

Nursing students do not question the persistent need to prove oneself to other nurses, it is inevitable and necessary, but the perceived emotionally abusive tone of evaluation contributes negatively to their experience with a mental health concern. In the following quote, a student speaks of the consequences of emotional abuse at the hands of nurses in authority, and the consequences to her mental well-being.

the whole idea of nurses eating their young, I think that's why I get really nervous around nursing stuff, (...) I would never do anything to upset anyone and so when that person of authority acts aggressive unnecessarily it makes me panic, Mary, 715-720

Despite encountering the perceived emotional abuse, nursing students with mental health concerns have the knowledge, skills, ability, and judgement as other nursing students, to prove themselves as competent nurses. Nursing students with mental health concerns in this study did not run from this forbidding rite of passage, the continuous testing of competency, but faced it directly, met expectations and progressed through the program. However, upon reflection they believe the tone in which evaluation of competencies was conducted was intentionally emotionally abusive.

What also emerged from the data was that competency as defined by the Nursing Regulatory Body as knowledge, skill, ability and judgement left much room for interpretation. Interpretation of what each of these four concepts or pillars of the Regulatory Bodies competency framework by the nursing students in this study set the stage for nursing myths regarding what it means to be a professional nurse. These nursing myths entangled with nursing rules and what nursing students with mental health concerns came to believe was integral to nursing competency and the nursing profession. The following paragraphs will elaborate on how nursing students come to understand nursing rules and how nursing myths materialize.

The first myth that nursing students came to believe was that nurses must put the care of others before their own. Nurses are to sacrifice their needs over those of others. This myth came in conflict with how nursing students with mental health concerns understood recovering. Summer and Leila want to be a nurse and care for others and are willing to accept the nursing myth that the care of others comes before self-care, however they face a paradox how to maintain their own self-care central to their mental well-being that is essential to caring for others? This nursing myth is in direct conflict to what they have come to know as essential for their recovery. However, nursing student with mental health concerns are so committed to nursing that they are willing to risk forgoing self-care, which the myth equates the role of the professional nurse. The following quote illuminates this myth and its impact on student mental well-being:

I have worked so hard. I have always been (...) very self-aware and to take care of yourself and you know look after yourself. (...) that might be a little bit different in the workplace. (...) it's just you have to look after other people so I think it's going to be a bit of a challenge for me to find a balance between still looking out for myself and you know protecting and taking care of myself while also taking care of and protecting other people, Summer, 996-1004

Maintaining recovery requires self-care. Summer alludes to this myth of needing to sacrifice her care, if she is caring for others. She states to be a nurse: "I need to be focussed on other people and not myself" Summer, 994-995. Regrettably, in accepting this self-sacrifice nursing myth her recovery is threatened. The following quote eloquently explains the tension this nursing myth poses to the nursing student with mental health concerns.

[A]s a nursing student sometimes I feel that I kind of have to, (...) exist outside of health concerns because I am going to be looking after other people with health concerns. (...) I cannot have mental health concerns in particular because I am going to be looking after other people with health concerns. Physical it is kind of different. (...) you break your foot it happens but yeah I guess I kind of feel like I think that maybe in the future in the workplace I'll feel like I have to keep that [mental health concern] under wraps, just because I need to be focussed on other people and not myself, Summer, 980-995

Summer believes nursing requires her to put her mental health aside as other nurses do not understand her lived experience. She elaborates that if she had a physical concern others in the nursing would understand that she needs to take care of herself to heal, however mental health concerns are not understood, as physical illness is, by other nurses and therefore no similar accommodation is made in the workforce. Consequently, there is no point in admitting to having a mental health concerns. Summer, and others in the study, come to conceal their lived experience with mental health concerns, on one hand because it served no purpose in the nurse-client relationship and on the other hand, the experience has no place in the nursing profession. As a researcher, I cannot help but ask where does this nursing myth originate? Summer and Leila, the two nurses that spoke most often to this nursing myth, were primarily exposure to the nursing profession through their education. Consequently, it is purported that this nursing myth cultivates in the nursing program; by means of what is taught, what resources students are guided too, such as the regulatory body websites, and by their encounters from practicing nurses while in clinical.

Associated with the requirement to put the needs of others first is a belief that nurses with having mental health concerns will be distract by their own needs and therefore unable to fulfill this fundamental requirement of nursing. Although this is never stated out-right in the nursing program, the following quote illustrates that nursing students feel compelled to remain silent about their mental health concerns: "I'll feel like I have to keep that [mental health concern] under wraps a bit, just because I need to be focussed on other people and not myself", Summer, 980-995. Here the covering up of the mental health experience is a means to demonstrate nursing students put the care of another first. This is not the same as the need to remain silent about their

lived experience with mental health concerns because of stigma. This will be explored will be explored later in this chapter.

Another nursing myth that participants alluded to was that nurses needed exceptional capabilities to be able to work in environments that would otherwise be toxic to mental well-being, “we have a problem with nursing (...), expecting our nurses to be superhuman when they are people too you know”, Mary, 493-495. Nursing students come to understand that nurses need to do what is humanly emotionally impossible and not experience a mental health threat. Mary believes the myth that nurses are super human originated in the subtleties of classroom lectures. Not by what was overtly said, but by the discourses that were absent: “nurses cannot speak out about mental health issues because they have to be like the strong ones (...) so even our mental health class it was like a subject touched but not discussed”, Mary, 482-484. Mary alludes to a curriculum and textbooks that promote this myth and never present nurses with mental health concerns as professionals or that nurses can have mental health concerns. The absence of genuine discourse led nursing students to a belief that mental health concerns do not belong to the depiction of a ‘professional’ nurse. In the classroom, Mary learned: “I find like with a mental health issue like especially in the nursing it doesn't really fit the perfect picture of a perfect manners and so I definitely feel like that affects me” Mary, 171-174. In the classroom in the nursing program somehow and somewhere the message was given that mental health concerns make for a less perfect nurse or perhaps tarnish the nurse so that she is less than the expected superhuman nurse. Not being able to meet the requirement of the myth of ‘Super human nurse’ was something that added stress to Mary’s emerging professional self and to her experience of her mental health concern. Seeing herself as a less than this ‘super human nurse’ erodes on Mary’s self-worth and her sense of competency, even if this image of a nurse is unrealistic and

pathologic. Sasha felt less capable as a nurse because of her mental health concern; even though she was confident, she demonstrated knowledge, ability, skill, and judgement in a comparable to others in her class, fashion. Mary and Sasha believe they will be viewed as inferior nurses, because of their lived experience with mental health concerns and thus have no choice but to hide their mental health concern from other nurses and the nursing regulatory body. In the following quote, it is clear that nursing rules and related myths drive conduct and affect on the lived experience of having a mental health concern.

I think would they hire me knowing this [they have a mental health concern]? Over someone else who is equally qualified, has the same assessment skills, the same, you know knowledge base? Would they choose me or would they choose the other person knowing that I have a mental illness? (...) the answer, unfortunately, is they'd choose the other person. (...) not that people try to be like that. It is just the way things are, and I do not want that to ever happen. So, keep it to myself. Yeah Sasha, 292-297

This quote illustrates that nursing students with mental health concerns feel powerless in face of nursing rules and myths, “it is the way things are”. The way things are, the culture of nursing means denying self and negating personal mental health needs. Jane shares, “[H]onestly I think that’s the one thing about nursing that’s difficult. It is always hard to leave your baggage at home but it is so hard to walk on a floor [and] feel like crap, Jane, 316-317. Nursing students learn to park their emotions outside of the therapeutic nursing relationship as; the profession expects this.

In summary nursing students, understand that as a *Psychiatrized-Self*, they experience forces that effect their lived experience with mental health concerns. University rules influence what mental health services were available and accessed on campus. Insurance rules determine what services are reimbursed thus manipulating care options and mental health outcomes. Nursing rules set determine professional competency, claiming to determine skill, ability, knowledge and judgement that is required for nursing practice. The impact on the lived experience of nursing students with mental health concerns was less obvious however; upon

reflection, they had a profound influence on the nursing students emerging sense of professional self. The language of nursing rules left nursing students with mental health concerns unclear about their place in the profession. Nursing student then engaged in interpretation of nursing rules which open the door for the establishment of nursing myths that negatively impacted students' mental health and wellbeing and went so far as to damage steps made toward even impeding recovery. Analysis will now turn to how nursing students with mental health concerns experienced the *Stigmatized Self*.

5.2.3 Stigmatized Self. All twelve participants contributed to the category, *Stigmatized-Self*, under the theme *Psychiatrized -self*. Pages of quotes spoke to how nursing students with mental health concerns encountered stigma although no interview directly asked about stigma. For example, when asked what hinders her mental health and contributes to her mental health concern, Sasha replies emphatically, "It's the massive ginormous stigmatization" Sasha, 453. Evidently, this concept holds significance to Sasha and to all the participants in this study and requires analysis to gain an appreciation of this significant theme in the lives of nursing students with mental health concerns.

Stigma entails a distinguishing mark of social disgrace. People with mental health concerns are stigmatized out of fear and misunderstanding of their lived experience. Stigma can originate from others or be self-directed as in the case of self-stigma. Nursing students in this study experienced both forms of stigma. Stigma from others came at the expense of peers, friends, family or faculty learned of a student's mental health concern. Stigma from others further divides into the following sub-subthemes; Insecurity, Mixed Messages, Flawed Citizen and Unfit for Practice. Self-stigma surfaced when nursing student judged themselves as inferior to others because of the *psy* label attributed to their lived experience by their *psy* expert. Self-

Stigma divides into three sub-sub themes; I am fake, Self-Silencing, and Impeding Recovery. In the following pages, the analysis of the data as it relates to the category *Stigmatized Self* is presented.

Stigma from others. Seven of the twelve participants in the study experienced stigma originating from others. This form of stigma contributed to a sense of insecurity, which in turn negatively affected their lived experience.

Insecurity Stigma from others started, for most of the participants in this study, in high school and left wounds that continue to fester and affect the nursing students' self-esteem in university. These wounds corrupted thinking and fostered additional mental distress. Mary describes her experience of stigma from others, as follows:

[In] high school you don't feel like you belong like you don't feel normal and I think that can also bring on the depression as in like you know with bullying and being put down often you can start seeing yourself the way other people see you, Mary, 356-360

Stigma from others fueled a state of ambivalence in nursing students regarding their capability. Jane speaks of the stigmatizing encounter she experienced at the hands of an administrator and fellow students at the university after she disclosed her mental health concern. She describes how their stigmatizing beliefs affected her sense of *being*. She clearly felt the sting of being stigmatized, "it's just one of those things (...) some people are judgmental. (...) They don't think there's a place for it [mental health concerns]" Jane, 458-460. Because of the stigma from others, Jane began to fear if she could continue her studies, "It was terrifying. I thought I was going to be kicked out of the program". Jane 783-784. Sasha describes how omnipresent stigma from others is in the nursing program and how stigma and nursing myths regarding competency link. Stigma from others, as understood by Sasha, is likely at the heart of the falsity that nursing with mental health concerns are incompetent. However, as a nursing student she is powerless to

challenge stigma from others. Fear of stigma from others drive her conduct and her lived experience with mental health concerns.

Because automatically people think you are not capable (...) I wish it [mental health concern] was better understood. But it's not yet, so you do have to be cautious about who you tell, what you tell. That is just the nature of the beast.
Sasha 460-465

Mixed Messages Stigma from others can also perpetrate mixed messaging and thus create a state of confusion for the nursing student with mental health concerns. A few nursing students, three of the twelve participants, mentioned how they experienced stigma from others that left them bewildered about themselves and exceptionally stressed. The stigma from others, in the form of mixed messages, surfaced when nursing students were told that mental illness is acceptable in one group or association and not in another. For example, among friends or in the general society, talking about mental health concerns is encouraged “my generation (...) are very open [about mental health and illness] which is very good which I guess helps a lot more people open up to their friends”, Winter, 408-410. However, in the nursing profession it is perceived as perilous to admit having a mental health concern as competency, in particular judgement, of the nursing student will be put into question. This mixed message confuses the nursing students, especially as they are encouraged by media and public health anti-stigma campaigns to speak about mental health concerns (Bell Let's Talk). Likewise, they have learned that talking about their mental health concern makes connecting and learning from others with a mental health concern possible. This learning from others and belonging, is an integral part of their recovering and will be analysed in detail later in the chapter. However, the nursing profession, which symbolizes to the nursing student a profession of acceptance, healing, and support, implicitly hinders healing or recovery for its members, nurses or nursing students, who struggle with mental health concerns. Hindrance or impeding of recovery happens because other nurses

stigmatize nurses and nursing students with mental health concerns. Mixed messages are depicted as a “crazy making” cycle by Sasha. Sasha feels dis-genuine, because she is present for others who need to talk and who need support with their mental health struggle, while she fakes mental well-being, because she cannot admit to her lived experience with mental health concerns. She recognizes the threat to her mental well-being when she says, “I am not worried”, although her anxiety rises because of her need to be inauthentic. She knows that her emotional tension would subside if she could honestly speak about her mental health concerns. Her experience of stigma from others hinders her recovery, because stigma leads to fear of having her competency scrutinized. To cope with the mixed messages regarding stigma, she feigns a mental state that denies her mental health concern.

[A]s much as people say, Oh, I’m not going to judge you in a particular way because you have a mental health disorder, (...) they do. Research shows that they do. You know, the stigma’s still there. (...) because this is a professional program, I feel like I really need to hide (...) any signs or symptoms (...) I try to almost pretend I’m like this person that has it together all the time. Like when my classmates are really anxious and stressed out, I’m the one that kind of tries to comfort them or, you know, if a prof says something like, “Oh, you have to not worry so much.” I am just like, “Oh, I’m not worried. I am not worried.” Sasha, 138-146

Stigma from others also gives nursing students mixed messages in that they come to believe that certain health conditions carry more stigma and are thus worse to have, although theoretically they learn that a person’s perception of illness is unique and dependent on the individuals understanding not on the nature of the illness. For example, nursing students understand that it is acceptable to be a nurse with a physical problem but not acceptable to have a mental health concern; although nursing as a profession touts that all aspects of the human condition be it physical, mental, cognitive or spiritual make up the holistic being and are equally important. Sasha explains this paradox,

The big thing for me is just stigma, and how we view people differently because they have mental illness, whereas, you know, if they have a broken arm or something. There is a giant discrepancy. Like, you know, even though we are really trying hard to eliminate that, it is still there, Sasha, 306-309.

It is Sasha's perception that nursing stigmatizes those with mental illness far more than someone with any other health concern. This is a blatant mixed message. She concludes these mixed messages need to be addressed as they lead to injustices within the nursing profession.

Mixed messages cause emotional tension to nursing students with mental health concerns and lead them to question their identity as a nurse. For example, Andrew sensed stigma from other nurses regarding his addiction to nicotine. He explains that in nursing school his professors spoke about the complexities of addictions, including risk behaviours, health implications and the role of harm reduction in treatment. However, it was his perception that the profession had little tolerance for his addiction to nicotine. In fact, it was his belief that certain substances seem to hold more stigma and nicotine tops them all. It has been Andrew's experience in nursing school, that excessive drinking of alcohol is an accepted part of the nursing student culture and condoned by peers, faculty, and the greater university community. Alternatively, smoking is unacceptable in the nursing community and highly stigmatized by nursing peers and faculty.

[T]here's lots of stigma (...) but then you look at socially acceptable things like drinking and you know you can know friends that you know will go out every weekend to the bar and what not you know and that might be for them and it might be socially acceptable and smoking not so much. Andrew, 1163-1167

Smoking is highly detrimental to health, and so much of the nursing curriculum, according to Andrew, focuses on the risks of smoking. Andrew fears he will be labeled a fool who would have extremely poor judgment if he admitted his nicotine addiction to his peers or faculty. Stigma from others in his nursing school drives Andrew to hide his nicotine addiction. He slips away from his peer, and isolates himself for a smoke when his anxiety rises, he then feels ashamed for smoking and questions if his smoking hinders him becoming a real nurse because he is not living

the expected healthy life style expected of a nurse, perhaps this relates to this ‘super nurse’, alluded to earlier in this analysis. Andrew struggles with the mixed messaging he is receiving from faculty and peers; that nurses care about people with addictions, but that no educated nurse could ever smoke and if they do, it is the result of their poor judgement. Yet judgement does not come into questioned in nursing students who partake in extreme risk, such as binge drinking, as a means deal with stress. In fact, drinking alcohol even excessively is acceptable to peers in the program and the greater community. Andrew is left feeling flawed, imperfect, and inadequate, because of stigma from others and the mixed messages he is receiving from peers and faculty. Andrew believes the nursing myth that nurses must be perfect and his smoking confirms to him that he is imperfect.

[N]urses are supposed to be (...) that shining light in the hospital. (...) I view nursing as a highly respectable career yeah we are supposed to maintain that image of optimal health. (...) we are the care providers (...) not the patient. (...) there definitely is a lot of stress and especially what we're learning about we know we understand the human anatomy we understand physiology we understand what these things do to our body and we can read all about it. It's just addiction, it really exists and it's difficult to deal with, Andrew, 1144-1154

Andrew believes stigmatized by other nurses because he smokes, but questions the mixed message that smoking is worse than binge drinking. He feels powerless, in face of this mixed messaging and in the end, chooses to hide his addiction to nicotine because of stigma from others. He says nothing about it and therefore forfeits any opportunity to deal with his addiction and foster his recovery. Through the interviews, it becomes apparent that stigma is a force that influences the conduct of nursing students with lived experience of mental health concerns.

Flawed Citizen. Along with being, subjected to mixed messages that stigmatized students with mental health concerns perceive come to see themselves as flawed in some way. Stigma from others experienced by nine of the twelve left nursing students with the perception that they

were imperfect and thus defective because of their mental health concern. The sub-sub theme, flawed citizens, qualifies this recurrent, detrimental lived experience, typically at the hands of others in positions of authority in the university and nursing school. Students felt like a flawed citizen with a fundamental imperfection requiring fixing. “I knew I was a little depressed but I was kind of in denial for a long time because (...) there's such a stigma to it but last summer I was really sick and automatically I thought it was something physical, physical wrong with me” Sophie, 34-39. Nursing students with mental health concerns as flawed citizens had automatic thoughts, imbued with the stigma from others that led them to erroneous explanations for feeling unwell. For example, physical illness is acceptable for nurses, mental illness is not, and therefore depression, typically considered a mental health concern, is not acceptable for a nurse so symptoms are ‘rationalized’ as physical in nature. Stigma from others makes a nursing student believe that physical illness, like cancer, is acceptable. Physical diseases happen to you, it is not your fault, and thus you are not inherently flawed. However, mental health concerns demonstrate internal weakness a flaw in character. Nursing student hears from others that they need to show internal fortitude to deal with their mental health concern. The following quote illustrates how nursing students feel inherently flawed and must muster up their strength by themselves, without support from others, to take action against the mental health concern if they are to be recognized as competent and not ‘one of those people’ flawed, imperfect people.

If I had cancer or something, I think it would be a lot different, but I just... I am just one of those people (...) I am just someone that is anxious or, you know, you can deal with it. Just be strong and get through it. Sasha, 183-185

Some nursing students verbalize stigma from others that leads them to feel like a flawed citizen, originates from nursing professors, peers, or family members. Lectures prepared by nursing faculty and the class discussion that occur in class illuminate this stigma from others and how nursing students come to see themselves as flawed citizens, flawed nurses. Summer shares the

following reflection, tears up and remains silent for a period after voicing how challenging emotionally this reality is for her, “so yeah sometimes like that kind of content can be difficult to sit through in a class and especially when people raise opinions on the matter [mental health concerns] it's difficult to sit through”, Summer, 490-492. Even during a private discussion with professors following class or in an office, nursing students with mental health concerns felt stigmatized their competency and judgement questioned. The following quote illustrates how one student, after opening up to her professor about her lived experience with a mental health concern, felt stigmatized as a student looking for excuses, rather than acknowledge for her academic achievement.

I have had that experience before where I have had to disclose to the professors, and I just feel like, you know, I am a really good student and I pride myself on that. I pride myself on working hard. I do not want people to think I am using it as an excuse or something like that. Sasha, 159-162

The stigma that this student perceives drives the student to work even harder to prove herself, this excessive driven then exacerbated her mental health concerns. Stigma from others was a result of, and a cause for, the lived experience of mental health concerns. Nursing students also faced stigma from nursing peers. Nursing students with mental health concerns voiced that they feared that if they told peers about their lived experience, their nursing peers would see them differently, as “ill”, flawed, in need of nursing care,

If they find out they would care for me. (...) I don't want to be treated as a patient. I want to be treated as a peer and I think that is the big difference. (...) all of a sudden, I would become this person with a health problem and they are viewing me from the [nursing] aspect rather than you know as a peer as another nurse, Mary, 445-453

Nursing students with mental health concerns also felt stigmatized by family members and carried this sense of being a flawed self to nursing school. Eleanor reveals with a tone of disappointment, that her father believed she was weak, “his family have always been in the

mindset that like mental health or needing mental health treatment is being weak” Eleanor 89-91. Eleanor continually heard the message from her family members that taking *psy* medication that confirms she is imperfect, and if she was not taking medication she would be stronger in the eyes of her father and others “he's kind of had the attitude like why are you taking that medication you don't need that”, Eleanor, 104-106. Mariam encountered the same stigmatization at the hands of her family; the labelling of having a mental health concern as a weakness of character: “Oh, like this family member I have who thinks mental illness is because you're weak” Mariam, 843-844. Sophie is also stigmatized by others and laments how family members deny that her experience with her mental health concern is real, stating that it is nothing more than natural hormonal cycling. This familial stigma infers that Sophie is less or frailer than another woman, consequently flawed: “she doesn't think depression is a thing and she's like oh you just have your periods and stuff like that, and that's just it frustrates me”, Sophie, 307-310. The label ‘flawed citizen’ adds an immense emotional burden to the nursing students and aggravates their mental health concern. Sasha shares she specifically participated in this study in hope that her story would reduce stigma from others, something that has haunted her for years. Sasha eloquently explains what this haunting has meant to her “It's like... because automatically people think you're not capable (...) [they think] you're this fragile little flower, when really it's the opposite. (...) you have been through stuff. You're a concrete flower” Sasha, 461-463. Sasha wants her accomplishments to define her not the stigma from others. She wants the same for all nursing students with mental health concerns.

Unfit for Practice. Once labelled as a flawed citizen, because of the stigma from others comes the label “unfit for practice”. The determination that students with mental health concerns were ‘unfit for practice’, without any substantiation, was for the most part a product of stigma

from faculty in the nursing program or other practicing nurses in the clinical setting. Jane explains that this form of stigma from others festering when a profession is focused on an evidence based practice model “it’s a mental health issue so there’s no physiological, you know, proof or like there’s no pathology to it. So, it’s [mental health concern] harder to accept I think, when it comes to nursing”, Jane, 842-844. This hard to get a handle on, or difficulty proving mental health concerns with evidence, Jane understands as the source of an unwillingness of nursing to explore mental health concerns and the resulting lack of understanding fosters the stigma among nursing professors and those in authority. Mary claims that she realized quickly that faculty and nurses in authority ascribed to the belief that “You shouldn’t have mental health issues if you’re on a floor”, Mary, 462-463. Sasha heard utterances of stigma from others when overhearing her professors talking. “When nursing professors or something are talking about, you know, people who are mentally ill and they kind of talk about them like, you know, it’s this thing that they just can’t control” Sasha, 329-331, inferring that nursing students with mental health concerns lack control of their practice and therefore are unfit for practice. Knowing that faculty and nurses in authority held these unsubstantiated pre-conceptions, rooted in stigma, meant that nursing students with mental health concerns lived with a constant fear of being found out and possibly losing their place in the nursing program. Nursing students with mental health concerns felt strongly that they could control the symptoms associated with their mental health concern but not how the stigmatization by others. This ‘uncontrollable’ wild card in their lived experience with mental health concerns added tremendously to nursing students’ stress. Nursing students in this study felt they could provide no evidence to substantiate their competency if faculty held the preconceived notion that nursing students with mental health concerns are unfit for practice. Stigma from others determine their competency not their practice. Jane expounds on

her perception of being judge unfit based on no evidence, “I would just be kicked out of the program and I feel like it would (...) it would happen. They would... they would justify it by saying its patient safety” Jane, 791-792. One hears in Jane’s voice that she feels extremely vulnerable and at the mercy of faculty in the school of nursing who have power over her and her future in nursing. Nursing authorities, decide her fate in the nursing program, and because of their stigma towards nurses with mental health concerns her fate as being labelled ‘unfit for practice’, was sealed, regardless of how successful she is in demonstrating competency. Sasha wants to end the stigma from others, and get the message out that nurses and patients do not have to harbour any fear about her competency or any other nurse who has a mental health concern. Having had an experience with a mental health concern does not make Sasha ‘unfit for practice’ she is competent and capable,

I want them to know that they are safe (...) their life in my hands. I am capable. (...), I am trained. (...) they do not have to worry (...) at one point, I struggled with, (...) suicidal ideation or whatever. That does not make me less of a nurse right now. Sasha, 520-524

Stigma from others also contributed to nursing students with mental health concerns having the sense they were under excessive surveillance regarding their ability to practice nursing. Sasha alludes to this surveillance, as being profound, and the risk of this unfit for practice judgement persistent: “It’s almost like when I’m looking at people that are like my superiors or something. It’s always I’m afraid of what they would think if they knew kind of what was going on in my head or something like that. Would they question my, you know, would they question my judgment?” Sasha, 320-323. Jane explains that after she shared her lived experience with a mental health concern with her faculty administrator following the death of a loved one, she was convinced that her competency was under more scrutiny because she

share she was grieving. Had she shared she suffered with depression, she fears things would have been worse.

I cannot imagine how much more scrutiny I would be under if I was like, oh, yeah I am like a walking nut-bag. I am not a nut-bag. (...), that is kind of how you view yourself sometimes. Like I am unhinged or, you know, I am uncontrollable because I have something that could happen at any point. You know, maybe you do not trust me so much. (...) then that extra level of scrutiny is actually what ends up pushing you over the edge, especially with anxiety Jane, 420-425

Jane describes how she perceived the surveillance as constant and at every level be it administrators, faculty, clinical instructors, and unit nurses. Stigma from others made Jane begin to question her own competence and made her hyper-vigilant in her practice.

Then on top of that, having the administration aware (...) made them so much more vigilant about me. "Are you sure you're safe to practice?" I got that a lot. "Should you even be on the floor?" Jane, 204-206

Jane concludes that not telling anyone in authority, that is, silencing herself would have been a wiser route of action as the stigma from others was immense. In the future, she would not open up to those in authority or faculty in the future:

To be questioned was also super insulting because I am like, I am thinking of patient safety and if I was going to be unsafe; I would not be at clinical. You know, and that's the type of experience that I had anyways in fourth year. That just reinforced everything I ever believed about not telling them anything when it comes to, you know, maybe I have an anxiety issue. Maybe I am depressed sometimes. Jane, 818-823

However, silencing condones maintaining the current order of affairs, where stigma from others flourishes. Those in authority understand so little about mental health concerns and therefore feel threatened by their ignorance. Only in facing the reality, that nurses have mental health concerns, and in discovering how competently these nurses and nursing students practice, will attitudes towards mental health concerns change and stigma be irradiated. Silencing nurses because they fear stigmatization hinders learning how to care for those with mental health concerns which is

the very knowledge or evidence for practice and research that the nursing profession is lacking.

The following quote articulates the vicious nature of being stigmatized as a nurse and learning to perpetuate stigma while studying nursing.

I am stigmatized. (...) it is awful because even I am taught to be [a stigmatizer]. (...) I have my own mental health issues, but sometimes I catch myself looking down on certain people for their issues. (...) it is awful to say that, and I'm going to be honest like it happens, because we're taught a certain thing, to view certain things, and then, you know, then we have the issue and we're like okay. Hide it from everybody. Jane, 1099-1100

The nursing program promotes the culture of the nursing profession. Jane believes the program therefore perpetuates stigma to those with mental health concerns, and those with mental health concerns are silenced and thus unable to help or substantiate the science needed to improve the nursing profession. This silence robs the profession of the stories or voices of those with lived experience. The cycle of stigma from others that drives self-silencing regarding the lived experience of being a nursing student with a mental health concern must be broken.

Self-Stigma. The persistent bombardment of stigma from others can lead a person to espouse negative beliefs about themselves, as the stereotypes that others hold begin to take hold in the person with mental health concerns own understanding of themselves. Tacitly and passively stigmatization erodes the person's self-esteem and self-efficacy; ultimately contributing to poor mental health outcomes. Unfortunately, the majority of nursing student, nine of the twelve participants, in this study, self-stigmatized following their encounter with persistent stigma from others. Their words, in 35 quotes, powerfully described what it is like to live with self-stigma. How it settled into their lives and affected their sense of self and relationships. Students also voiced how self-stigma contributed negatively to their overall mental wellbeing. The three sub-sub themes that emerged from the data that described the aforementioned realities

a nursing student with mental health concerns experienced are Self-Silencing; I am a Fake and; Impeding Recovery.

Self-Silencing. Nursing students in this study were intelligent, quick to reason and sensitive to social contexts. No doubt, these talents serve nurses well in their practice as they attempt to assess the needs of others and implement meaningful care. This sensitivity to social context when used by students to create quality care plans leads to astute quality care often praised by faculty. However, awareness to social cues may foster a hyper-vigilance to stigma and an astute awareness to professional consequences. “I would never want my profs to know kind of what I’m going through, because there’s still that stigma there”, Sasha, 135-136. The nursing student with a mental health concern, sensitive to social cues may notice the frequency of stigmatizing commentaries within the profession, and come to self- stigmatize. These cognitively and socially sharp nursing students learn staying mute regarding their mental health concern serves them better professionally. The link between the influences of stigma, the student’s awareness of the situation, the fear of being found out and the need to be silent is alluded to by Sasha is speaking about stigma and the negative professional consequences. “Like it’s not that people try to be like that [stigmatize]. It is just the way things are, and I do not want that to ever happen. So [I] keep it to myself”. Sasha, 296-297. Several other quotes described how nursing student felt that as evolving nursing professionals they had no choice but to hide their mental health concerns, even to the detriment of their mental well-being. Fear of professional consequences drive their silence, as Jane admits: “My biggest fear throughout most of nursing school was somebody would know”, Jane, 416-417. Andrew describes his faculty-student relationship as supportive however sharing his mental health concern was a taboo because of stigma: “I didn’t bring up specifically my mental health concerns [because of stigma]

but no I kind of just left that out but I was able to talk to them about personal life things”,

Andrew 296. Sasha shares that she was never told there would be negative consequences; she just fears it and self-silences to protect herself;

I have not actually been told like [not to speak about mental health concerns] (...) in all honesty, I have not been open about the fact I have mental illness because I have been trying to hide it. I do not know if the school would be more, you know, supportive if I said I am struggling with, you know, this. I do not know. I have not had the guts to see, Sasha, 194-197

Further in the interview Sasha explained more about her perception, her fear and what negative professional consequence could arise if she would disclose to faculty that she had a mental health concern. In this quote, we learn the fear of the label ‘that student’ with mental health concerns drives her self-silencing as a means to protect her professional self:

I would never tell a prof (...) I would not. Because again (...) it’s just this whole level of professionalism that it’s not something you can talk about. It is... you are automatically pegged as, you know, that student. Sasha, 273-275

Stigma from others becomes self-stigma as the student nurses come to believe they must never speak of their mental health concern because others, namely those in positions of authority in nursing would think them a less capable nurse. This need to hide any symptoms of a mental health concern reaches absurdity when nursing students feel they cannot show signs of stress or anxiety, even if the practice environment warrants a stress response: “I’ve been kind of walking on eggshells not trying to show any signs of stress or anxiety in an environment that breeds stress and anxiety. So that’s been hard” Sasha, 153. Students with mental health concerns perceive they have to go to extremes to demonstrate they are calm in face of the stresses inherent in the profession; they have to work harder to hide symptoms that run the possibility of association with mental health concerns, because of the fear of stigma. Delving deeper into the data, the researcher learns that nursing students see themselves through the eyes of those that stigmatize,

as imperfect and possibly even imposters. The energy required keeping up this façade of being a stress-less nurse takes its toll on the mental wellbeing of the nursing students, as it would for any nurse with or without a mental health concern. The difficulty is palpable in the following quote:

I feel the need to cover it [mental health concern] up. (...) just because it is nursing (...) I honestly wouldn't want my employer to know I have mental illness either, because (...), how's that going to affect her clinical skills and will she be able to... you know, there's that stigma (...) same deal. I do not want my profs to know that either (...) it has been really hard. Sasha, 147-152

This nursing student is expending immense amounts of energy to hide her mental health concern and she feels, all the same, that she is constantly being tested because of the stigma the profession holds. The tragedy is that this nursing student risks burning out not because of her mental health concerns, but rather because she cannot verbalize the stress she experiences in the health care environment. She comes to believe if she verbalizes her stress this puts her at risk of having her 'imperfection', her mental health concern, found out. The stigma from others, her self-stigma and the resulting self-silencing, impedes any self-care initiative that would ultimately protect her mental well-being. The caustic nature of this cycle cannot be underestimated. The student experiences the stigma, she self-stigmatizes, she self-silences, her mental health concern exacerbates. The personal strength required to break out of this caustic cycle is tremendous. Later in this chapter the third major category *Recovery-self* will be presented and more will be learned about how nursing students overcome this cycle and are able to live and work with their mental health concerns and become capable nurses, and even see themselves as exceptional nurses.

Delving yet further into how the nursing students with mental health concerns understand self-stigma; their need to self-silence extends beyond the administration and faculty to nursing peers, friends, and even family. Nursing students with mental health concerns cannot find comfort in their fellow nursing students. In the company of fellow nursing students those with

mental health concerns have felt that their experience was analyzed as if an experiment even when peers were wishing to-be helpful. However, their peers did not extent support or a genuine desire to listen. Mary reflects on her experience: “ I try not to share too much of it with my nursing friends because I'm kind of scared to be looked at as like a science project to be like observed and like applied to the practice, and less as like a friend”, Mary, 232-235. Mary explains why she believes sharing her mental health concern with fellow students was deleterious. Nursing students are quick to put their nursing process into action, they want to fix the problem, thus fix their peer, but miss listening to their fellow nursing student with a mental health concern. They miss the most important aspect of caring, simply listening, and letting someone with mental health concerns talk.

I do not like sharing with my nursing friends because they have that clinical view. (...) they are trying (...) to understand it so that they can become better nurses but I do not want to be the patients when I am there friend. (...) I do not share with them because I do not want them to look at me from a nursing point of view because I am not their patient they are my friends Mary, 306-313

The nursing program teaches a way to think and act in order to nurse. Unfortunately, a nursing student cannot yet discern when to be a nurse and when to be a friend. They muddled these two aspects of their being. This makes it difficult for nursing students with mental health concerns to find support in peers at nursing school. Peers that mean well but mix roles contribute to why nursing students in this study self-silenced, they do not wish to be ‘patients’, or recipients of the nursing care from their nursing peers. This suggests that addressing mental health concerns in the ‘caring professions’ may, paradoxically, be more difficult than among non-caring professions or perhaps other academic faculties. Sasha, like Mary, had experienced stigma in the nursing program, then self stigmatizes in response, and in the end silences herself although she wishes she did not “So yeah, I just... I wish it [mental health concern] was better understood.

But it's not yet, so you do have to be cautious about whom you tell what you tell. That's just the nature of the beast." Sasha, 463-465. The majority of the nursing students in this study all feared discussing their mental health concern with others in their program, only Jessica talked to peers about her mental health concern; however, she chose to speak by using metaphors. She thought that using physical health terminology rather than *psy* terminology, would be less incriminating, inferring that naming her mental health concern would add to her experience of stigma

I remember telling her [a nursing student peer] something like I felt like a kidney that had taken a hit. Which is just a joke because we had done the renal system that weekend. We had talked about how sensitive kidneys are and how they can be damaged very easily. I remember and we laughed about it and I think she understood. (...) that was a far as I have ever talked to someone at school about it, Jessica, 576-582.

Rather than self-silencing entirely, Jessica uses ambiguous language, much like a secret code, which she believes is understandable by those who share in her experience and have a mental health concern themselves but not to those who would not understand, those without the lived experience. This 'secret code' is also a form of self-silencing, one that allows only as much as is deemed safe to be said. Then, what is said is carefully weighed, to protect both the speaker and the recipient from stigma. Although Jessica is afraid to speak directly about her mental health concern, she believes that mental health concerns are common among her peers. Speaking openly about mental health concerns would be to state the obvious and that would be uncomfortable for all her peers: "I went with people at school with that stuff [mental health concern] and I think everyone is going through the same thing so it's no point complaining to someone", Jessica, 586-588. Jessica seems to mix student stress and distress with mental health concerns and sees them as one in the same. She alludes to all nursing students being depressed at some time in the program and talking about your mental health concern would be drawing attention to one-self, and in effect setting ones-self apart from the group by claiming that your

concern is unlike everyone else's. This fear of drawing attention to one-self is what keeps Jessica silent.

At school, we are all going through the same thing. Why should one person be more depressed than the other (...) we're all going through the same thing so why does it matter that you're having a harder time than everyone else. (...) so, I think that's something that kept me from telling people at school about it, Jessica, 653-659

It is unclear from Jessica's words if this fear of drawing attention to one-self stems from the nursing myths mentioned earlier, nurses need to self-sacrifice or perhaps need to be perfect or is it altruistic in nature? What does emerge from the data is that not one nursing student interviewed felt comfortable to speak to others in the nursing program about their mental health concerns, and this stemmed from stigma from others and their own self-stigma. Jessica admits her silence does stem from a fear of weakness "yeah 100% just didn't want to seem weak" Jessica, 510. This begs another question is it that nursing students cannot trust that peers, faculty, or administrators will not judge them more critically because of their mental health concern? Unfortunately, a sense of trust is not something all students in the nursing program experience. At least according to Jane,

I would not say I have shared any of my mental health concerns with very many students. I do not think I have ever felt that level of comfort; even if I spend a whole semester with these people (...) there is not that level of trust (...) and same with instructors. Jane, 472-475.

Being in a nursing program, which Jane perceives lacks trust between peers and between students and faculty, forces Jane's conduct. She self-silences because she cannot trust confidentiality will be maintained. Neither faculty, nor peers are trustworthy with the knowledge of a student's mental health concern because of the perceived stigma they harbour. In one of Mary's final declarations at the end of her interview, one can hear that Mary self-stigmatizes runs the risk of having others realize she is imperfect. Mary will speak to no one, not peers, not faculty or

even close friends, as they will also take on this “certain way”, a stigmatized way, of viewing her.

I wouldn't always share what was going on [mental health concern] especially with people who were close to me because I didn't want them to think of me in a certain way”, Mary, 953-955.

I am a fake. Only one of the twelve students in this study spoke to this sub-sub category, I am a fake, under Self- Stigma, however his desire to share this sentiment was so profound that it warrants special mention. Self-stigma happens when a person internalizes the negative stereotypes that others attribute to a mental health concern. Andrew felt this immensely as he struggled with his nicotine addiction and he believed that he could not be a nurse if he smoked. In fact, every day he was on the unit nursing he felt like an imposter because of his addiction. He felt the need to state he is a nurse, inferring he felt less than one,

Oh I'm a nurse, and you see nurses at the hospital smoking and whatnot how can they do that don't they know that cigarettes are contained 60000 plus toxins or whatever and you think how could I ever be in that situation and then here I am in that situation trying to quit smoking, Andrew, 116-1120

His conflict of self and professional image stemmed from the stigma he continuously heard from others in his lectures, clinical or from peers. His self-stigma meant that he began to believe he was less than a nurse because he did something so contrary to what nursing knowledge considered good for health. As a result, Andrew smoked clandestinely, and never spoke about his addiction to any of his faculty or peers.

You are an idiot, you know what are you doing stuff like that, and then I do not tell anybody. I do not smoke in front of anyone here, nursing you know, just because of that assumption, what is he doing smoking and whatnot. Yeah it is kind of like my own secret little thing that I have, Andrew, 1133-1137

In qualitative research, the unspoken is as valuable as the spoken. Consequently, this analysis notes that only one of the twelve students understood themselves as ‘a fake’. The

majority identified strongly with being a nursing student and becoming a nurse. Their experience with mental health concerns did not challenge their sense of being a nurse although external forces like stigma, regulatory forces, and university and insurance rules would have made them understand themselves differently and their changed their conduct (Goffman, 1963, Foucault, 1977).

Impeding recovery The concept of recovery in mental health is defined by the Canadian mental Health association as “the personal process that people with mental health conditions experience in gaining control, meaning and purpose in their lives” (CMHA, 2016, p. 36). Self-stigma that results from internalizing the stigma from others hinders recovery of a person with a mental health concern by squelching their belief in their own abilities or the power to take voice and ask for help. The detrimental association of stigma and impeding recovery was recognized by three of the twelve students “I didn't want to get help because I didn't want to bug anyone really I was scared of being labelled as having depression I didn't want to be different so that also added to it [mental health concern], Mary, 415-417. The fear of additional Stigma from others and her pressing self-stigma, where she sees herself as different, makes Mary choose to be silent. Rather than speak out, to access the help she knows could be available to her, she says nothing and hides her mental health care concern. This self-silencing, to the point of impeding recovery, surfaced in the data, “I know a lot of people are not comfortable sharing the fact that they're depressed or that they have other mental health concerns”, Julie, 224-225. Sasha concludes it is hopeless for her to speak out about her mental health concern, as she believes those in authority, or *psy* experts will just tally her story up as a statistic, with no sensitivity to her experience or how she can find helped. “You know, as a number, you are a statistic. As a statistic, you are just like everyone else with the mental health disease or disorder and this leads

to, you know, the stigma and that leads to stereotyping and that leads to discrimination”, Sasha, 838-841. The nurses here reported feeling that as they reported mental health incidents this counts against them because they felt that there was no sincere interest in learning about the experience of living with mental health concerns or the realization that recovery was not only possible, but also probable. This made the students bitter and their fear of stereotyping and stigma continued to rise. Sasha, perhaps from a place of righteous anger was willing to participate in this study as she felt her voice might make a difference and begin to change the stereotyping and stigma in nursing and in the university culture.

Fortunately, it is not all for loss. Three students in the study felt that students in their generation were starting to rise up and speak out about their mental health concerns and this brought them hope for the future. These students had experienced that when they spoke out stigma from others and self-stigma diminished. “I’m starting to see now that movements are changing a little bit a lot of people are aware and the stigma really is going especially for mood disorders, the stigma is really starting to go as more and more people come forward about it”, Summer, 692-695. In speaking out students are learning not to fear mental health concerns because of rising incidence, but rather to find solace in their commonness, “I feel like it's becoming more acceptable like I definitely know a lot of people now with mental illness and people are more willing to share”, Mary, 301-303. Speaking out helps nursing students find others like themselves who have lived experience with mental health concerns, “they [the participant’s student generation] are very open which is very good which I guess helps a lot more people open up to their friends, (...) I feel like it, like I would talk to my friends about it”, Winter, 409-412. In finding peers with mental health concerns, they come to accept their experience, which mitigates the self-stigma and opens the students up to learning from others

who have experienced mental health concerns. In learning from others, discoveries are made that people with mental health concerns can cope, have control of their lives, and move towards recovering.

For me keeping the conversation open is important. (...). Because I kept what I was going through a secret for such a long time and especially the self-injury which was really, really, harmful (...) to my self-image (...) my health. Keeping the conversation open has been what's prevented me from continuing to do those behaviours, Summer, 435-442

In the literature, there is an important dialogue afoot, that of the anti-anti stigma campaigns, where advocates like Davidow (2013) write that “perhaps the problem is the idea of developing and then promoting a solely medicalized way of understanding our distress is creating the very ‘stigma’”. To address stigma and its associate self-stigma, we must admit that the problem is not the mental health concern. Rather it is how our culture decides what are and are not acceptable ways of being- in- the- world. Smith (2013) challenges readers to consider stigma not as a mark but as a dynamic relational process. It is clear from the data that nursing students with mental health concerns face stigma from others and self-stigmatize far too frequently. Faculty, administrators, and students need to explore this relational dynamic and the origins of how and where stigma resides in our profession if we are to make sense of the lived experience of nursing students with mental health concerns.

5.3 Theme Three: Recovering Self

The third major Theme that emerged in this study was data that spoke to the Recovering Self. Summer describes her experience of recovering as being “comfortable within myself so I don't have a hard time coping with it [mental health concern] positively” Summer, 552-553, Leila sees recovering as being, “in a pretty good place”, Leila, 47. Recovery is not easy or straightforward. It requires perseverance and by working through difficult steps often, great

rewards follow. The data in this study revealed that nursing students with mental health concerns experienced a state of being akin to a recovering process. Andrew explains, “I say about 20 to 30 percent of my and life is affected by my mental health concerns whereas it probably consumed more like 75% of my life during first year, second year so yeah. That’s where we're at now”, Andrew, 171-174. This state of recovering entails taking steps to find optimal health; it is fluid in nature and it does not mean finding a cure for a mental health concern.

well I have recovered, have been recovering I still am recovering. (...) it’s just a process of finding (...) the best way possible and, just trying to maintain your optimal health through whatever recovery methods are available to you. Yeah I think cure was the word I did not want to use just because I do not know I do not think there is a cure to depression or anxiety, Andrew, 810-817

Nursing students with mental health concerns understood the recovering-Self as complex and they experienced it as feelings, normalization and becoming,

5.3.1 Feelings. Many of the nursing students with mental health concerns spoke about feelings they experienced as they sensed that they were coping better with their mental health concern. They could identify a time when things changed for them, where they transitioned from the *Concerned-Self* and the *Psychiatrized-Self* to a new state of being the *Recovering-Self*,

Since Christmas (...) everything [mental health concern] went away everything I loved it (...) I just had more time and I was able to reconnect with the things that I like to do and it didn't feel heavy anymore so I've been good ever since” Jessica, 53-56.

As noted from the above quote there is point in time when something shifted, different feelings appear that contribute to what students with mental health concerns understand as the *Recovering-Self*. Feelings, in this study, are mental associations swayed by personal experiences and beliefs and are subjective in nature (Damasio, 2004). Certain feelings surfaced from the data as being associated with the *Recovering-Self* state of being. The feelings expressed most often by the nursing students in this study were a sense of being hopeful, motivated, balanced, belonging

and supported. Each of these feelings are categories offered some understanding of the students' experience of recovery. Curiously, these categories at times preceded the state of recovering and at other times followed the state of recovering. For example, being hopeful that recovery is possible set the condition for recovery, whereas being in a state of recovery, made a person more hopeful about their lived experience with their mental health concern. The following paragraphs will explore this interesting interrelationship between each of the categories and the *Recovering-Self*.

Hopeful. A feeling of being hopeful was voiced by three of the students in this study. All three shared they were hopeful that recovery was possible and they believed they would get better. Getting better did not necessarily mean an absence of their mental health concern, rather it was realizing that some aspect of the mental health concern might remain with them yet they could still be in a state of recovery.

there definitely is a recovery I think mental illness is similar to physical injury or injury illness, you will recover, you will, (...) not you might recover, (...) but I just think it's [mental health concern] always there and it's [mental health concern] kind of like a scar which is a weird analogy but yeah you do recover, Andrew, 806-810

Another student expresses hopefulness as important in her recovery, although she does not use the word. She describes having confidence that her lived experience with her mental health concern will improve, although now it is difficult. Her hope is strong, she uses phrases like "I know I will get better" when speaking of the concept of recovery, although at present she is struggling with her mental health concern. Here hopefulness precedes recovery:

I think that's a word that's mine it's [recovery](...) it's definitely mine I know like I've said to my friend before I know there's a joy in life, I can't see it right now but I know that it's there I know I'll get better I can't be like this forever, Julie, 479-481

Hopeful can be something that wells up from within a person, a 'joy in life' or it can be a result of outside conditions. Being hopeful about your life situation can nurture mental well-being, which protects an individual from the threat of a mental health concern. In this case, the barriers to hopefulness are negative feelings that manifest as mental health concern, such as unhappiness, depression, and anxiety. A nursing student can experience the negative feelings if they are not in a 'good situation'.

I definitely think it was situational. (...) put [anyone] somewhere where they are not happy for long enough they will get burnt out depressed anxious. It is just a human response so I think it's situational and as soon as I was out of the situation all of those feelings went away. Jessica, 922-926

Negative feelings arising from the unfavourable situations student experience, squelched hopefulness, and in turn, recovery. Establishing or finding a 'good situation' is a requirement for hopefulness, and Jessica found purpose in life, or a passion. Jessica's passion is nursing and this contributes significantly to her sense of recovery. She shares, "I think I really blossomed in university because I found my passion as a nursing student" Jessica 9-11. Blossoming meant being able to focus on what had meaning to her and not being bogged down by her mental health concern.

Finding meaning in what you are doing also gave Sophie hope in her future and in her recovery. She had to work hard to overcome her mental health struggles and to succeed in school. However, because of her belief that recovery was possible she was motivated to do what she needed. The following quote describes the interplay between hope, motivation, and recovery,

I think it is motivating so I know that all of this like struggling, studying, and all of this hard work will pay off. (...) I will be able to experience it [mental health concern] in a different way so I'm excited for that so yeah it helps me like I tell myself that I'm doing this for a reason it's going to be ok so it is motivating it does help Sophie, 478-482

Motivated. As Sophie mentioned, five other nursing students spoke of a relationship between being motivated and the *Recovering-Self*. Being motivated was finding the strength within oneself to change a way of thinking or behaviour in order to foster recovery. Motivation follows thought whereby the students comes to determine what is and what is not in her/his sphere of control. Once realized a student can take action and change behaviour to their benefit.

I go through this and I go, why am I anxious? What is out of control? Can I change it? And almost always the answer is no. Then I just realize it is out of my control. So why be anxious about it? When it is in my control, then okay. Change what you are doing. Go towards that thing that is going to help you. Jane, 390-393

Change in thinking can be an act of will that precedes recovery as the above quote illustrates, or change of thinking is a product of recovering. Either way, there is an association between recovering and changed thinking.

I was actually doing better. It was warmer weather and the medication was starting to work (...) I remember I saw my therapist a couple of days later, I am like what do I think about now? Like my mind is just not taken up with anxious thoughts. What am I supposed to think about now? Like what is normal? So just that like (...) there is life without being anxious? Like there is an alternative? Because I have been so anxious for so long I did not realize there was. Mariam, 346-352

Coming to know there are alternative ways of thinking and *being*, motivated the nursing student to make steps towards being a *Recovering-Self*. However, this way of thinking and being are not static, they wax and wane. Learning to recognize and live with impermanence seems to be another important quality of the *Recovering-Self*. Mariam recognizes that some days she will be more motivated than others “I’ll still have the negative behaviour patterns, but I can acknowledge that they’re negative”. Mariam, 69-70. Sophie accepts that she will have bad days that will rob her of her motivation that will affect her life as a student and that is all right. Days can have the quality of good than bad than good again.

sometimes like when like I said when I do have my bad days then it affects my schooling a hundred percent, sometimes if I can't get out of bed then I'm not going to class so that's affecting my grades and I'm being behind so it's getting better like I said so I'm missing less classes Sophie, 231-235

The *Recovering-Self* understands that motivation can be re-kindled; a state of recovering entails realizing one has to be motivated to think and behave differently “so it's kind of learning to do that on my own and I think I'm doing pretty well so far it's just you know still figuring out how to get myself motivated again Summer, 251-254. Being motivated is a hallmark of the start of being in recovery.

Balanced The majority of nursing students, nine of the twelve, believed that finding and maintaining a feeling of balance, namely balance between school, social relationships and self-care, was important for their *Recovering-Self*. Being able to recognize an imbalance and act to counter the imbalance is a testimony to, nursing students that they moving towards the state of being a *Recovering –Self*, “just really doing anything social I think is what helps me. (...) So say I'm like still stuck on (...) work or school and I can't seem to see anything outside of it, just like doing something fun, kind of changes my view on things and makes me [feel better], especially exercise, Eleanor, 170-174. Finding and maintaining the right balance is an ongoing process that requires adjustment and an acceptance that setbacks will happen. “If I wake up early and exercise or go for a run or something my day is definitely off to a good start if I sleep in, it still doesn't bother me obviously if I need sleep I need sleep” Andrew, 130-132. A *Recovering-Self* is comfortable with flux in school, social and self-care and needs. A *Recovering-Self*, does not require ‘a prescription’ for how much time and energy should be allotted to each aspect of student life, but can trust the process of finding the right balance. The *Recovering-Self* will not focus excessively on one aspect of the nursing student life at the expense of another. For example Mary shares, as a *Recovering-Self*, she will not let her academic life dominate her

being, as she has come to learn that she needs social relationships where she can talk authentically to maintain her mental well-being. Without a healthy balance, her mental health concern will get the best of her. “I try not to (...) focus too much on school because then I get too much anxiety definitely trying to have time, like I have a boyfriend, I try to spend time with him and chat with other people”, Mary, 139-142. Other students came to the realization that in order to favour the conditions for their *Recovering-Self* they needed to balance their self-care and academics. More often than not, this would mean accepting lower grades because they had chosen to take time to exercise or sleep rather than study longer.

Like after first semester finishing a course, (...) you got an 85, not a 95. (...) whereas this year, even if it was like an 80 I was like okay, you got through it, you did it. So, there’s been a huge difference obviously now that I’m mentally well. Leila, 380-383

As a *Concerned-Self*, the stress evoked by not obtaining an A+ or not reading every assigned chapter was excessive and exacerbated the experience of the mental health concern. As a *Recovering-Self* nursing student with mental health concerns, could be at peace letting the need for very high grades, or thoroughness and perfectionism go, if it meant a better mental state of mind. Mariam realized, “If I read it after class one day, it’s not going to kill me. Or if I skip this chapter, it’s not going to kill me”, Mariam, 523-515. Leila explains she knew she was recovering when she could be comfortable, or balanced emotionally with lower grades. The need for high grades no matter what cost to her well-being, was to Leila a sign of her poor mental health.

Leila could identify that when she first started in the nursing program, she felt pushed, by her need for high grades, to try harder and harder to obtain high grades and this aggravated her mental health concern. Gaining a perspective that included the need for a balanced approach to success in nursing was significant to her *Recovering-Self*. Andrew affirms that recovery for him began with his realization that balance is essential to support mental well-being, “I’ve definitely

recognized the importance for maintaining that optimal mental health and trying my best to keep it at that level as much as I can throughout the school year and even when I'm not in school" Andrew, 194-197. Gaining and maintaining balance is part of an ongoing process that moves a nursing student with mental health concerns towards recovery.

Belonging Another feeling that several nursing students with mental health concerns seemed to experience, as their mental health improved, was a feeling of belonging. As a concern-self, who struggled with failing mental health, the nursing students felt isolated often because they felt like they needed to be someone they were not. As their mental health improved, and they moved towards a *Recovering-Self* state of being, they no longer felt isolated but rather they felt like they belonged to a group of people. "So I should have to fit into this perfect image but I didn't and none of my friends do either so which is good because then I have people to spend time with" Mary, 403-405. The *Recovering-Self* came to realize that trying to attain perfection was not possible for them or anyone and this flawed sense of self fostered shame and isolation. With this discovery that belonging mattered came a turning point in their relationships: the nursing students with mental health concerns began to open up to other students and learnt that others nursing students and even faculty were experiencing similar struggles. An awakening to the commonness of the experience fostered a feeling of belonging; this was fundamental to recovery. A feeling of belonging or finding common shared characteristics, most importantly mental health concerns, made for an environment where nurses felt they could speak about their mental health concern. They felt no judgement related to their mental health concern from this group and thus could be themselves, free to be their authentic selves: "I don't think like with my friends they don't, they don't care [that Mary had a mental health concern] they accept me for

who I am”, Mary 638-639. For some this group was a group they had been part of before their mental health concern, an established group where relationships had waned,

reconnecting with my friends was big too, (...), it was just being with people and not isolating myself and that just helped me to cope with things better, maybe even more, more willing to talk about anything I was going through so yeah that just really helped, being with other people. Winter, 904-911

For others, this meant reaching out to a new group of friends with whom they felt supported and where their recovery flourished.

You know hanging out with friends’ healthy friends that don't smoke (cannabis) (...) you will do what your friends do and I have a group of friends that they are very studious and you know they're fun, Winter, 210-214

Thus, *Recovering-Self* seeks out relationships that bring a sense of belonging. It is also clear that nursing students with mental health concerns understand the importance of belonging and can discern when a relationship is supportive to mental health and well-being.

Supported A feeling of support also surfaced from the data when nursing students with mental health concerns spoke of what promotes their mental wellbeing. Feeling a sense of support in relation to a mental health concern in the form of help with nursing school challenges were cited as important to the nursing students in this study and contributed to the participants sense of *Recovering-Self*. The awareness of support was central to the *Recovering-Self* and this awareness often came abruptly, from one moment to the next. “I kind of realized like okay, I’m spending \$150 an hour and I’m in a pretty good place right now and I mean I do have a lot of support from friends and family and such”, Leila, 301-303. Knowing one is supported is something that nursing students are thankful they have and see as essential to their recovery, “I have support I am very grateful that I have support because I know a lot of people who don't there are people who have to deal without any support so I'm glad that I definitely have some”, Julie, 495-498.

Feeling supported can mean having someone to talk to about mental health concerns, and someone you can trust with your story. “If I just want to talk to her about something a little she's there for me so I think that's a huge support and I trust her so that's a huge thing right to have someone you trust and able to talk to you”, Sophie, 142-145. Feeling supported to a nursing student with mental health concerns is a sense of encouragement from other students in the nursing program. “I definitely can get a support for my nursing friends who like really push me and like you can do it and just keep going and we're here for you they definitely help me study and focus”, Mary, 224-227. Sasha shares that she feels supported by classmates “I do have a lot of really great friends, you know, (...) my classmates are supportive” Sasha, 212-214, and she articulates how the support mitigates her mental health concern: “I didn't used to use people as my support line. I used to use compulsions. But I find people work a lot better”, Sasha, 242-243. Feeling supported can happen over time and can contribute to recovery in small doses that ultimately accumulate to have a major impact on a nursing student's mental health. Nursing students currently struggling with their mental health concerns can feel hopeful and supported. These feelings can fuel their *Recovering-Self*,

I keep getting help from people then that will help me to eventually feel better I don't want to be stuck here obviously like I know what's wrong I want to fix it and that's my goal just to get over this, this hump that life has thrown at me Julie, 481-486

A feeling of support and the awareness that it has contributed to mental wellbeing can be contagious. Once a nursing student with a mental health concern realizes the role of support in his or her recovery, they were more apt to support others. As they help others, they claimed that their mental health improved

I think it was mostly being very involved with school that really helped me which is kind of weird but I like started this club at school and I put more energy into there and I kind of started to include academics in my self-worth Winter, 578-581

This symbiosis between having experienced a mental health concern and coming to know what fosters recovering is the third category becoming, under *Recovering Self*.

5.3.2 Normalizing.

This category spoke to a process that nursing students with mental health concerns used to explain their behaviour and situation as ‘normal’ and not as a deviant. Beginning to see themselves as ‘normal people’ with or without a mental health concern seemed to be a significant step in their understanding of themselves as a *recovering-self*. Data that spoke to this theme was abundant; nearly 50 quotes from all but one of the participants. Normalizing their lived experience with a mental health concern took several forms: the first was to note how common it is in their student population to have a mental health concern. Commonness became one of three subthemes under the theme normalizing. Many of the nursing students also shared that their mental health concerns were not stable but could fluctuate. In order to see themselves as normal it was important that the nursing students with mental health concerns accepted these fluctuations, these ‘ups and downs’, as part of their recovery process. Up and Downs is the second subtheme, under the theme normalizing. The last major cluster that describes how nursing students with mental health concerns came to see their lived experience with mental health concerns as normal was to view them as part of a natural maturation process. Maturing will be the third subtheme under normalizing that provides a deeper understanding of what it means to a nursing student with a mental health concern to be a *Recovering-Self*.

Commonness. Many nursing students in this study came to a realization that their experience with a mental health concern was common to others and that it was not unique to them and this brought them comfort by negating their sense of deviancy, or abnormality. With each shared experience with another person with a mental health concern the nursing students

with mental health concerns seemed to chisel away at their *Stigmatized-Self*, their view of themselves as imperfect and abnormal. As the abnormal or deviant self-melted away, the *Recovering-Self* surfaced bit by bit. A sense of commonness could surface in people from all circles of the students' social life. At times, commonness surfaces in the lived experience with the family members of those with mental health concerns. Andrew respects his father and knows his father has had an encounter with PTSD. This does not affect his respect for his father; in fact, his father's experience with a mental health concern makes his father's counsel all the more valuable, and meaningful to Andrew's recovery,

He has definitely been able to talk to me about lots of things and we have definitely had discussions and support, (...) going through what he has gone through he can help me and, yeah I think him going through that has better helped me even though we should not be going through these things Andrew, 475-480

Mary also shared that her father supported her recovery and she felt understood because he too has struggled with mental health concerns. The common bond they share drove them closer. They understand each other in a profound way, something that is impossible with her mother, whom does not share in the common experience of mental health concerns.

I guess that really helped [her father having a mental health concern] because I knew I could talk to him about it. (...) I know that he can talk to me (...) there is so many times where my dad is having a bad day and he'll come down to talk to me. (...) before we were never really close (...) I was always closer with my mom and now I say I'm a lot closer to my dad because my mom is a lot less understanding (...) she tries but she doesn't get it, Mary, 329-335

The *Recovery-Self* recognizes that help comes from this unique relationship between two people who have struggled with mental health concerns. Sophie has learned from a relative that recovery is possible because this same relative has struggled with mental health concerns and is now mentally well. This relative has made herself available to Sophie because she understands Sophie's experience. This availability, support at any time is invaluable to Sophie and supports

her recovery, “she married my cousin and she dealt with depression too and anxiety stuff like that, so I like, always have her to talk to which is great”, Sophie, 138-140

Finding a sense of commonness within the family has also helped Mariam deal with the negative impact of stigma. She knows mental health concerns have touched members of her family and many are now in recovery. She does not fall victim to self-stigma, although bombarded by messaging reinforcing that mental illness is in your head, but her family believes otherwise. She believes that her path to recover is somewhat easier because she has not faced the same stigma because she found commonness in her family, “My family as well, there’s a history of mental illness in my family. So again, there is this validation, like it’s not in your head. It’s an actual problem”, Mariam, 431-432.

Other nursing students found their friends understood their mental health concern as so many shared the common experience “my friends are on a more relatable level of understanding, similar experiences” Andrew, 458-459. Mary shares “I’m friends with a lot of strange people and a lot of them have depression and it’s really common in like my friend group so it’s not a thing I can’t talk about” Mary, 348-350, and talking about her mental health concern supports her recovery. Leila’s friends are vital to her maintaining recovery. She realizes that she needs to process her deleterious thoughts and feeling quickly and her friends, who have the common experience of struggling with mental health concerns, understand her. Their willingness to respond to her even by texting is a tremendous support to Leila’s *Recovering-Self*.

I guess a big thing is that I have a lot of friends who have also had mental issues and who have also sort of like been down that road. So even if I do not directly approach them about what I am thinking or feeling or whatever, even just knowing that, okay, if I text them, it will kind of get my mind off things. Leila, 165-169

Sometimes recovering was fostered when friends who have had mental health concerns know exactly what a fellow nursing student with mental health concerns needed to recover and that surprisingly; could have meant leaving their friend alone. Here one can see that commonness set the stage for deep understanding of mental health concerns and knowing what is an appropriate intervention. This kind of knowing what to do seemed to come from this common understanding of the lived experience with mental health concerns:

I had a really awesome friend who'd actually also gone through a lot of mental health issues at that point. One of my friends he had a really bad home life and that kind of thing so he went through his, his own stuff and my other friend had a lot of anxiety issues and everything so they understood, so they give me space, Summer 147-153.

Summer also provided insight into how finding the commonness in experiencing mental health concerns can also serve as a catalyst for more meaningful friendships and support networks. Summer was new to the university and needed to nurture new friendships. Although she did not intend to speak about her mental health concern, she did mention her medication regime and to her surprise, her roommate had the same medication for a mental health concern. Their discovery of their commonness in experience facilitated a friendship. They felt a common bond; they felt they would understand each other and support each other's recovery and well-being.

know if you mention oh yeah I'm on medication for this, I mentioned I'm on this medication and my roommate is like me too, it's like ok cool you know (...) it's just kind of the conversation is a little bit easier to get going I think at the university Summer, 348-353

Finding this commonness quickly to support her recovery was of particular importance to Summer as her circle of support was back home, and not easily accessible,

It [mental health concern] was quite common actually. I come from a pretty small town so I know, especially one of my friends and other people I knew in the school. It was like it wasn't strange if you were seeing a counsellor or on

medication and everybody talked about it a lot like quite openly because it is a small town. Summer, 321-327

Nursing students with mental health concerns also expounded on how at times clinical and class content as well as discussions could foster a sense of commonness. During clinical practice, nursing students would hear the stories of the people in their care. Sometimes these stories triggered their mental health concern, as was mentioned in the category *Concerned–Self* earlier in this chapter; however, other times these patient stories supported the nursing student’s *Recovering–Self*. Jane admits that she felt a common bond with those in her care and that made her reflect on her situation and state of being “you spend your day listening... you know, I listen to this one patient’s... the saddest story. You know, going through [their] hell and it makes you appreciate that you’re not the only person that’s going through things”, Jane, 318-321. This sense of commonness manifested in theory classes, when a guest speaker spoke about their mental health experience, and content spoken resonated with the student. What also served to foster recovery was when these speakers shared their own life lessons as student with mental health concerns listened attentively for effective coping strategies,

Class and learning, guest speakers people who have gone through some things (...) experience with psychosis (...) and, a schizoaffective disorder and just talking about their own experiences and, and learning and I don't know those are kind of positives and learning more about themselves and their stories Andrew, 527-535

When professors are candid, open about their own mental health concerns, and share their stories of recovery this resonates profoundly with nursing students with mental health concerns. Winter can remember clearly, when her professor spoke to the class about his mental health concern and his recovery. His story was common with Winter’s and this gave her tremendous hope in her own recovery and in her being able to succeed in nursing school.

Coming from a prof and him being so excited about it [recovery]. Him explaining actually his own issues going through university. [Him saying] I struggled with (...) [a mental health concern], during my university years I almost failed. (...) and it was really me getting into eating healthy and working out. That really changed it around for me (...) which was really awesome to hear because you know that that's evidence right then and there and him saying that to a class (...) but yeah that really helped winter, 436-445

Mariam found solace that fostered her recovery when a university chaplain shared his experience with a mental health concern, “That was actually helpful, (...), because this chaplain had also been diagnosed with GAD, so it was again, like been there, done that, so that was nice”.

Mariam, 316-317. Once again, it is obvious that when a person in a position of perceived authority shares their common experience it can be powerful and support nursing students' mental well-being.

A sense of commonness surrounding the level of stress that nursing students felt while in the nursing program also supported the *Recovering-Self*. Just knowing that all students, those with mental health concerns or not, were feeling immense levels of stress trying to meet the expectations of the nursing curriculum, normalized their experience: “we were all going through the same thing so we did talk a lot about how tired we were or how stressed” Jessica, 567-569. Knowing that everyone in the program was struggling with stress and found it difficult to maintain their self-care made nursing students with mental health concerns feel normal and as capable as others and this validated their *Recovering-Self*:

Oh, it also helps (...) [to] know, my classmates are going through the same thing. They are like, “Wow, you just cannot find time for yourself, or like this is so stressful. Do you find this course is going a little overboard,” like blah blah blah. So, it's good to be able to talk to them. Sasha, 246-248

Hearing the common stories and learning how others are dealing, or not dealing, with their stress provides nursing students with mental health concerns with a benchmark to evaluate their own recovery. Sasha says, “That kind of helps. Like to know, I am not the only one finding it

stressful. In fact, I'm like one of the people handling it better than a lot of others", Sasha, 254-256. These same nursing students in turn felt a responsibility to help others with mental health concerns to come to sense this commonness so they to could move closer to a sense of recovering:

I did kind of presentations and stuff like that in my home community on kind of my story and resources people can contact and stuff like that, and through that, a lot of people my age came to me and, you were really open about talking about their mental illness and, you know, that was inspiring to see, Sasha, 311-315

The nursing students with mental health concerns also recognized that the consequences of not fostering a sense of commonness was grave for other students with mental health concerns, and not having this sense of commonness greatly impeded recovery. Jane spoke to her own lived experience of witnessing another nursing student with mental health concerns in crisis because she was fundamentally alone,

I felt very bad because she ended up, I think, having an anxiety attack, and she left the floor and she never came back. (...) it is tough because I feel like people feel like they are alone (...). She should have talked to her course mates. She might have found out that two of us actually had anxiety problems. Or, you know, something else. Maybe we could have given her strategies. You know, this is what works for me, Jane, 442-447.

Ups and downs. The *Recovering-Self* faces gains and setbacks as mental health concerns exacerbate and ameliorate in face of daily stresses and life events. Recognizing that these periods of 'ups and downs' are part of normal life is a significant milestone in recovering in the lives of nursing students with mental health concerns and thus formed the second subcategory under *Normalizing*. Eight of the twelve participants voiced that they experienced these 'ups and downs' and accepted them part of their lives and as a normal part of living with or without mental health concerns: "I think you might always have periods of up and down but I think it's always pretty much there with you in your life", Eleanor, 504-506. The journey through life with a mental health concern is challenging but does not rob students of hope for a happier healthier life.

Accepting that there will be gains and setbacks is crucial to maintaining hope and solidifying a sense of recovery. The following quote by Summer powerfully explains how she understands recovery and how it thrives as she exercises her acceptance of these ‘ups and downs’. Summer carefully chooses her words to clarify her position that she will never recover, rather, she will always be in the process of recovering. Even as her mental health improves, she is cautious to remind herself that setbacks are possible and this caution protects her recovering –self. Summer wants to embrace all the life will offer her and thus must be aware and prepared that her mental health concern may exacerbate or ameliorate in face of what life brings. Her ability to accept these periods of ‘ups and downs’, today, and in her future, is central to her understanding of a *Recovering-Self*. It is also pivotal to her sense of hope in a happier and healthier future.

This does not mean I'm fine or I'm recovered or I'm not going to start to struggle anymore. It just means (...) a new step and I'm still recovering. (...) I still have bad days. (...) I feel like if I use (...) a past tense almost like it happened before and now it's over. (...) it's always going to be something I have to be aware of but it doesn't necessarily mean that it's going to control my life. (...) I have certain weaknesses and bad [days]. (...) and just being comfortable with recognizing that it's not necessarily gone. (...) I've always kind of used recovery and I don't know when or if I'll ever kind of consider myself recovered. (...) because you know you never know (...) with ups and downs in life it can always come back but you're still working towards happier healthier life. Summer, 725-747

Winter echoes Summer’s belief that full recovery is likely not attainable, but it is worthy of hope. For Summer being recovered is a disheartening goal, rather learning from the process of recovering, is what is important. During the recovering process, the self learns to encounter life’s struggles and with each encounter, the *Recovering-self* becomes more apparent to the nursing student. Full recovery will likely never be possible, but learning made through the process of recovering is invaluable. “I don't think you fully recover because it's [mental health concern] just

a voice that's always there (...) I hope you recover but I don't right now think you fully recover I think it's a constant struggle but a struggle that is less and less”, Winter, 724-728

The dominate emotion that is associated with the *Recovering-Self* is the sense of happiness. What quantifies it is less bad days; this is not to be mistaken by only happy and having no bad days, “I'm a lot happier now and I experience less and less like those depressive phases which is good so I'm pretty happy”, Sophie-116-118 . Andrew articulates how he quantifies his level of recovering as a ratio of good to bad days, admitting that both are part of his lived experience with mental health concerns. “They'll be like bad days and good days it's kind of varies, I'd say there's more the good days [and they] are starting to outweigh the bad days over the past year”, Andrew, 92-94. Sophie also shares the ratio of good to bad days, as a measure of recovering. She states that the ebbing of bad days validates her state of recovering to herself and those dear to her,

Usually on most days I'm ok. When its ok like its fine. But sometimes when I am sad like during that period like it's hard to get out of bed and it's hard to do things. (...) I'm such (...) an outgoing person so like people around me really notice when I'm having those kinds of days but it's happening less and less, Sophie, 108-113.

The *Recovering-Self* comes to know what can contribute to the ups and down experienced by a person with mental health concerns. The nursing student comes to know how to manage the good and bad days as part of what it means to live with a mental health concern, “it's chronic, but right now I'm in a place where I'm pretty good like I know how to manage those things”, Sasha, 76-78. Mary, like Sasha has learned to manage or control the ups and downs, however she alludes to the challenge of managing her ups and downs when she started University: “I got a bad cycle (...) but otherwise it's a lot better control now than it was even like earlier in my degree” Mary, 29-31. The stresses associated with university seem to tax the

nursing student's ability to manage the 'ups and downs' and threatens their *Recovering-Self*, their sense of feeling better,

I had a really bad episode at the end of January when we returned from our long break [Christmas university vacation]. (...) it kind of just escalated from there. (...) there's days that are really good for me. There's days that are bad, so it's hard to tell like if I'm doing better off not. (...) I would say that I have experienced some of my worst episodes while in University, Julie, 401-408

However, not letting these bad episodes define them, not letting them rob them of their hope for success, and a good future is paramount to the *Recovering-Self*. Being able to see the bad days, the downs, as a bump in the recovery process is significant to maintaining mental well-being. "Yeah it [setbacks] doesn't define me as a person I feel like it's just like an obstacle that sometimes it's harder than some days but I know that I'm going to do great things when I get older", Sophie, 627-629. Recovering slowly becomes a possibility for nursing students with mental health concerns: "I do feel like I'm doing really well (...) I'm comfortable coping with obstacles", Summer, 1029-1030. It is tragic when those in authority, such as university professors and administrators, or institutions such as regulatory bodies and the psychiatric complex, believe otherwise. It is this disbelief in the possibility of recovering, and the power this disbelief holds, made manifest in the policies and practices established by those in authority, that creates the context that squelches mental wellbeing in nursing students with mental health concerns and erodes the *Recovering-Self*. The good news is that students, by overcoming these negative messages, develop inner strength. The *Recovering-Self*, despite the negative messages from those in authority, the *psy* expert, administrators, and faculty, comes to understand their lived experience with mental health concerns as positive. The nursing students in this study came to understand themselves as more than they would have been otherwise, as gifted because of

their experience. The gift they acquired was an inner strength and a self-understanding that they believe will serve them well throughout their lives.

Maturing As age they come to mature and this is a normal part of life. Nursing students with mental health concerns follow the same life trajectory. Almost half of the nursing students that participated in the study believed that maturing had some bearing on their mental health concern experience. One nursing student shares that her mental health concerns might have been a result of her immaturity, she was not prepared mentally or emotionally for university life,

I was not mentally prepared for the [university]. I am independent now. I was still in [high] student mode, where there is someone always watching and someone to look after you and if you make a mistake it will be caught by someone else. So I think it was a mature... I do not think it was a mental health thing (...) I think it was a maturity thing. Mariam, 265-269

For another student as life progressed and he matured it seemed that his mental health concern ameliorated. He claims his recovering had more to do with a process of maturing than something he or others did to him, “it was mostly depression but a couple of years ago and it slowly starting to fade out or work itself out”, Andrew, 26. For something to ‘work itself out’ it needs time. To recognize something is ‘worked out’ one needs awareness. Both time and awareness are elements of maturing.

Several nursing students with mental health concerns communicated that they could recall a point at which they came to some awareness which offered them perspective regarding their mental health concern, “I have a bit more perspective, like I’m older. I think that was, looking back; I can see that the lack of perspective was a big thing [in her mental health concern experience].” Mariam, 73-74. Age brought with it maturity and perspective followed suit. Other nursing students claimed maturing brought with it understanding about themselves and their

mental health concern. This new understanding gave way to perspective, which nurtured the *Recovering-Self*, “I now understand (...) anxiety or depression better now. (...) you kind of just look at the bigger picture more”, Andrew, 544-546. Summer also sees maturing as integral in her recovering and questions if recovering is even possible when you are young and likely more immature,

It maybe has to do with the age possibly. (...) you know obviously we are all still kind of teenagers but you're getting into that young adulthood (...) kind of thing and I guess something I've noticed a lot of people experience, mental health issues when they're in high school. For the first time, just from what I've seen and understood (...) by the time you get to university you're in recovery or you're aware of those issues, Summer, 335-343

Maturing is what makes awareness of other people’s experience with mental health concerns a possibility. As a teenager, Summer, was becoming self-aware, and could not yet comprehend that she was not alone in her mental health concern experience. Not yet having this awareness hindered her mental wellbeing and challenged recovery. The simple act of maturing made gaining this awareness easier, and thus movement to recovering possible. Andrew echoes the same realization that maturity sets the stage for recovering. Simply maturing changed his mind set and university was a place that cultivated this significant change,

As I grew older, I think I just matured and started to realize you know other people are going through, other people go through the same thing. (...) I recognize from going from high school into university, I was kind of close-minded. (...) then in university, you gain all of these relationships with people and you do mature into you know young adult and you realize the bigger picture, Andrew, 925-934

It appears that nursing students in this study came to understand, given their toxic environment, and their lack of skill to navigate it, their mental health concern was inevitable. However, the challenges related to their mental health concerns declined with maturity, leaving the nursing students to question the validity of the *psy* diagnoses or *psy labels* they received.

Many of the students in this study came to believe that their experience of a mental health concern was more a struggle of a stage in maturation, or a question of maturing, than a *psy* illness.

5.3.3 Becoming

Becoming describes a budding sense of self and professional identity that eleven of the twelve nursing students with mental health concerns spoke about in their interviews. This significant category had over 40 quotes that divided into two categories: *Gifted Person* and *Gifted Nurse*. Careful analyses of the data lead the researcher to interpret many of these quotes as a reaction to the experience of the *Stigmatized-Self*. Nursing students with mental health concerns were no longer accepting that they were flawed and held a *psy* label rather they defined themselves as a gifted *being* who was more than they would have ever been because of their lived experience with a mental health concern. Sasha's powerful quote summarizes this very important finding of becoming someone exceptional because of an experience with a mental health concern,

Because automatically people think you are not capable (...) you are this fragile little flower, when really it is the opposite. (...) you have been through stuff. You are a concrete flower. Sasha, 461-463

Through an experience with a mental health concern, where a nursing student has been a *Concerned-Self*, *Psychiatrized-Self* and then *Recovering-Self*, then gain insight into what it means to be a human. It is hard for a nursing student to notice that their self-understanding had changed by virtue of living through an experience with a mental health concern; however, in the interview it became apparent that nursing students believed they were different in some way because of their lived experience with a mental health concern. Perhaps it is this exercise of exploring how a person thinks and how they think of themselves that gives insight into a way of

seeing oneself and the world, their *being- in- the- world*, which makes for the realization of giftedness.

I cannot say (...) I have fully recovered like I think it's a daily constant struggle. Just the hardest part about it is the way of thinking. Which is so philosophical hard to think about the way you think and do things. But going through it definitely (...) changes your experiences and you see things in a different way
Winter, 721-726

Gifted Person. Two sub-sub categories surfaced from the data to describe what it means to the nursing student with a mental health concern to be a gifted person as a result of being in some stage of recovering, where gifted is to have a special talent. The two sub-categories describe processes of coming to an understanding of oneself and an understanding of others. Giftedness arises when a person sees life with a mental health concern as a means to polish oneself, not as a means to be ground to dust and nothingness.

Understanding self is key to the recovering process and foundational to becoming a gifted person. Being self-aware, knowing one's strength and weaknesses and patterns of being that foster recovery is integral to understanding self and becoming a gifted person, "I just have to be really conscious of like the pattern (...) I've learned to become very self-aware so yeah its good it's good", Summer, 311-315. Understanding of self does not happen haphazardly it develops by conscientiously dedicating oneself to building self-awareness: "I've worked so hard and I've always been tough throughout my recovery to be very self-aware and to take care of yourself and you know look after yourself", Summer, 996-998. It requires focusing on one's own needs, taking care of the self and might mean dispelling the myth of self-sacrifice: "I need to look after me first (...) helping people with what is going on in the world just has to come after", Summer, 1180-1182.

To become self-aware entails hard cognitive and emotional work that necessitates the following: to notice patterns of *being*, to face the implications of these patterns of *being* and to invest energy into developing coping strategies. These coping strategies go well beyond the temporary symptom relief afforded by medication. They are life lasting and life changing and are the source of what can make for a sense of giftedness in a person with a mental health concern.

If you go on medication now and you don't talk to anybody, it might help your mood but as soon as you come off of it, you're not going to be able to cope with, you're not gonna have those good coping strategies and you're not gonna have that awareness of yourself, Summer, 836-840.

Medication alone would mute symptoms, therefore, over the long term, run the risk of denying a nursing student with mental health concerns the opportunity to become self-aware, develop coping strategies, and ultimately come to see themselves as recovering.

Nursing students with mental health concerns can recognize how their life experience with their mental health concern has changed over time. Being aware of this change made it possible to qualify what it meant to the nursing student to be a recovering-self.

I cannot experience what everyone else is experiencing, but you know, objectively, I am handling it pretty well in comparison to some other people even, and that is... I do not want to say I am inspired by that, because that sounds terrible, but just to know I am not the only one that finds this program stressful. It kind of validates the progress I've made. It's like, you know, before, a year ago, you were in the hospital and here you are doing a program only [number in program] people got into (...) that's been nice, Sasha, 257-263

Being self-aware makes it possible to see accomplishment and to see growth in one's abilities to face challenges. Being self-aware also means accepting setbacks as a student shares: “[It does not] necessarily mean that it's [mental health concern] going to control my life it just means that I have to be aware that I have certain weaknesses and bad [days],” Summer, 738-741. This understanding of self, which includes the possibility of setbacks, is important to how recovery is defined: “I guess being in recovery I always have to be aware that you know this [setbacks]

could happen and if it does its okay it's just and I know it's okay because it's just another part of getting better” Summer, 1018-1020.

The experience of living with a mental health concern will bring with it challenges however these challenges can contribute to self-understanding if the person gains personal insight and new methods of coping with these challenges. By virtue, of their lived experience with mental health concerns, and overcoming associated difficulties, nursing students developed and refined life coping skills. The nursing students with mental health concerns believe their experience with mental health concerns contributed to them becoming more than they would have otherwise. They feel that they have more understanding about themselves. The mental health concern comes as a catalyst for personal development. It begins a process that refines who a nursing student becomes rather than taints his or her being. In this way living with a mental health concern, becomes a valuable experience, not one to disregard or mask. Sasha passionately speaks to the value of her lived experience with mental health concerns. She is thankful for the experience; it privileged her with life skills that prepare her for life's challenges. To Sasha her experience with mental health concerns is something valuable, something that taught her self-awareness and coping skills that put her at an advantage.

I would not trade it [mental health concern] for anything. Like I am so fortunate to have gone through what I did (...) I cannot even begin to describe how thankful I am for that experience; (...) it has made me better able to handle stressful situations like this [nursing school]. I feel (...) I have kind of advantage on my peers (...) It's a struggle, but at the same time I have the tools I need to deal with things, rather than other people, you know, experiencing stress, have never dealt with that before and it's... you know, for me, it's kind of like oh. Well, this is just another thing. Sasha, 531-538

Understanding others. Living with a mental health concern also makes it possible to understand others who are struggling with threats to their mental health well-being: “I'll mentor other students because like I know what it's like to be a student with mental health issues”

Mariam, 427-428. The insight a nursing student with a mental health concern gained affords her an intimate understanding of the lived experience of another person. This gift of understanding others is describe as an intuitive knowing, an awareness that happens with or without the nursing student overtly sharing their experience with a mental health concern with others. Jane shares that she ‘totally understands’ others with mental health concerns and adjust her care accordingly and feels that her care is well received and benefits the other because she can better understand what they are living. However, the care she delivers is not dependant on her verbalizing that she too had mental health concerns, in fact sharing might be professionally questionable. “So I will say having mental health issues and dealing with mental health patients, sometimes is hard. (...) it is drawing that line. Like you want to help them but you also don’t want to tell them that you have all these issues, but I totally understand where you’re coming from”, Jane, 334-337. Julie believes that she can practice from a place of authenticity when working with people with mental health concerns, be they peers or patients, because she understands ‘the other’ who is experiencing a mental health concern. She may choose to admit to her struggles simply to reinforce that no one is alone when dealing with a mental health concern or she may not. Julie believes she has a gift of insight because of her experience with a mental health concern; that she has become particularly sensitive to the unique perspective of each person with a mental health concern. Her gift of insight does not negate her appreciation that each person uniquely experiences his or her mental health concerns, but it aids in establishing relationship, something fundamental to healing. “I want people to know that they're not alone (...) I understand like oh this is how it feels I mean it's different for everyone but at least you have a general idea of what it feels like” Julie, 226-230. Like Jane and Mariam, Julie believes that her experience with a

mental health concern gives her a gift, a special understanding of others with mental health concerns, something someone who has not had this experience, risks not comprehending.

Gifted Nurse. Just as several nursing students explained that, their experience with a mental health concern gifted, or bestowed them with insight in understanding themselves and others, the same experience, they believe distinguishes them as nursing student and serves them well in their developing profession role. “I think it [mental health concern] has helped become a better student nurse hopefully a nurse one day”, Andrew, 501-502. Living with a mental health concern gave the nursing student an understanding of the importance of the therapeutic nurse-patient relationship, as these students, over the years, were the recipients of both meaningful and meaningless therapeutic relationships and consequently know at a personal level the importance of the therapeutic relationship. The nursing students have felt what a good therapeutic relationship can do for someone’s mental well-being and they will not compromise this extremely important aspect of their care. Nursing students with mental health concerns strive academically with the *science* of nursing, but also in the *art* of nursing. They intuitively have come to appreciate what caring should feel like and how much it means to the recipient because of their lived experience with a mental health concern. The participants in this study believe their experience gives them an advantage in establishing a therapeutic relationship a foundation for providing quality care:

So there’s kind of like the academic, you know, applied the evidence-based practice kind of portion of nursing, and then there’s the human side of nursing that incorporates, (...) her experience and connect with patients, I guess, to develop that patient-nurse relationship. (...) I feel like I have kind of a unique foundation to be able to be that kind of student. Sasha, 42-46

This advantage manifest in the level of empathy they demonstrate, the holistic practice they provide and in their commitment to empowering those in their care. The following paragraphs will expound on how seven of the eleven nursing student in this study came to understand

themselves as becoming gifted nurses because of their lived experience with a mental health concern.

Empathetic. To be empathetic is to show you understand the other person's feelings, thoughts, hence leaving them with a sense, of 'being understood' and not alone (Cunico Sartori, Marocnolli and Meneghini, 2012). The nursing students in this study felt that their lived experience with a mental health concern had accorded them a better understanding of what it is to be an empathetic nurse. "I think this whole experience that I've gone through has helped me better empathize with people ". Andrew, 488-489. Being empathetic is often rooted in experience with empathy. Sasha explains how she gained an invaluable perspective on what it is to be empathetic from her lived experience of hospitalization. She goes so far as to say that she is 'lucky' to have her mental health concern because it made her experience the health care system as an insider. As an insider, she 'knows' that nurses can be empathetic or not. She claims having felt a lack of empathy at the hands of the nurses is what drives her to believe she will do otherwise and assure being empathetic is a priority in her care.

I am really lucky (...). I am going to be a good nurse because of that [mental health concern], and I wish people knew that. I wish people knew that I have that different kind of perspective (...) I can empathize and I have been in hospitals. (...) I know it stinks. I know the food is terrible. (...) I know nurses can sometimes just kind of brush you aside and, you know, okay, I am coming in and I am giving you an injection. Okay, I am going to document it now. Bye. You know, I'm not going to be that kind of nurse because I know what it feels like to literally be a task. Sasha. 551-558

Sasha and other nursing students believe they are empathetic student nurses because they know how important feeling understood was to their own *Recovering-Self*. They were recipients of care that felt standardized, impersonal, and task oriented which they interpreted as lacking empathy. Because of their experience, these students are determined to be empathetic nurse and make every effort, no matter where they practice nursing, be it in a mental health or medical setting, to

understand the others lived experience. According to the nursing students in this study, listening attentively for the feelings of others is paramount to nursing care. They believe their experience with a mental health concern has given them a unique understanding, a sensitivity to understand the other and be able to read and acknowledge the emotional realities associated with a given lived experience. This being able to ‘connect’ with the insider perspective is what makes the nursing students with mental health concerns believe they are empathetic.

[I]t’s kind of like being able to say (...) I see that it looks like you are feeling this. And even just, you know, being able to acknowledge emotion and people are like, yeah, you’re not just noticing that I’m having trouble, you know, unlocking my wheelchair, but you’re also seeing that I’m struggling and (...) It’s being able to connect. That has been positive. Sasha, 615-620

In this quote and those that follow it becomes apparent that by having had mental health concerns a nursing student comes to know how important emotional wellbeing is to recovering. Nursing students with mental health concerns believe this sensitivity to the emotional needs of others gives them an advantage over other nursing students in their program,

I feel like that gives me an advantage. It’s not an advantage I’ll be evaluated on. It’s not an advantage my clinical instructors will pick up on, but I know it’s going to make a difference in people’s lives and that is valuable to me, so I’m very lucky to have that “. Sasha, 569-572

Becoming an empathetic nurse is a subtle progression that participants in this study believe came easier to them because of their lived experience.

I am an understanding and empathetic towards patients (...) knowing how they are [emotionally] (...) some people [nursing peers] just ask just because it's their job. I actually like to listen and know how they're doing and feeling because I think what if I was in their shoes and how would I want to be treated Sophie, 24-29

Nursing students with mental health concerns believe that their gift of empathy enhances their ability to advocate on behalf of others, another important nursing skill.

I feel like I will be able to help people a lot, just knowing kind of what the patients are experiencing. Obviously, I am not going to assume they experience

the same thing I am experiencing, but just kind of knowing the system and I feel like I will be able to advocate for patients better, Andrew 284-287

The participants share that part of their own recovering entails that they remain cognisant of how they are responding emotionally to the feelings they were assessing. Sasha shares: “I’ll be more empathetic towards my patients (...) But at the same time, I have to make sure not to kind of jump right in with it with them. Like I have to be empathetic, but not, you know, sympathetic.” Sasha, 636-640. This student mitigates the risk of being ‘sympathetic’, describe as being pulled into the emotional state of the other, by continuously reflecting on her own feelings as she provides care to others. Andrew, on the other hand, believes that at this point in his studies his *Recovering–Self* could be threatened by being too close to the insider perspective, and for this reason he chooses to reframe from practicing nursing in a mental health setting, although he believes he has a sensitivity to the lived experience of others with mental health concerns. He alludes to a career in psychiatric nursing later, when he is a more confident practitioner and feels his own experience with mental health concerns, will serve him well in the future,

so I definitely did recognize a lot of the boundaries and, I did see myself in the future working in mental health I felt like oh I could definitely, I know I have some relatable experiences and maybe some, something that could help me pursue a career in mental health Andrew, 609-613

Another perspective on the phenomenon ‘becoming an empathetic nurse’ shared by some nursing student in this study was that their perceived their unique sensitivity to being empathetic had little to do with what they learned in the nursing program. In fact, they did not learn to be empathetic because of their theory or clinical practice; rather they believe they came to the nursing program with this sensitivity because of their lived experience. Winter explains that because of her experience of a mental health concern she understands what it feels like to be mentally unwell, and wants to make a difference in the lives of others. It is this desire to make a

difference that made her want to be a nurse “I understand it [mental health concerns] more. I can put myself in other people’s shoes and you know it’s made me go into this profession” Winter, 733-735. Winter sees this quality of being empathetic in her peers who have also had mental health concerns.

I think a lot of people in nursing (...) have dealt with a lot of mental health problems and now they are so much more empathetic because of it they are so much more understanding because of it and they know like they know that people have to keep trying so and they have more faith in people, Winter 737-742

Winter brings to light another important attribute of the subcategory *Gifted Nurse*, the quality of having faith in others. Faith for Winter entails believing that people with mental health concerns can get better and will recover. Winter eloquently voiced in the above quote, and in others to follow, that a lived experience with mental health concerns nurtures the capacity for a student nurse to have faith that the *Recovering-Self* is possible. The nursing student who sees himself or herself as recovering has learn to cope and has faith that others will be able to do the same. This faith in the ability of others to come to a state of recovering, fuels the second sub-sub category to emerge in the data, *Empowering*. Nursing students with mental health concerns describe themselves as being empowering because this concept was significant to their own *Recovering-Self*.

Empowering. Two nursing students shared that the challenges they faced living with their mental health concern taught about the importance of *being* empowering, which they have come to identify as an vital construct in nursing practice. Empowering is what a nurse does to make another person, typically someone in their care, feel more confident: especially in controlling their own life and related affairs. Nurses are empowering when they focus on a person’s strengths and assist them in taking responsibility and control of their own life or whatever aspects of their life their health allows them to control. Sophie affirms “I think it’s

good to like tell everyone that even though you have a mental health issue you can still do amazing things and you can't let it stop you", Sophie, 622-624. Taking responsibility of one's own life is hard yet pivotal in supporting the *Recovering-Self*. The nursing students in this study believe that the health care system and its agents are more often than not acting in a disempowering manner. Their experience with the health system took their power away. These nursing students want to counteract this reality and they believe are more sensitive to their peers regarding how powerless a person in the health care system can feel. The participants in this study are committed to be empowering because they have come to know, from their experience, that they needed to be empowered to begin to heal: "I know what it's like to be in the system and it's terrible. So, you know, if I can be one good thing in the system where I know they're just going to have a lot of uphill battles, I really like being that person" Sasha, 625-627. As with being empathetic, nursing students with mental health concerns believe they have a gift to be empowering nurses because of their lived experience with a mental health concern. In the following quote, Sasha explains how she feels she is a gifted nurse, and how she goes about empowering a person in her care. She firmly believes this gift of being empowering is the result of her 'gift' of having lived with the struggle of a mental health concern,

I am very fortunate to have gone through what I did. I am able to (...) sit down with them [a person with a mental health concern] and say, you know, it is important to know that you are not (...) your disease; you are not your disorder. You are more than that. You as a person have not changed (...). Even though you have these symptoms, you are not your symptoms. (...) you are so much more than that, and then, (...) when someone cries after you tell them that, it's like thank you. I needed to hear that (...) I would not have been able to tell them that if like I hadn't gone through what I did. Sasha, 539-550.

This quote speaks to an understanding of the principles of nursing, that go far beyond the expected for a second-year nursing student, which Sasha was at the time of the interview. As a professor in nursing, this researcher is astounded by this participant understanding of what it is

like to struggle with any illness be it a mental health concerns or otherwise. This depth of understanding the other is more likely to come with years of experience in the profession. Is it possible that somehow lived experience with a mental health concern has sped up the learning process?

Holistic. A few participants in the study claimed that their experience with a mental health concerns made them appreciate the important of practicing nursing from a holistic perspective. Holism is the process of providing nursing that considered the whole person, which included their mental well-being. The participants believed that their lived experience made real to them the important of evaluating a person's mental well-being no matter the area of practice. It was impossible for the participants to reduce the person in their care to only a physical being in need of physical nursing tasks, which the students in this study seemed to see happening with other nurses and with their peers during clinical rotations. Because of their lived experience with a mental health concern they knew that there was much more to each person's story in a given situation and they saw themselves as particularly in tune to this reality, and therefore more gifted to respond holistically;

I know that patients do not want to be tasks. They want to be persons. They are dealing with things. You know, they are scared. (...) they have those emotional needs and I'm more attuned (...) early on I've been very aware of the person behind the tasks. Sasha, 559-569

When describing a clinical experience Andrew also speaks of his holistic perspective and talent, which to him also seemed more astute than in his peers. He states it seemed natural for him to see the person in a holistic framework, and he equates this to his lived experience with his mental health concern, where he came to know the value of the holistic perspective on care for his

Recovering-Self. This holistic perspective he equates to what it means to be human:

I was looking at the patient as a whole and holistically looking at all aspects of their life. You know not just their physical health but their mental health cognitive

you know their relationships (...), you know the bigger picture and its helped me way more just empathize with them and understand that there's way more to a patient than their chart and their profile, Andrew, 492-499

Andrews's holistic perspective, seeing the whole person before him, the whole person within a big picture of their life, not simply a person with a chart and task to do, comes naturally to Andrew because of his lived experience with his mental health concerns. Jessica shares that she doubts she would have come to an understanding of the importance of a holistic perspective on nursing care had it not been for her lived experience with her mental health concern. Jessica's struggle taught her that health is much more than physical wellbeing and that a nurse must address every aspect of a person being when someone faces a health threat. A person's mental health is vulnerable alongside physical health concerns. Having learned this she believes she will be better equipped to protect her *Recovering-Self* and encourage others in her care to do the same. In addition, having had her encounter with a mental health concern taught Jessica that any health threat comes with a unique lived experience. Nurses, she believes, need to have this awareness to practice well and she considers herself fortunate to have gained this awareness so early in her career.

Going through my experience (...) there are so many different shades of grey it's not just people who can't function and end up in the hospital. (...) it fluctuates. You're still functioning very well and you know you don't know (...) who is going through a hard time and so that opened up my eyes a lot to the mental health from seeing as a nurse being in a hospital and then going through it. (...) you realize it is everywhere I mean you realize how many other people went through this. That has definitely painted mental health in a whole new way. Jessica, 516-529

Jessica has come to a new understanding of the human condition, that mental health concerns are part of many people's lives. She is not alone in her story and if anything, having had the experience gives her insight into becoming a better nurse.

In conclusion, several nursing students in this study related to this aspect of becoming a gifted person and nurse strongly. To become a gifted person or nurse, according to the participants in this study, is to become someone who understands himself or herself and understands the other; a lived experience with mental health concerns brings this understanding to the forefront. Becoming a gifted nurse seems an extension of this gifted person. MHC has led them to acquire understanding of self and others; making them more empathetic by empowering instinctive and holistic practice. Nursing students with mental health concerns use their gifts to favour recovery because they themselves know what it means to be recovering.

CHAPTER SIX

DISCUSSION

This chapter will present a discussion of the major findings that were described in Chapter 5, the analytical portion of this research project. I will compare and contrast findings to existing theoretical frameworks and the current literature that touches the subject under study: the lived experience of students with mental health concerns. The research questions of this IPA study serve to organize this discussion: What is the experience of nursing students with mental health concerns? How do nursing students with mental health concerns describe themselves? How do nursing students with mental health concerns understand their experience and make sense of their experience in light of the psychiatric apparatus that permeates student life?; How do institutional policies, procedures and technologies help or hinder nursing student mental wellbeing. The chapter will end with the strengths and limitations of the methodology and the implications of results for education of nursing students, professional nursing practice, and future research.

6.1 The Experience of Nursing Students with Mental Health Concerns

The lived experience as *being in time*. I have chosen to explore the experience of being a nursing student with a mental health concern through a Heideggerian phenomenological approach. Human beings are relational historical beings whose fundamental nature is an everyday life construction, where life includes culture, relationship and social influenced. To understand a person's experience requires an appreciation of the person as '*being in the world*', or as Heidegger coined *Dasein*. *Dasein* requires an appreciation of a person's situatedness within space and time. By listening to nursing students' accounts of their experience of what it is like to be a nursing student with a mental health concern I have learned that their being *in the world*, is a

complex experience influenced by numerous influences, some obvious to the nursing student, others so subtle they required deeper analysis to understand. Critical theory applied to the data, permitted in IPA, gives a fuller understanding of the lived experience, particularly as it relates to these subtle influences. I will explain how nursing students understood their lived experience and how socio political and economic influences, arising from the *psy* complex, the corporate university and the nursing profession influenced the lived experience of nursing students with mental health concerns.

The experience of nursing students with mental health concerns begins with a feeling of knowing something has changed within themselves in their relationship with the world. This internal experience entailed a shift from a sense of being hopeful, engaged, and motivated, to a sense of *being* concerned, which entailed feeling frustrated, out of control, hopeless and being alone. This reflects similar findings in the literature that explored mental health concerns in college and university students (ACHA-NCHA Canadian Reference Group, 2013; Storrie et al. 2009). For the students in this study this experience began in high school, lingered for a few years, and then shifted to a sense of more positive *being*, that of recovering described as hopefulness, motivation and belonging. This finding, that students move from an optimistic emotional state, to a despairing emotional state and then come to a new hopeful emotional understanding of *being*, is absent in the vast number of studies reviewed. Looking more deeply into this dynamic nature of the lived experience of nursing students with mental health concerns it became apparent that the participants experienced their mental health concern as something that emerged somewhere in adolescence. At this point, they understood themselves as changing. Their experience with mental health concerns peaked in late adolescence and early adulthood, where peaked came to mean it was most disruptive to their daily living or *being in time*. This

experience of disruption continued into their university experience with periods of waxing and waning, where for the most part, each cycle decreased in intensity of disruption over the years.

Participants in this study experience the onset of their mental health concern as incomprehensible. Nursing student understood this incomprehensibility as related to lacking maturity, although this realisation came later in their experience with mental health concern. At first participants had no prior experience or understanding from which to make sense of this emotional experience. In attempting to understand, they sought and accepted direction from parents. Parents, in turn, wanting to do what was best for their child sought direction from *psy* experts, who made claim that they could restore the students' state of mental well-being. The participants at this point in their experience felt obligated to engage with the *psy* expert although they saw no reason, while their parents, as understood by the participants, seemed desperate to find help for their child. This experience concurs with the writings of Healy (2102) and Frances (2013) who contend that parents attempting to help their child with a mental health concern are particularly vulnerable to the *psy complex* and its related discourses. Modern society sees doing what is best for your child as good parenting, and seeking the advice of the expert, particularly in affluent societies, demonstrates good parenting. This speaks to Foucault's conceptualization of power as pervading the lived experience (subjectivity) through regimes of truth, which are the background for acceptable discourses and practices. The *regimes of truth* permeating into the lived experience of the nursing students are that they are too young and inexperienced to make decisions so they entrust this decision making to their parents. Parents are inexperienced and lack understanding of mental health concerns, so they find *psy* experts to help and 'rescue' their child from their condition, as *psy* experts are considered the authority on all things related to the lived experience of mental health concerns. Parents want what is best for their child and do not want to

see them struggling. Seeing their child's struggle pains them. Their child sees their parent's pain. Both succumb to the *psy complex* in desperation. Thus, regimes of truth subtly and not so subtly affect the decisions made, actions taken, and the lived experience of students with mental health concerns.

Psy and the experience of mental health concerns. Participants shared that the *psy* expert evaluated their internal state of being as multifaceted and attributed multiple *psy* labels to their lived experience. Their lived experiences become categories according to the DSM. Their reality branded as illness. More *psy* labels/diagnoses means more illnesses. According to the *psy* discourse, each illness require intervention. Prior to having a *psy* label, the students did not consider themselves ill. Once labelled, they came to see themselves as "ill". The most common "illnesses" or rather *psy* labels were depression and anxiety. This concurs with most research exploring the mental health and illness in university students (Wynahen et al, 2013; Bayram & Bilgel., 2008), however these studies and others typically categorized mental health concerns in terms of one given *psy* label; they do not speak of multiple labels per student experience. Categorizing the lived experience of the student nurses according to the DSM served to assist the *psy* expert, but served no benefit for the nursing student in relation to understanding of their experience. Using *psy* categorizations the *psy* expert determined interventions and tried to mitigate the 'symptoms' associated with the lived experience of the student nurses with mental health concerns. By far the most common intervention was *psy* medications, similar to the findings of other researchers (Bondi & Burman, 2001; Holmes et al., 2011). However, these *psy* medications were, for the majority of the nursing students, ineffective, which confirmed the findings of Van Den Tillaart, 2002; Reimer and Ste Marie's, 2010, but contrasts the findings of Kranke et al, 2013. Nursing students experienced innumerable deleterious side effects that

worsened their lived experience. The side effects led several nursing students to stop their medications. Some who attempted to stop returned to taking the medications because the symptoms of withdrawal were worse than the deleterious side effects. Others never took the medication prescribed because they feared negative consequences. Their fear stemmed from what they had heard or had seen in the lives of friends with mental health concerns.

In attempting to gain a better understanding of the lived experience of nursing students with mental health concerns, particular in relation to the *psy* expert, *psy* labels and *psy* medications, a critical theory perspective has been added where applicable to enhance analysis. Critical theory speaks of *power* as a relational, ubiquitous, network that permeates the lived experience, producing and constraining subjectivity (Gordon 1999). This conceptualization is near to Heidegger concept of *Dasein* as it relates to *Enframing* (*Gestell*) (Dreyfus, 2003) where *enframing* is the destining character of *Dasein* (Sawicki, 2003). The students feel that they have no power or ability to help themselves, as they have been told that only the *psy* expert knows ‘the truth’ and only the *psy* expert can help them. They experience their situation as if they were subjects who must remain passive, and accept *psy* treatment. These conceptualizations help to understand the complexity of the lived experience of nursing students with mental health concerns and to realize the influence of *psy* power on how the lived experience comes to be. Nursing students with mental health concerns do not, at first, have an understanding of their lived experience with mental health concerns. Their experience is new to them, they have no language or understanding to describe what they are living. Some participants believed this is because they do not yet have the maturity to make sense of the experience. Regardless of why this is, in their clouded state the nursing students come to accept the dominant discourse touted by the *psy* expert, and from this point *psy* discourse begins to drive that which is poorly

understood, their lived experience with a mental health concern. They are also *subjectified*, as the subject-function, mentally ill, has been fixed onto them, as Foucault theorized (2003).

This experience of being a nursing student with a mental health concern happens within a context or background. The background is the *psy complex*, described by Rose (2003) as the institutional, physical, administrative and knowledge structures that exercise power on and organize life especially as it is revealed in relation to mental health concerns (Rose, 2003). The *psy complex* was integral in the nursing students' life as it influenced their parents decision to seek the *psy expert's* advice, it set the criteria for how their mental health concern was categorized and treated. Francis, 2013 and Healy, 2003 claim big pharma aligns with the *psy complex* for mutual gain. The findings from this study support this claim as all the nursing students were offered *psy medication* as their primary intervention while only a few were offered talk therapy. Those that experienced talk therapy found it invaluable as it promoted the acquisition of coping strategies that nursing students believed gave them the tools to cope with their mental health concern and to engage with other life challenges. *Psy medication* as the only intervention was ineffective in addressing mental health concerns and for most nursing students deleterious to their overall mental well-being. As a result, nursing students with mental health concerns began to look for alternative ways and means to find help to deal with their mental health concerns, as the *psy experts* offerings were meagre, for the most part just *psy medication*. On their own the nursing students in this study found exercise, and talking to others who shared the common experience of living with a mental health concern, to significantly improved their mental well-being. Their discovered interventions proved beneficial, and over time, their symptoms associated with their mental health concerns lessened. As the symptoms lessened the nursing students began to question the value of the *psy interventions*, and several students stopped taking

their *psy* medication. The searching out of I interventions other than those of the *psy* complex interventions as well as refusing to take the *psy* medication is a form of resistance as theorized by Foucault. Resistance is co-existent with power and specific to the changing struggles experienced by a person in space and time (Farrell, 2005). In light of having few helpful interventions proposed by the agents of the *psy* complex, the nursing students began to separate from the dominant hegemony and embraced alternative interventions such as exercise and talking to others who had shared in a common lived experience with mental health concerns. Resistance may also be central to how nursing students came to experience themselves as a recovering being. Resistance allowed them to change their understanding of their mental health concern from one of deviance from the norm, as put forth by the discourse of the *psy* complex, to one in which their mental health concern was understood as how they expressed their evolution into a mature adult. Rose notes that resistance to subjectification is possible, and happens when “techniques of relating oneself as a subject of unique capacities worthy of respect run up against practices of relating to oneself as the target of discipline, duty and docility” (Rose, 1998, p. 35). This speaks to how nursing students with mental health concerns experienced recovering. The experience of recovering began when nursing students with mental health concerns came to resist the *psy* norms and standards that the dominant discourse offered. They came to experience themselves as someone who was capable of overcoming challenges (resilient), capable of coping with life, and capable of taking care of their self-care needs and others, all of which made them worthy outside of the *psy* disciplines norms.

The nursing students with mental health concerns detailed their experience of finding commonness with others who had mental health concerns. This discovery of commonness made for a gradual change in their mental health concern experience from realizing they are not alone

to finding a sense of belonging, balance, and hope all of which contributed to a new recovery oriented perspective, which began to shape their lived experience. The norms and standards of the *psy* complex had less meaning, they did identify with a *psy* label that needed to be fixed, but rather identified with others with mental health concerns (commonness), accepted life had ‘ups and downs’ and saw their mental health concerns as a factor of maturity. Although the literature did not speak to specific interventions for college students with mental health concerns as being more effective than others, Leamy et al. (2011) did speak to the importance of the experience of empowerment (taking personal responsibility) and connectedness (being part of a community), as contributing to a person’s recovering. By exercising and talking to others experienced others, students maintained they were able to improve if not restore their mental well-being. Nursing students with mental health concerns experience recovering as feeling hopeful, motivated, balanced, belonging, and supported.

The experience of being a university student with a mental health concern.

The lived experience of being a nursing student with mental health concerns included the transition from high school to university. Here again the importance of exploring the lived experience with an appreciation of the person, *as being in time*, cannot be underestimated. The nursing students with mental health concerns experienced the transition from high school to university as a threat to their recovery. Only one student interviewed experienced their mental health concern as starting while in university. The others were in recovery and experienced nursing school as a threat to their recovery. When the participants began their nursing program they experienced *being a number* in a large class, rather than being a person and this threaten their mental well-being. Where in high school, the nursing students knew others and other knew them, in university, they were lost in a sea of bodies. Being one of so many meant, being infinitely small, and valueless. They did not have a sense of belonging to the nursing class, they

were a number, and this contributed negatively to their mental well-being. Students likened the experience of being a number to losing their personhood, which literature contends contributes negatively to a person's sense of mental well-being (Myrick, 2004, Rose 1998a). As a number in a large class, the nursing students experienced being alone. This experience further spurred their mental health concern, as Leamy et al., (2011) had found. The experience of being a number and loneliness compounded by other social and economic realities, namely losing significant support and relationships whilst transition forms high school to university and financial concerns all set the stage to re-ignite their mental health concern and threaten their state of recovering that was in place before they began their nursing studies. This supports findings from Macaskill, (2013) and MacKean (2011), which have shown that social and economic realities affect post-secondary students' mental well-being; however, this study brought to light how these realities can contribute to mental health concerns but also jeopardize recovering. For example, economic imperatives in the corporate university drive classroom sizes up (Myrick, 2009). In the 15 years that I have been teaching in a BScN program, I have seen the number of students in each class increase tremendously. As a result, I would concur with Rolfe (2013) that faculty connecting with nursing students or students connecting with other students is difficult and not only hampering the quality of nursing education (Myrick, 2009; Rolfe, 2013) but may also be contributing to an environment that hampers mental wellbeing or the recovering of nursing students with mental health concerns.

The corporate university has its own inherent *regimes of truth*: efficiency and standardization are paramount and trump what were once the goals of post-secondary education, the development of minds and knowledge for its own sake (Shore, 2008). These *regimes of truth* theorized to threaten mental health and well-being of students (Myrick, 2004) as the discourse

“dehumanize both students and staff making them as part of the education machine” (Harper, 2013, p. 513). In this study, the experience of nursing students with mental health concerns did support such the theory that the corporatization of post-secondary education with its rules, inherent to *regimes of truth*, does contribute negatively to the students’ mental health experience. Being a number, rising tuition costs, being valued only by grades in large classes are postulated as integral to how the corporate university is experienced and these set the stage for mental health tensions (Harper, 2013, p. 513). This was supported in the narratives of the nursing students in this study. Along with efficiency and standardization, the corporate university purports that individuals are autonomous beings and thus ultimately responsible for his/her self. This framework sets the tone for blaming the student with mental health concerns for their behaviour and negates the role of outside forces on their lived experience. The lived experience of nursing students with mental health concerns reveals otherwise; that many factors are at play contributing to their lived experience of mental health concerns. The data even goes so far as to suggest that corporatization of post-secondary education may itself be contributing to what some considered a mental health crisis in university students. Levinson and McKinney (2013) claimed that the *psy* complex and the corporate university have an affinity and both serve each other’s interests. In this study, nursing students were very unlikely to avail themselves of *psy* support although it was all that was available on campus. Within the corporate university, the nursing student with mental health concerns could have access to mental health services. It was the experience of the participants in this study, that they are unlikely to access these services for a number of reasons: i). Services poorly advertised, therefore, few students know of the services; ii). Services are not easily accessible. Corporate efficiencies, not student needs, determine the location of services. Therefore, services are centralized and not available on the campus were

nursing students have their classes and iii). Services are of poorer quality as compared to mental health services off campus. Services on campus focus primarily on academic success strategies not mental health concerns or coping strategies. It was the experience of nursing students with mental health concerns that efficiency and standards, techniques of corporate university, the dominant *regimes of truth*, reign on the university campus with no space for the unique needs of nursing students in recovery.

Nursing students with mental health concerns in this study experienced the workload at the onset of the program as tremendous. This finding resonates with other research (Byrne and Mooney, 2011; Gibbons, Dempster & Moutray, 2008; Timmins, Corroon,). Student experience the workload pressure as constant throughout their BScN studies, however over time nursing students come to perceive the seemingly impossible workload as manageable as the experience is common to all nursing students. In finding a common plight, although it is difficult, they conclude that together they can do it. This is a new finding not mentioned in other nursing studies and leads this researcher to question the importance of building experiences that foster connectedness earlier in the BScN program to nurture mental well-being. Discovering ‘commonness’ required being connected, and establishing some form of relationship with other nursing students who also experienced the demanding workload. By means of connectedness students came to see their reaction to workload stress as a normal not as a symptom of a mental health concern. Students normalized workload stress, as “this is nursing”, “this is nursing school”, and finding commonness made what was at first perceived as impossible, possible. Nursing students with mental health experienced technology as a double-edged sword. It was experienced as something that allayed mental health concerns when it improved communication between students and faculty, for example, making it possible to view recorded lectures if

amotivation prohibited attending. Technological tools like Blackboard assisted students with organization and studying practices, which also supported their mental well-being. This finding support nursing literature claims that the use of technology in nursing education is beneficial (Schmitt, Sims-Giddens, and Booth, 2012). However, technology also eroded human contact, as less face-to-face communication became the norm. Students experienced technology as giving the illusion of creating connectedness, but in reality, each person is very much alone and not enjoying the benefit of relationship, nor connecting with life. This speaks to what Heidegger warns is the threat of technology (technicity) and how it fosters an antagonistic relationship to being and time (Theile, 2003, p, 217). Technology can be a tool that is perceived by the nursing students with mental health concerns as beneficial if used to foster connectedness however dangerous if it “undermines our efforts to discover and inhabit a worldly home” (Theile, 2003, p. 217).

Nursing students experienced periods where their mental health concern waxed and waned. Their experience of mental health concerns waxed when external factors, such as structural forces, university, regulatory, system (provincial health care system) and funding policies made for conditions that added to student stress. Waxing also happened when significant support relationships changed, or when *psy* experts offered ineffective and perceived detrimental *psy* interventions. Their mental health concerns waned when nursing students found means and ways to help themselves, and when they were able to connect with others in their program who had mental health concerns and shared coping strategies. This experience of periods of waxing and waning of mental health concerns was an aspect of recovering. The lived experience is dynamic and here again the importance of describing the lived experience of nursing student with mental health concerns in relation to a being-in- time becomes apparent.

Another important finding was that the lived experience with the mental health concern began before the participants came to the university. This speaks to two points of interest, firstly the participant were experienced in living with a mental health concern prior to coming to the university and secondly they were more than capable to meet all the pre-requisites for the nursing program while living with a mental health concern. This finding is contrary to literature that contends that mental health concerns are more likely to manifest in university (Bewick, Koutsopoulou, Miles, Slaa-Barkam. 2010; Cleary, Walter & Jackson, 2011; Hunt & Eisenberg, 2010). Although no research has been conducted that explored the lived experience of nursing students with mental health concerns some indirect comparisons from findings in other studies are congruent with findings from this study. Congruency exists with Adlaf et al, (2004) who contended that, 'A' grade oriented students were at greater risk for mental health concerns. Although my study did not verify student CGPA, the majority of nursing students in this study described themselves as 'A' grade oriented students. This can be indirectly corroborated as the grade point average to enter any nursing program in the province where this study took place is ever increasing and would require the candidate to be an A student. It is arguable that the grades from high school may be inflated meaning that more students in high school receive 'A' grades. This said, these nursing students would still have been the highest performing students' relative to their peers. Literature has shown that Canadians have an insatiable desire for post-secondary education, and because spaces in program are finite, when more applicants apply, the average required to enter into the program rises correspondingly. If 'A' grade oriented students are indeed at greater risk for perfectionism and mental health concerns then an unintended consequence may be that nursing schools are now accepting more 'A' grade oriented students who are more likely to be at higher risk for mental health concerns and more of them suffer from

trying to be perfectionists. This demonstrates how norms and standards the tools of power can influence the lived experience of nursing students perhaps setting the stage for mental health concerns. This warrants a shift in research from studies that focus primarily on the student with mental health concern to the development of guidelines on how to support student with mental health concern (McAllister et al, 2014) as well as a critical review of how university policy and strategy affects the lived experience of students with mental health concerns. I have watched as students abandon their nursing studies because they do not have the support, despite proving they can meet or even exceed program requirements. Faculty members, peers, or administrators do not understand the experience of being a nursing student with a mental health concern. Their ‘thrashing’, once again using Menninger’s analogy, is seen as problematic, as evidence that they are the wrong candidate for nursing rather than a sign of burgeoning resilience, an important skill required to maintain sanity in modernity. I believe the research findings thus far have demonstrated that nursing students in the study experienced their lived experience mental health concerns as arising from a socio, political and economic context and not merely from internal flaws as the *psy* complex would have them believe.

6.2 How Nursing Students with Mental Health Concerns Describe Themselves

The first question asked in the interview was, how would you describe yourself as a nursing student? The majority of the students describe themselves as academically strong students, who possessed qualities they attributed to being a good nurse; namely empathetic, caring, and committed. When asked to elaborate in their own words on the nature of their mental health concern the participants used the language of the *psy complex* and were what Rose considered *subjectified* (Rose, 1979). The nursing students as the *psychiatrized-self* describe themselves as abnormal as they do not meet standards of normalcy as defined by the *psy*

complex. They had become *Docile Beings* who are to be ‘improved’ (Foucault, 1977, p. 136). As *psy* naive student they did not question *psy science* and its corresponding norms and standards which. Some authors would argue that this serves the interest of the *psy complex* by permitting more social and emotional ills to be ‘medicalized’ and treated with *psy* pharmaceutical interventions (Francis, 2013; Healy 2009; Rose, 1979). Students may be describing themselves using these *psy* labels because they have yet discovered other words or ways of describing their state of *being*. Lacking their own words, they become an embodiment of the discourses provided them. It is interesting to note that nursing students in this study later came to describe themselves as recovering. This word, used by the nursing students, describes a sense of mental well-being. Recovering, according to the participants in this study, had little to do with the presence or absence of *psy* symptoms as defined by norms and standards, but more to do with how a student relates to the world around them. Recovering was described as belonging, being supported, finding commonness with others who share their experience which countered the isolation and stigma they as psychiatrized-selves.

Interestingly the nursing do not describe themselves as victims of a mental health concern. However, they do indirectly describe themselves as victims of the *psy complex* because of the ineffective and debilitating side effects of *psy* medications. A victim in this sense is a person who is cheated, or fooled, by someone. Eight of the twelve nursing students were told that *psy* medication would ‘correct’ their neurobiological imbalance, and thereby restore their sense of control. The *psy* medication did not live up to these claims, and several nursing students described *psy* medication as harming their quality of *being*. Rosenberg’s (2006) and Healy’s (2013) critical works bring to light that decisions in *psy* clinical practice may be influenced by powerful stakeholders, namely the pharmaceutical industry and are not situated in a person

focused care model. As well Goffman recognized that stigmatized individuals are vulnerable to exploitation and victimisation (Goffman, 1963, p. 4) and this might also be at play in the lived experience of nursing students with mental health concerns as stigma, which will be discussed in question four, also plays a significant role in the lived experience of nursing student with mental health concerns.

Eleven of the twelve nursing students in this study described themselves as isolated. Isolation was a trigger that exacerbated their mental health concern. It arose from the background or context, or was understood as a condition associated with their university experience, where nursing program workload and class size fostered isolation. Participants described themselves as isolated because of the workload that required so much of them that they needed to sacrifice social relationships. They felt isolated because the atmosphere of the classroom inhibited belonging. They described themselves as isolated because of the lack of peer-to-peer connections, as well student to faculty connections, which was near to impossible in the early years of the BScN program because of curriculum design. This finding supports Turkle (2011) who found that thwarting authentic connections would contribute to mental health concerns.

Nursing students in this study also described themselves as isolated because their lived experience as a nursing student with mental health concerns was 'falsely represented', or worse, denied. False or inaccurate representation happened in theory classes when professors presented the lived experience of people with mental health concerns as always being out of control and made no mention of recovery. Denial of the lived experience of nursing students with mental health concerns occurred in clinical when instructors and other nurses inferred that nursing students and nurses could not have mental health concerns and practice the profession. Nursing students in this study perceived that in nursing school the messaging in the nursing program is

that nurses help others with mental health concerns but nurses themselves do not have mental health concerns. Thus, being a student with a mental health concern became an isolating experience, a sense of being an outsider, someone who is not understood, and someone that is not considered a 'real nurse'. This supports the finding of Tei-Tominaga, Asakura, & Asakura, (2014) who explored the lived experience of nurses with mental health concerns.

This non-representation of the lived experience of being a student nurse or a nurse with mental health concerns was also stigmatizing, where being a nurse with a mental health concern was different, something no one else in the school of nursing or the profession experienced. Stigma as theorized by Goffman (1962) arises when a person is, seen as different. Differentness leads to isolation, and has implications for their state of *being*; this was certainly the case for the participants in this study. It can also be theorized that stigma arose from *regimes of truth* inherent in the profession of nursing, that nursing students or nurses with mental health concerns would not have what it takes to be a nurse. Their lived experience of having a mental health concern puts their ability to demonstrate competency into question. Nursing students in this study described themselves as "a fake", because they denied their lived experience with a mental health concern, because they feared their competency would be questioned or they would be more harshly judged against the norms and standards of a 'real nurse' as per the nursing rules and myths they encountered throughout the nursing program. In order to subsist in the nursing program, nursing students with mental health concerns describe themselves as needing to self-silence. They did not let on that they had experience with a mental health concern even when they saw themselves as recovering. Living with mental health concerns required nursing students to become self-aware; to recognize triggers, to develop personal coping strategies, and to accept that 'up and down' days are part of life. These life learnings contributed to what nursing students

describe as aspects of recovering and possibly maturity. The need to self-silence, and not share their lived experience with anyone in the nursing program persisted throughout the program, they continued to describe themselves as different. However, nursing students did share their lived experience with others outside of the nursing program and these relationships proved to support their recovering. Goffman determined that those who have a particular stigma, tend to share similar learnings from their plight and similar changes in conception of self, or as Goffman conceptualizes, a moral career (1963). This moral career favours new relationships with others that are themselves stigmatized. The new group finds connectedness and come to see others in this group as 'normal' and gradually the stigma associated with mental health concerns lessens. Nursing students in this study did find these new connections, which contributed to their sense of recovering, yet these connections were outside of the nursing program. Nursing students with mental health concerns described these connections as a means of fostering belonging support and of learning from others in a common state of *being*, much as Goffman theorized. The interviews with the nursing students described that students with mental health concerns felt stigmatized in the nursing program however, the connectedness they experienced beyond the program, gave them a sense of commonness and an opportunity to feel normal and apply learnings that changed their state of *being*. What they learned from finding commonness with others outside nursing contributed to their developing nursing role, their 'becoming' a nurse. The nursing students in this study described themselves as more empathetic, empowering and holistic nurses because of their lived experience with a mental health concern however, the participants would not share this insight with a professor, administrator or peer in the nursing program. No research spoke to nurses or nursing students describing themselves as more empathetic, empowering or holistic because of a lived experience with mental health concerns Only negative

consequences of mental health concerns on professional practice were captured in the literature (McAllister et al, 2014; Joyce et al, 2012; Joyce et al, 2009; Joyce et al, 2007). This research points out that positives also arise from the lived experience of being a nurse with a mental health concern.

Finally, nursing students also describe themselves as believing recovering was possible, although they did not come to this belief by engaging with *psy* experts, faculty, or administrators in the nursing program, nursing peers, or the greater university community. In fact, from *psy* experts, faculty and administrators they felt repeatedly stigmatized and were made to feel unfit for practice, flawed and likely permanently disabled which is congruent with the findings of Bjorkman et al, 2008; Haddad et al, 2007; Hansson et al, 2011; Ross and Goldner, 2009; and Thornicroft, 2007. However, if by chance, they encountered a faculty member who had personal experience with a mental health concerns, and were forthright about how they coped and managed their recovery, the students did find this person to be exceptionally validating and encouraging. This finding was substantiated in the work of Brockelman et al, 2006. This brings to light that *regimes of truth* contribute to what becomes *Dasein*, the lived experience. Understanding the lived experience of nurses and nursing students with mental health concerns, and not denying it exists by non-representation, will benefit the profession. Simultaneously addressing the stigma and isolation experienced by many nursing students and nurses will foster recovery, once such an understanding is gained.

6.3 How Nursing Students with Mental Health Concerns Understand Their Experience in Light of the Psy Apparatus.

With a phenomenological appreciation, nursing students with mental health concerns understood their lived experience with mental health concerns as distinct at a given period in time. Their understanding evolved from being a *Concerned-Self*, who is alone, out of control and susceptible to stress and triggers. To understanding themselves as a *Psychiatrized-Self*, when they docilely accepted *psy* labels and interventions. To finally understanding themselves as a *Recovering-Self* who is balanced, copes with life's up-and-downs and belongs to a group of people who share a common experience of mental health concerns. They understood their lived experience of mental health concerns as changing over time and being malleable to outside influences. These influences contributed negatively to their lived experience with mental health concerns and included student stress; triggers; *psy* interventions; university, insurance and nursing rules, and stigma. Nursing students in this study understood that a sense of belonging, achieved by finding commonness with others with mental health concerns, fostered mental well-being. Nursing students with mental health concerns understood 'maturing' as a phenomenon that drove the evolution of the *Concerned-Self* to the *Recovering-Self*. The *Psychiatrized-Self*, is the product of a stage in this evolution where nursing students did not have the understanding of their lived experience and thus relied on the advice of *psy* experts and others. Most of the nursing students understood that they encountered more obstacles than help as *Psychiatrized-Selves*. Nursing students in this study understood themselves as finding their own ways to cope with their mental health concerns, as *psy* medication offered by *psy* experts did not serve them. Nursing students with mental health concerns understood refusing *psy* medication, embracing self-care and talking to others with lived experience with mental health concerns, as pivotal in this evolution from *Psychiatrized-Self* to *Recovering-Self*.

Superimposing critical theory onto phenomenological findings, permitted with IPA, allowed for a deeper analysis of the experience of *being* a nursing student with a mental health concern within the university nursing school program dynamic environment as emerging forces, or *regimes of truth*, contribute to how the lived experience manifested itself. Although participants in this study did not name the *psy* complex or neo-liberal/ corporate ideologies as contributing to how their lived experience with mental health concerns evolved, by applying a critical analysis these influence on how nursing students with mental health concerns understood *being* or *Dasein* contributed significantly to clearer understanding of their lived experiences.

As *Concerned-Selves*, nursing students understood themselves as vulnerable to the direction of parents and *psy* experts because they felt out of control. They understood themselves as being lead to *psy* experts by their parents, who were desperate to find some way to restore control in their child's life. Their parents became unwitting agents of the *psy complex* that played to their helplessness when faced with their child's emotional distress. Students in this study understood themselves as defenseless against their parents' biddings to see the *psy* expert, and the subsequent *psy* interventions that their parents would support, especially if they themselves had no mental health experience. Thus, the lived experience of the nursing student with mental health concern is subjectified by power that infuses the lived experience through *regimes of truth* (*psy complex*) or Gestell (Enframing) that pushes *being* (*Dasein*) in a certain direction: that of understanding themselves as a *Psychiatrized-Self*, as mentally 'ill'.

All the nursing students in this study spoke extensively to how they came to understand themselves as psychiatrized. For all the participants, it began when they encountered the *psy*-expert and the attribution of multifaceted *psy* labels to explain their lived experience. While the *psy* labels were understood as doing little to help them make sense of their lived experience

others, such as parents, teachers, *psy* experts and friends, began to relate to them as being ‘mentally ill’. Their lived experience with mental health concerns was categorized according to norms and standards, which had meaning to the *psy* expert, served to guide the *psy* interventions but did not help nursing students cope better with their distress. The participants understood that these *psy* labels authorized access to mental health care and support within their community, and at the university and thus served a purpose. They understood that the university would only make accommodation if they had a *psy* label and that insurance would only have reimbursed their mental health concern care if they had a *psy* label. They had no choice but to accept the *psy* labels and the accompanying bio-medical model of understanding of their lived experience if they wished to access any care or support. As a means to restore neurochemical balance and control in their lives, all the participants in the study were advised to take *psy* medication. Some nursing students took the *psy* medication and understood that they had no other options. A few refused to ever take the *psy* medication as they understood *psy* medication to be damaging to their mental well-being and this understanding came from seeing others family or friends take *psy* medications. Some started to take the medication but then stopped because the side effects were more debilitating than their mental health concern. These nursing students understood that taking *psy* medication was detrimental to their mental well-being. Less than a third of the participants in this study understood *psy* medication as contributing positively to their lived experience and none believed that *psy* medication was significant in helping them finding balance, which they came to understand as more important than restoring control, which was the claim of the *psy* expert.

Although the students in the study did not speak overtly of the *psy complex* they did allude to forces beyond them directing their choices, options of care, and how they came to

understand themselves, their state of *being*. Power, according to Foucault (2006), pervades subjectivity, which in this study is the lived experience of the nursing student with mental health concerns. Foucault's concept of *biopower* a concept similar to Heidegger's *technology* (*technicity*), is a destining character, or force, that manages individuals and acts on docile bodies (docile selves) or being. The nursing students understood themselves as subjectified and needing to be improved (corrected), to meet the norms and standards for improvement as determined by the *psy complex*. The nursing students with mental health concerns came to understand their lived experience as understood by the discourses of the *psy complex* and by the norms and categorizations the *psy* expert used. This categorization set the stage or provided the background for the assessment of their lived experience, specifically as having multifaceted *psy* labels; being hospitalized to correct their 'illness'; taking *psy* medications despite little benefit; and talk therapy. They came to understand themselves as docile selves who accepted correction and did not deviate from the norms and standards of the *psy complex* as enforced by the *psy* expert and unwitting parents. However, later in their lived experience, they began to understand themselves as resisting biopower or normalizing forces controlling them. Over time, the students began to question the effectiveness of this *psy* intervention and discovered on their own that exercise, talking to others, believing that they could take back control of their health and refusing *psy* medication fostered their mental wellbeing. A major shift transpired where students began to trust themselves as legitimate knowers of what they could do to help themselves recover. They understood themselves as resisting when they started to initiate their own means of dealing with their mental health concerns. Resistance, understood by the nursing students, arises not in reaction to power, but rather as a response to a specific and changing understanding of their mental health concern in space and time. Nursing students came to understand themselves as

mentally capable of taking action to improve their state of being, no longer simply a *docile self* in need of improvement. This change in understanding being is similar to how O'Farrell (2005) explains Foucault's conception of resistance.

Nursing students with mental health concerns also understood themselves as *Regulated Selves* where regulated meant that forces beyond them directed their conduct or ways of being. These regulative forces could have negative consequences on the mental well-being of nursing students. Negative consequences arise when institutional regulations and ensuing policies and procedures denied non-conforming ways of *being*, where the *psy* complex once again determined non-conforming. The nursing students with mental health concerns understood themselves as regulated because Insurance Rules, University Rules, and Nursing Rules were rooted in the norms and standards of the *psy complex*. Insurance rules regulate the reimbursement of services. Insurance rules readily reimbursed *psy* medication for all the nursing students and was by far the easiest intervention to access. *Psy* medication was the least expensive if the student had no private insurance. Although talk therapy was favoured by the nursing students with mental health concerns accessing this intervention was difficult and for some prohibitive because of insurance rules. Those that had private insurance stated that their insurance policy limited the number of sessions, leaving them with an insufficient intervention, although they perceived these sessions as beneficial for their mental wellbeing. Nursing students with mental health concerns understood insurance policies as negatively influencing their lived experience as these rules were seeped in *psy* culture, leaving no room for alternative or 'deviant' understanding of their lived experience.

Nursing students with mental health concerns also understood themselves as regulated in relations to University Rules, which included overarching administrative and nursing school

policies and processes. University rules dictated what mental health services would be available on campus. Although nursing students did not understand university rules as being an extension of the *psy complex*, university rules were understood as being primarily concerned with standards and efficiency, cardinal attributes of the corporate university. Participants understood university rules as written and enforced in ways to favour institutional needs over students' needs. Nursing students understood standardization as limiting options or ways of being and coercing students with mental health concerns towards expected norms, for example to taking *psy* medication, having *psy* labels to access *psy* approved interventions on campus. The norms left no room for deviance and thus disregarded the unique considerations of the nursing students with mental health concerns. The students understood that while standardization was trumpeted as a way for all students to be treated 'fairly' the real role of standardization was understood by the participants to be a justification for offering basic, non-specific, ineffective treatment that did not meet the unique needs of nursing students with mental health concerns. Digging deeper into the data, university rules, meaning policies and procedures, were rooted in a *psy* understanding of mental health concerns, where *psy* understanding reigned and little understanding of recovery was present.

Nursing students with mental health concerns understood university rules driving efficiency, another tenant of the corporate university. The institutional commitment to be efficient determined the background from which a student with a mental health concern would experience life on campus. Efficiency drives what kind of treatments that would be available, namely the least costly, those supported by insurance rules and the *psy complex*. Efficiency drives where services would be available, for example, only on the main campus, leaving students on satellite campuses with limited access to resources. Although participants did not

have an obvious understanding of the corporatization of post-secondary education and the accompanying requirement for standardization and efficiency, they did feel underserved, uncomfortable and misunderstood because of the forces of standardization and efficiency. Like Reimer and Ste. Marie, (2010), who critically studied the lived experiences of women university students with mental health concerns, the nursing students in this study, experienced little quality mental health services on campus and thus understood that services completely missed the needs of the students, for example, no mental health services were available on satellite campuses.

Digging deeper the data revealed that the corporate university, by means of its rules, also fed into the *regimes of truth* inherent in the *psy* culture: that those with mental health concerns are responsible for their state of *being*. Levinson and McKinney's (2013) concluded there is an "elective affinity" between *psy complex* and the corporate university where both placed emphasis on individual responsibility and accountability. This current research study supported the same finding, as nursing students with mental health concerns understood they had to take responsibility for their mental health and go out of their way to access services at the university. They understood that they were accountable to faculty and administrators if they did not access these limited, ineffective, hard to access services. Nursing students understood that university rules dictated that their mental health concerns were their own problem, inherent to the student, and that in no way was the university responsible for the students' problems. The Corporate University never considers that rules, and associated policies and procedures contribute to a toxic learning environment that threaten mental well-being however the nursing students with mental health concerns did understand their recovery as threatened when they transitioned from high school to university alluding to the toxicity of the environment.

The corporate university rules and the associated requirement for efficiency drive the large classes in which nursing students with mental health concerns find themselves in today. Students understand themselves as being corralled into excessively large class with no authentic encounter between faculty and students, or students and students just as Myrick had found (2004). Nursing students understood themselves as isolated, alone, dehumanized, and a number in a large corporate university class and understood this experience as hindering their mental well-being. Although nursing students in this study did not overtly understand how university rules imbued with *psy* and corporate culture contributed to their experience with mental health concerns, it did become apparent that their lived experience with mental health concerns revealed itself against the background of the corporate university rules.

The nursing students also understood that Nursing School rules threatened their mental wellbeing and these rules were enforced by two policies; 1.). Two failures meant expulsion from the program and 2.). Absenteeism in clinical required physician documentation or would be considered unacceptable and would warrant a failure. The students understood that to be a nurse required a high level of knowledge and skill and that patient safety was and had to be paramount. However, nursing student with mental health concerns questioned if current nursing policy that threatened expulsion took into account the reality of living with a mental health concern. The participants in this study described themselves as academically strong and committed but feared that they could find themselves at odds with these policies because of their lived experience with mental health concerns. Simply having this fear compromised their mental well-being. They understood these nursing policies as punitive, not pedagogically derived. Enforcing these rules demonstrated that the school of nursing had no understanding of the lived experience of students with mental health concerns. Nursing students with mental health concerns understood an

absenteeism policy that required obtaining a physician's note to justify absence as a mockery and disavowing to evolving professional behaviour. Students understood that obtaining a physician's note would require unethically behaviour. Students explained that seeing a *psy* expert on short notice is impossible, therefore, the exercise of obtaining a physician's note is nothing more than a ruse. A ruse where a nursing student with a mental health concern would pay a health professional to write a note. In this case, with limited therapeutic interaction, no care for their mental health concern is possible and likely, the nursing students with mental health concerns experienced more stress in the process. Nursing students with mental health concerns understood what they needed to do to improve their mental well-being; they needed to foster their recovering which required them to manage setbacks by tapping into their coping strategies and engaging in self-care. Nursing students with mental health concerns understood these nursing school rules and associated policies as punitive. The nursing rules also validated that Nursing faculty and University administrators have no comprehension of mental health concerns and no understanding of recovery. Indirectly nursing students as *Recovering-Selves* understood these punitive nursing policies as permeated with *psy* culture where *psy* experts treat mental health concerns, with *psy* interventions and not by self-care measures that foster recovery

Nursing students with mental health concerns also understood nursing rules as the authoritative voice on who is considered capable and competent and somehow nursing students come to understand the being mental ill is conflated with being incompetent. Nursing students understood the need for the profession of nursing to have rules that set the norms and standards for competency; however, they feared that the foundation for these nursing rules was a bio medical model seeped in a *psy* culture understanding of mental health concerns. Nurses and nursing students with mental health concerns were always ill, with little understanding of

recovering, and therefore prejudged competency in nurses with mental health concerns. Participants in this study understood that being a nurse or a nursing student with lived experience of mental health concerns would mean that their competency would be under scrutiny by others in the profession. The finding echoes Vanheule, (2011) who found those with mental health concerns face disqualification as legitimate knowers and often deemed incompetent. Joyce et al (2009) found that nurses with mental health concerns come to understand their professional identity as situated on binary axis where a nurse is either mentally healthy, implying goodness, predictability, being in control and reliability, or mentally unhealthy, depicting badness, unpredictability, lack of control and unreliability, although no evidence to support this exists. Nursing student in this study understood that once given a *psy* label, they would always be judged by the agents of the profession to be at risk of losing control and therefore considered as incompetent. No research substantiates this claim that nursing competency and capability is at risk when a nurse has experienced a mental health concern, yet the participants understood nursing rules as based on this premise. Although nursing students in this study understood that their competency will be scrutinized they believed themselves to be more capable and competent because of their lived experience with mental health concerns. They understand that their experience has made them more empathetic and empowering, which are building blocks for nursing competency and capability, as per nursing regulatory standards (CNO, 2014). This warrants further research that explores nursing competency and capability in nurses with mental health concerns, because where there is an absence of understanding, the *psy* complex and its *regimes of truth* offer an ill researched yet socially and culturally accepted explanation.

Along with Nursing Rules, Nursing Myths, beliefs that were understood as truth by the participants in this study, but not institutionally substantiated, also came into play in how nurses

with mental health concerns came to understand their experience with mental health concerns. The students in this study understood that nurses need to take care of others and cannot require care themselves. Needing self-care equates with being incapable, or being unfit for practice. The experience of being a student with a mental health concern has taught the participants in this study the importance of self-care to maintain their recovery; however, they understand the profession of nursing and its agents as seeing a requirement for self-care as a weakness. These contradictory messages cause stress for the nursing students. Perhaps this nursing myth is rooted in the shrouding of the lived experience of mental health concerns in the profession that arises from stigmatization, discussed later in this chapter. Nursing student with mental health concerns understand this myth does not support a culture of recovery and therefore threatens the mental wellbeing of the students in this study. In addition, the students understood that nurses expected nurses to be self-sacrificing and ‘super human’; entailing physically and emotionally giving of oneself for the care of others at all cost. The profession praised self-sacrifice but to resist self-sacrifice as part of promoting self-care is not being a ‘good nurse’. Nursing students in this study came to understand themselves as being at risk of being judged inferior because they could not be self-sacrificing as it put their recovery in danger. Although this myth and how it is understood by nursing students in this study does not relate to how the *psy complex* may permeate into the lived experience of nursing students with mental health concerns it may be more reflective of gender role expectations which also bring with them *regimes of truth* that contribute to the lived experience.

All the nursing students in this study understood themselves as stigmatized by *psy* experts, family, and peers that saw them as ‘sick’. University administrators questioned if they should be in nursing because of their mental health concern and the nursing faculty pre-judged

competencies and capabilities of those with mental health concerns. Students came to understand stigma, as Goffman had surmised, as a by-product of the norms and standards of the *psy complex* and the tendency of large corporate institutions to treat all members equally (1963, p. 17). They understand that equal treatment does not equate with fairness or successful treatments. These *psy* norms and standards embedded in university, insurance and nursing rules make the sting of stigma far reaching.

Nursing students first understood themselves as stigmatized when *psy* experts used *psy* constructions of normal to disqualify and disadvantage their lived experience. This occurred when they realized the stigma associated with their attributed *psy* labels. Nursing student experience a devaluing of their lived experience as Liegghio (2013) described as ‘epistemic violence’. The nursing students understood themselves as being in a distressed state, however believed their experience was more a matter of maturity than being a *psy* illness. Nursing students also understood themselves as stigmatized because they did not fit the services or the model proposed by the university. One stop, one size fits all efficient model of the university do not meet the needs of nursing student with mental health concerns. Not being able to access meaningful mental health services on campus made nursing students with mental health concerns understand the university had no interest in supporting their needs. This left them feeling different from other university students and not understood.

Nursing students also understood themselves as stigmatized by the nursing profession. Nursing students with mental health concerns came to understand they were flawed and unfit for nursing practice, despite stellar academic and clinical evaluation that attested otherwise, by the comments made by professors in theory classes, by clinical instructors and other nurses in clinical environments. They learned quickly that having a mental health concern means you will

be stigmatized, which will mean your competency and capability will be continuously questioned. They learned quickly to avoid scrutiny by hiding their mental health concerns from nursing professionals. Silencing themselves further engrains the stigma and makes them feel like an imposter which leads to harbouring a destructive fear of being found out which in turn exacerbates the mental health concern. Nursing students understand their lived experience as stigmatized, as Goffman theorizes. Their awareness of inferiority, as programmed into them by the *psy complex*, sets the stage for a chronic feeling of insecurity, and this contributes to anxiety (1963). The nursing students lived experience with mental health concerns is enmeshed with how the *psy complex* organizes itself for its own advantage, where stigma can fuel more mental health concerns. By self-silencing, in face of the stigma, the nursing students aggravate their mental health concern as silencing makes them come to believe they are alone in this experience, without a sense of commonness, such that they understand themselves as abnormal. These findings in relation to stigma support Goffman's research that stigma can be profoundly discrediting and corrupt a person's sense of *being* (Goffman, 1963, p.3). In this way stigma is a coercive power that subjectified the nursing students' sense of *being*.

Goffman went yet further in his analysis of stigma and determined that persons who have a particular stigma tend to share "similar learning experiences regarding their plight, and similar changes in conception of self- a similar moral career" (Goffman, 1963, p. 44) and this was apparent in the data from this study. Nursing students did identify with other people who had similar lived experience with mental health concerns and commonness set the stage for the *Recovering-Self*. This *moral career*, according to Goffman has stages; the first being when the stigmatized person learns and incorporates the norms and standards of society into their *being*, the second when the person learns in detail the consequences of having the stigma (Goffman,

1963). Nursing students in this study experienced these phases. First, when they incorporated the norms and standards of the *psy complex*, university and nursing profession, as explained earlier, into their understanding of themselves. Secondly, when they could clearly articulate the consequences of stigmatization and thereby rise up against it to become a different *being* in their own eyes. This moral career experience favoured new relationships with others who are stigmatized (Goffman, 1963, p.49), as they would have been rejected by the 'normal'. In these new groups of the 'stigmatized' they find connectedness and come to see others in this new group to be ordinary or 'normal' (Goffman, 1963, p.52). Nursing students found commonness with others who had experience with mental health concerns, stigma, and *psy* interventions and discovered new norms and standards that served as part of their experience of recovering. However, their nursing profession was not included in this commonness. From the nursing profession, and from experiencing its associated rules (norms and standards) nursing students felt isolated and alone and unable to speak of their mental health concerns. This experience sculpted how they came to understand themselves as a nursing student with a mental health concern. They understood themselves as different, as flawed, and as unfit for practice. Drawing on Foucault's work, this link between how norms and standards set the stage for stigma and how a person comes to understand themselves, nursing students with mental health concerns encountered *normalization*, as theorized by Foucault (1977), a means of exerting power by means of norms and standards, at the hands of the nursing profession. However, participants understood that despite the obstructive nature of nursing rules on their development as *beings*, namely as professional nurses, they did find commonness with others who had experience with mental health concerns. Through this commonness, they discovered new norms and standards, thus *normalization*, the means of exerting power through norms and standards, shifted ever so

slightly to permit for a new understanding of self, a burgeoning understanding of the *Recovering-Self*.

Nursing students with mental health concerns in this study came to understand themselves as *recovering-selves*. The students understood recovering as a process, not an end. Recovering entails finding meaning and satisfaction, and coming to an understanding of what a good life is for each person. Recovering is not easy or straightforward process. It requires perseverance, but in the end, personal rewards are substantial. Recovering was understood as a shift in a student's state of *being* that included the *concerned-self*, *psychiatrized-self* and the *recovering self*, where each state brought with it unique feelings and awareness of what their *being* in the world constituted. As a *concerned self*, students understood themselves to be frustrated, hopeless, out of control and alone and at the whim of stresses and triggers. As *psychiatrized-Selves* students realized that *psy* labels had consequences; they felt the sting of stigma and understood that forces beyond them influence their lived experience with mental health concerns. For example, university and insurance rules, dictated the services they could access as a student with mental health concerns and could inhibit recovering if not person centered. They also came to understand that nursing rules and nursing myths negatively affected mental health concerns and can impeded recovering. As *recovering-selves*, they understood their relationship to the world as differently. They felt hopeful, motivated, balanced, belonging and supported, and that they had much to offer others in terms of being empathetic, and being empowering, because of their lived experience with mental health concerns. The nursing students with mental health concerns understood that their state of *being* had changed and this change did not happen because of *psy* therapy or because of the learning they received from nursing school, rather it happened despite these influences in their lives. They came to understand that change in

being, towards *recovering –self*, happened when their lived experience with their mental health concern was ‘normalized’, where normalized, as Foucault conceptualizes it, is a force that makes people homogeneous. Where once they were ‘abnormal’ as per *psy* norms and standards, they came to understand themselves as ‘normal’, sharing a commonness with others who have lived experience with mental health concerns. For the students, the norms and standards that once compared, differentiated, hierarchized and excluded (Foucault, 1977, p. 183) had shifted to new norms and standards, no longer dictated by the ‘*psy*’ *complex*, but new norms more in tune with the mental health recovery movement. For example, nursing students with mental health concerns came to understand that experiencing ‘ups and downs’ in their lived experience with a mental health concerns is normal, not abnormal as the *psy* complex had led them to believe. As well, they do not need to be in control, as the *psy complex* would have them believe, but rather ‘control’ was replaced with finding balance, namely between self-care and workload, so as to live a meaningful life which may or may not include their mental health concern.

Almost half of the nursing students that participated in the study understood that maturity had some bearing on their mental health concern experience and the shift in their state of *being* from *concerned-self* to *psychiatrized self* to *recovering self*. Whereas theories regarding the concept of maturation once examined biological forces, then evolved to include cognitive development, modern conceptualizations describe maturation as the process of learning to cope and to react in emotionally appropriate ways (Skinner & Zimmer-Gembeck, 2009). Students understood that as they matured they gained awareness of themselves and their relationship with the world around them, which included coping skills to balance life and their emotional responses to life. They also understood that this maturation process began when they transitioned from high school to university. This participant insight, lead this researcher to question how the

concept of maturation as it is understood in modernity might play into the lived experience of nursing students with mental health concerns in the early years of their nursing program when they are bombarded with stresses associated with transitioning. Maturation as understood by the nursing students in this study brought with it a gaining of coping skills and an awareness of others. Coping skills provided a means to deal with life's 'ups and downs' and a sense of self-efficacy. Participants understood awareness of others as moving their attention from a self-centred, egotistical view, to a 'bigger' picture of *being*, which included their relationship to others, as well as their relationship to social, political and economic realities. The nursing students understood maturity, as integral to recovering.

Another finding is that nursing students came to understand themselves as empathetic, empowering and understanding of others with lived experience with mental health concerns or in need of any aspect of the health care system. This understanding of self as special because of encountering stigma may speak to what Goffman theorized as the lived experience of those who "suffered as a blessing in disguise, especially if it is felt that suffering can teach one about life and people" (Goffman, 1963, p. 21). It is in this way, a "blessing in disguise", that nursing students come to understand their lived experience as nursing student with mental health concerns.

In conclusion, the nursing students in this research study make it clear that rather than looking at their lived experience with mental health concerns as an 'illness' their lived experience is more a matter of a means by which they learned life skills. They understand themselves to be sensitive and intelligent young people responding to a toxic environment in the best way they can, given their level of maturity. With appropriate recognition of this lived experience and appropriate support that is tailored to their unique situations, the supposed mental

health 'crisis' can be contained. They understand they must come to find a sense of belonging within institutions of higher learning and within the nursing profession. Nursing students understand that this will require fundamental changes in the culture of the university and the nursing profession. Changes include a willingness; to identify and deal with stigma towards nursing students with mental health concerns; to question the relationship between competency and nurses in recovery; and to explore how the corporate university affects nursing education and contributes to creating a toxic environment students' mental well-being.

6.4 The Rising Rates of Mental Health Concerns as the Distillate of the Psy Complex and a By-Product of Student Stress.

The findings of this study lead this researcher to conclude that the rising rates of mental illness diagnosis and mental health concerns in students is both a distillate of the *psy* complex and a by-product of student stress. Firstly, the students have a broad understanding of their lived experience with mental health concerns and do not see their experience as merely the product of internal physical or psychological abnormalities as the *psy* complex would have them and society believe. Rather mental health concerns as experienced by the nursing students in this study, are part and parcel of life as a developing *being*, who is transitioning from youth to emerging adulthood (Frances, 2013) whilst encountering a toxic environment that threatens their mental well-being (Levinson and McKinney, 2013; Reimer and St. Marie, 2010; Van Den Tillaart et al, 2009). The stresses that students experienced were financial, workload, and grades, similar to the findings of other studies (Adlaf et al, 2004; Holmes et al, 2011; Ibrahim et al, 2012). However, a significant additional stress was that of *being* alone in their experience either as a nursing student, as the program does not nurture connectedness, or as a nursing student with mental health concerns, because of stigma. Having the feeling one is alone is fodder for mental health

concerns. These stresses support the claim, that the nursing students lived experience with mental health concerns is a by-product of student life.

Secondly, the nursing students experience with mental health concerns began in high school and they learned how to cope with their mental health concern prior to attending university. Nursing students understand this learning as part of their recovering. Although they understand themselves as being in a state of recovering when starting university, they did recognize threats to their recovering were inherent to the toxic environments they encountered in both the university and the general society. These toxic environments imbued with *regimes of truth*, stemming from the *psy complex* and the corporate agenda affected how the nursing students understood their mental health concern. These environments were quick to interpret students' reactions to stress as *psy* illnesses, as *psy regimes of truth* were central to how these environments understood mental health concerns. Consequently, nursing students experience with mental health became a distillate of the *psy complex*. However, this study also found that raising rates are a distillate of the stresses innate to the corporate university agenda driven by standardization and efficiency. Standardization and efficiency set the condition for a highly stressful toxic environment for students with mental health concerns who are in recovery. Here as well, it is important to note that the *psy complex* and associated *psy* culture set the foundation for many of the norms and standards that drive standardization and efficiency in the corporate university. Consequently, the toxic environment in the corporate university that threatens mental well-being of students is indirectly a distillate of the *psy complex* although this link is not apparent to the nursing students.

In conclusion, following critical analysis and quarry the rising rates of mental illness diagnosis and mental health concerns among university nursing students are the distillate of the

psy complex post-secondary students' experience. However, they are also a by-product of the stresses of student life where stresses include financial, workload and grades but also arise from the corporate university agenda where standardization and efficiency make for toxic environments that threaten student mental well-being.

6.5 Methodological Strengths and Limitations

Strengths of IPA. IPA as a methodology did help to understand the lived experience of nursing student with mental health concerns, which included what that experience entailed, the stresses, triggers and feelings as well as what therapeutic services and interventions students found helpful or harmful. The knowledge gained was new as these first-person accounts, with their rich narratives were absent from the literature, that to date, was mostly survey based thus biased by stress models, *psy* interpretation of mental health or illness, or epidemiological models. The methodology indirectly evaluated therapeutic services in that nursing students with mental health concerns shared that *psy* interventions, namely medications are ineffective.

What made this methodology particularly well suited for this research was that it permitted the development of understanding of the nursing students lived experience within the social and cultural context of the university as an increasingly corporatized entity. The methodology allowed for reflection upon the role therapeutic (Insurance Rules), institutional (University Rules) and legislative (Nursing Rules) forces played in the lived experience of nursing students with mental health concerns. All these above findings support the claims of proponents of Interpretative Phenomenological Analysis (Larkin, 2013) and build on research that substantiates IPA as an effective qualitative methodology for understanding the lived experience within a context. Data gleaned using this methodology, lead to reflection upon the role that faculty, administrators, services providers, and peers played in the lived experience of

nursing students with mental health concerns. The methodology permitted the retrieval of data that showed that the lived experience is not the product of the individual's actions but rather an amalgam of the relationships and forces within the context that the nursing students find themselves. Thus, the phenomenon under study was in fact a complex reality that warranted IPA (Smith and Osburn, 2003). The methodology also allowed the researcher to re-evaluate critical theory that spoke to the *psy complex*, and stigma. Theory that speaks to how the *psy complex* plays into the lived experience of individuals with mental health concerns was supported in this study (Rose, 1979) was supported in this study. As well as Goffman's (1963) theory on stigma from others and self-stigma. Both theoretical perspectives helped in gaining a deeper understanding of the lived experience of the nursing student with mental health concerns as IPA allows for second tier questions that can probe theoretical analysis (Larkin and Thompson, 2012, P. 3129). The depth of analysis and the richness of understanding gained would not have been possible without the second tier theoretically infused questions as the *psy complex* and stigma are resolutely engrained in the nursing students lived experiences and required exploration to make sense of their lived experience.

IPA as a methodology was also amenable in that it allowed for the surprising discovery of the *Recovering-Self*. Nursing students with mental health concerns come to university in some stage of recovering and that their experience as university nursing students threatens their recovering. Their recovering is experienced as seeing their commonness, that they belong, accepting ups and downs, finding balance and hope, all of which students come to believe might relate to maturing and not the absence of illness as the *psy complex* would have them believe. IPA requires the data to speak for itself and *recovering* emerged as a significant theme with categories and sub categories. This surprising finding speaks to how the methodology can be

open to new discoveries as well as supporting existing theory. Reflexivity according to Larkin et al, (2006) is not entirely possible although it is desired, however if the IPA researcher is reflexive regarding her biases and aware of values and preconceptions this can be brought to the analysis. It is precisely because of this reflexivity that the major theme *Recovering–Self* was identified as a surprising finding; by act of journaling, it is obvious that the researcher did not expect recovering, to be part of the lived experience. The researcher was frustrated with the institution when dealing with nursing students with mental health concerns however did not expect the nursing students to be recovering despite the institution and other external forces.

Limitation of IPA. Sampling in IPA is purposeful and requires the researcher to recruit participants who can provide a meaningful perspective on the phenomenon of interest (Larkin 2103). In this study, twelve students met the requirements of having lived experience with mental health concerns. Striving for homogeneity is imperative for IPA inquiry (Crist and Tanner, 2003) and at the onset of the study the homogeneity strived for was being a university student in a nursing program who describes themselves as having a mental health concern. However, future research could further develop homogeneity. For example eleven participants were women, a future study could require only women as some literature, particularly critical literature, speaks to how women experience mental health concerns and related therapy differently than men (Reimer and Ste. Marie, 2010; Tillaart et al, 2009). Year of study could also influence what emerged from the data. It was clear in this study that students who were in either third or fourth year of their baccalaureate spoke more to the *Recovering–Self* and seeing themselves as becoming a gifted person and nurse. This leads the researcher to question the role of years of study in determining homogeneity, although in this study most nursing students were

not freshman (only 2), their experience could have been different later in their studies and possibly more similar to the other participants.

Smith et al (2009) suggest that at the PHD level four and ten cases is sufficient to develop meaningful points of similarity and difference (p. 59). This study supports Smith's claims that less may be better, in that 12 participants produced an immense volume of data which required months of analysis and resulted in a lengthy dissertation. However, I was touched by how many students came forward in two-weeks and how important it was for each of them to speak to their experience. Their stories were rich in data. Their stories described many similarities and few differences that surfaced as themes, categories, and subcategories. Granted the methodology does not allow for generalization however transferability, which allows for understanding in a given context (Larkin, 2013) was possible.

Another limitation of the methodology was the concern of mixing phenomenological tenants with critical theory. Although some authors claim that the two philosophical perspectives are at odds (Shriner, 1982), this study came to the conclusion that the two perspectives could complement each other in the context of a study that wished to explore the lived experience of nursing students with mental health concerns (Dreyfus, 2003, Sawicki, 2003; Wyschogrod, 2003). The lived experience of mental health concerns could not be as fully understood without a critical lens that brings to light the influence of the *psy* complex, stigma and the corporate university.

6.6 Implications of Results for Education of Nursing Students

The results of this study have implications both on how we educate nursing students with or without mental health concerns, and how we understand the context in which faculty teach nursing students namely in the corporate university (Berg, Huijbens and Larsen 2016; Hawkins,

Manzi and Ojeda, 2014; Myrick 2004; Rolfe, 2013;). Peake and Mullings (2016) claim that although the literature speaks to the rising number of students with mental health concerns, almost no studies explore the relationship between the changing post-secondary environment and the increasing number of student experiencing emotional distress. In the rich data obtain from the IPA methodology; it became apparent that the context in which faculty, administrators and students find themselves might also contribute to how nursing student live their experience with mental health concerns. Universities are becoming increasingly commercial, business oriented, profit-making entities (Polster and Newson, 2015). In this environment, the students are pressured to achieve high grades leading to damaging tendencies for perfection (University of Pennsylvania, 2015), competition, individualization, and rising tuition costs (Peake and Mullings, 2015). It is alleged that the corporate university ethos of individuality, competition and measurements of norms and standards of productivity result in overwhelming feeling of inadequacy and isolation experienced by students. As *Concerned-Selves*, many of the students in this study elements of such an experience. Implications of these findings would lead this researcher to underscore the importance of developing the nursing students' sense of belonging to counter the loneliness inherent in the corporate university. Small learning groups that nurture belonging as opposed to large classes where students feel like number are essential to mitigate the corporate ethos that can be destructive to nursing student mental health. Based on this study's findings and the work of others (MacKean, 2011) creating this sense of belonging is paramount and has the most benefit in the early years of a post-secondary program. Therefore, curriculum design should insure that teaching in small groups occurs early in the curriculum.

In addition, faculty and administrators need to understand that high stake, high pressure learning contributes negatively to mental health and well-being of nursing students. There is a

need to explore other means of evaluating competency. There is a need to revisit the practice of using grades to select clinical placements or other choice learning experience needs as this practice fuels the drive for perfectionism a contributing factor of mental health concerns

Recovering needs to be emphasis in the nursing program. Presently many nursing curricula do not speak to recovery and the most current texts used to support nursing baccalaureate education in Canada do not mention recovery or issues related to student mental health and self-care. Unless faculty bring these concepts to the forefront early in the university program, students with mental health concerns will not have their lived experience validated.

More emphasis on mental health courses with more course hours demonstrates that mental health is as valued as physical health. Also having the mental health course presented earlier in the curriculum will give students language to describe their lived experience. Early exposure to mental health content will give knowledge to begin to understand their experience, providing faculty use a variety of models not just the bio-medical/ *psy* modules to teach mental health nursing. Faculty being mindful to teach mental health from a holistic framework that includes critical perspectives and an understanding of recovery, not merely from the dominant discourse, the bio-medical *psy* perspective that propagates the belief that mental illness is the fault of the individual. Nursing curriculum needs to introduce the concept of recovery if the *psy* complex and its agenda are to be counter-balanced. Recovery promotes critical literacy so that nurses can appreciate their role in bringing hope to others and themselves (McAllister, 2008). Barker and Buchanan (2011), as nursing educators, state that nursing needs to claim and develop the concept of recovery in the university and those in the process of recovering must be critical of how others with power come to refer to recovery.

Teach faculty that mental health concerns are often a reaction to stress imposed by the institution itself. That mental health concerns can arise from toxic environments and that the university can be a toxic environment. Teach faculty the importance of critically appraising the corporate university agenda, and its effect on student mental well-being. In doing so, they will contribute to creating environments that supports mental well-being. Faculty will come to understand that the perceived mental health crisis in the university is more complex than simply assigning *psy* labels to students' experiences. How curricula are designed, and how services are accessed play a crucial role in the well-being of students.

A final implication for nursing education is the significant role that those in recovery could play in nursing education. According to this research project and current literature, nurses who have lived experience with mental illness and are in recovery, yet they seldom disclose their experience for fear of stigmatization (Joyce et al, 2012; Tei-Tominaga et al, 2014), Educators need to be at the forefront of dispelling nursing myths in order to address stigmatization. Encouraging discussions about the stigmatization of nurses with mental health concerns, sharing the stories of nurses who are recovering and by understanding the lived experience of nurses with mental health concerns are first steps in dispelling these detrimental nursing myths. Nurses in academia and front line practice, need to demonstrate an acceptance and understanding towards nurses with mental health concerns, seeing their strengths, which may include, according to the findings in this study, being empathetic and empowering.

6.7 Implications of Results for Professional Nursing Practice

The study has several implications for nursing practice. The first relates to what is considered professional practice and nursing myths that foster stigma and mental health concerns in practicing nurses and in nursing students. The second relates to the need for the nursing

profession to develop a critical perspective on the pervasive *psy* complex. This lack of a critical perspective affects nursing care and impedes recovering.

Competency as defined by the Nursing Regulatory Body left much room for interpretation by nurses, faculty, and student nurses and led to nursing myths such as self-care, could and would be sacrificed by the ‘good nurse’ for the care of others; and the ‘good nurse’ is emotionally strong and cannot have mental health concerns. These myths are destructive to mental well-*being* and impede recovering and must be called out and dispelled through research. Every practicing nurse uses knowledge to empower those in their care, to promote mental and physical well-being and to not pre-judge and stigmatize. However, this study shows that the nursing profession has much work to do to create a professional body that does for its members what it expects and holds as requirement for its members to do for those in nursing care. In the words of one of the participants in this study “we have a problem with nursing (...), by expecting our nurses to be superhuman when they are people too you know”, Mary, 493-495. The absence of genuine discourse regarding and understanding of the lived experience of nurses with mental health concerns substantiates current myths and stigma. A second implication for the nursing profession is the need to promote recovery oriented practice environments and education. For example, nurses did not encourage students to take care of themselves; rather they often modeled nurses being self-sacrificing. Nurses must welcome the needed ‘talking’ that most students said was invaluable in their recovering; currently many remain silent. Nurses must help students understand their experience, just as they do when caring for others. Speaking freely about mental health will help student nurses to normalize their experience, and find commonness in their experience; rather than feel ostracized from the profession. Leigghio (2013, p. 127) writes that restoring a person’s epistemic existence requires conscious acts that construct, support, and give

legitimacy to the person as someone with legitimate ways of knowing and ultimately, legitimate ways of *being*. The nursing profession as understood by nursing students in this study denies that those with mental health concerns have legitimate ways of knowing and *being*. All nurses, be they in practice or educator, have a role to play in legitimizing and learning from the lived experience of nurses and nursing students with mental health concerns.

6.8 Implications of Results for Future Research

This study is a first to explore the lived experience of nursing students with mental health concerns using IPA and knowledge gained, discussed earlier in this chapter, will serve the nursing profession and nursing education. However, many more questions arise out of the findings that warrant further research. Comparing the lived experience of practicing nurses with mental health concerns to nursing students with mental health would be of interest in trying to understand how professionalism plays into the experience. Current research speaks to stigmatization and fear of disclosure however; it does not explore how corporatization might also contribute to how practicing nurses experience their lived experience with mental health concerns.

Recovering was a significant theme in this study that warrants more research. Exploring how belonging, finding commonness and normalization favour recovering could be beneficial in developing strategies that nursing programs could implement to favour mental well-being among students. Other research questions include exploring the role of maturation in this recovering experience and how this could serve in countering dominate discourses of the *psy complex*. Does maturation have a role to play in the lived experience of nursing students with mental health concerns that might explain some of the challenges students' experience that led them to seek *psy* intervention?

Investigating this need to restore a person's epistemic existence and give legitimacy to the person as someone with legitimate ways of knowing and ultimately, legitimate ways of being (Leigghio, 2013, p. 127) could be a means of understanding this 'becoming' a gifted person and nurse that the nursing students in this study described. This phenomenon of becoming someone with a unique talent because of a mental health concern is worthy of continue exploration as it could lead to mitigating stigma that is rampant, according to the students in this study, in the nursing profession as well as a better understanding of recovering and possibly empathy.

CHAPTER SEVEN

CONCLUSION

“On my path to recovery, something happened, something that was anchored in trusting another human being with my story. Mental health’s best friend is community and tribe. Its enemy is isolation and loneliness”

Sophie Gregoire Trudeau, Ottawa, September 2016

There is no denying there is pressing need to understand the lived experience of students lived experience with mental health concerns. As I am writing this conclusion the ACHA NCHA II Spring 2016 report reveals that over 60% of the Canadian College and University student experience overwhelming anxiety where in 2013 some 56% of the students did. This report yet again claims that the numbers of students struggling with mental health concerns continues to rise, yet it provides little understanding of what it is to *be* students with mental health concerns within the university. Research that has an appreciation of the stresses inherent to student life and how the university, rife with socio-political and economic realities, influences mental *well-being*, continues to be rare. This research project has added to the literature by adding a critical lens to the lived experience of students with mental health concerns within the corporate university. This research project has discovered that some nursing students come to university as students who are recovering from mental health concerns. It also showed that socio, political and economic realities associated with the corporatization of post-secondary education, can threaten mental well-being and recovering as experienced by nursing students. The research also showed that nursing students understand their experience with mental health concerns more as a product of maturation, *psy* context and the corporate institution then as a *psy* illness. Current research focuses on substantiating the need for more *psy* interventions on campuses however this research does not see a need for more *psy* interventions but rather substantiates the need for fostering

connectedness and belonging or what Trudeau –Gregoire would call finding a “community and tribe” to mitigate mental health concerns. Belonging is the antidote for isolation, which is at the heart of what hinders mental well-being and recovering among nursing students. This study has contributed to the literature that supports the claim that corporatization of education, makes university campuses places that threaten mental well-being, by hindering human connection, where students are numbers, channeled efficiently to reach an endpoint; the standardized educational experience they have purchased. Furthermore, nursing students experiences the consequences of insurance policies and nursing professional standards seeped in *psy* culture, which foster stigma and regulate behavior that further threaten nursing student mental well-being and recovering. Finding means and ways to address the mental health concerns of nursing students requires attending to the contexts in which students find themselves and the forces that shape their lived experience. The forces inherent to the contexts that condemn them to being mentally ill as per the *psy* complex, rather than understanding them as being in recovery. Returning to Menninger’s analogy presented at the onset of this thesis; this research has opened the door to exploring the pond, be it the corporate university, or in the arena of professional nursing practice, and how the pond comes to shape how nursing students with mental health concerns understand their experience. The research moves beyond the focus on the struggling of those with mental health concerns “that the world sees and it usually misunderstands” (Menninger, 1930) to gaining an understanding of the how nursing students with mental health concerns master their difficulties, come to recovering and become a ‘gifted’ nurse.

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Appendix A

Interview Guide

The following are the proposed interview questions designed to assist in exploring the area of concern: the lived experience of a post-secondary student with mental health concerns. Interpretative Phenomenological Analysis as a methodology uses first tier questions to explore a given phenomenon and second tier question to assist with theoretical analysis. It is important to stress that these second tier questions do not test theory but rather engage with theory to the extent that theory might help a person make sense of their experience (Smith et al. 2009).

The first nine questions are first tier questions. The last three are second tier questions.

1. How would you describe yourself as a nursing student?
2. Can you tell me, in your own words, what your mental health concern is? Prompts: What do you experience? What happens in a typical day? How do you feel? How do you cope?
3. Can you describe to me what it is like to be a student in a post-secondary institution and have your mental health concern? Prompts: What is your experience? What happens in a typical day? How do you feel? What are your challenges? How do you cope?
4. Can you describe to me how your mental health concern affects your student life? Prompts: Affects your performance as a student? Affects your interactions/relations with faculty/administrators, support services? Affects your interactions/relations with peers?
5. Can you share with me your understanding of mental health and illness as it is reflected in your community, both where you live and where you study? Prompts: What do you think your family thinks, your peers think, your university faculty, administrators, support staff think regarding mental health and illness.

6. Does what others believe affect your experience as a nursing student with mental health concerns. If so how? If not why not?
7. Can you tell me how classroom experiences help or hinder (protect or threaten) your mental wellbeing? Can you give examples of help and hindrances?
8. Can you tell me how clinical experiences help or hinder (protect or threaten) your mental wellbeing? Can you give me examples?
9. Can you tell me how university experiences (interactions with faculty, administrators, support services or otherwise) help or hinder (protect or threaten) your mental wellbeing? Can you give examples of help and hindrances?
10. Do you believe that institutional policies, procedures and technologies help or hinder your mental well-being? Please elaborate on your thinking, how you have come to this belief.
11. What do you understand of mental health and illness movements, frameworks or philosophies of care for example mental health/illness survivor, resilience, the role of psychopharmacology and therapy and the therapist? Please describe your understanding and how any of the aforementioned, might or might, not contribute to your lived experience as a nursing student with mental health concerns.
12. Do you believe that social, economic or political realities affect you lived experience as a nursing student with mental health concerns? If so how? Please elaborate.



Appendix B

Université d'Ottawa University of Ottawa

Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Certificate of Ethics Approval

Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

First Name	Last Name	Affiliation	Role
Dave	Holmes	Health Sciences / Nursing	Supervisor
Carmen	Hust	Health Sciences / Nursing	Student Researcher

File Number: H01-15-01

Type of Project: PhD Thesis

Title: Institutionalized Anxiety: Exploring the Lived Experience of Nursing Students with Mental Health Concerns

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
03/27/2015	03/26/2016	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:

N/A

Université d'Ottawa University of Ottawa

Bureau d'éthique et d'intégrité de la recherche

Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

If you have any questions, please do not hesitate to contact the Ethics Office or by e-mail at: ethics@uOttawa.ca.

Protocol Officer for Ethics in Research

For Daniel Lagarec, Chair of the Sciences and Health Sciences REB



Université d'Ottawa
 Faculté des sciences
 de la santé
 École des sciences infirmières
 University of Ottawa
 Faculty of Health Sciences
 School of Nursing

Appendix C

Participant Informed Consent Form

Title: Institutionalized Anxiety: The lived Experience of Nursing Students with Mental Health Concerns

Thesis Supervisor:

Principal Investigator:

Participation in the research study is voluntary. Please read this Information Sheet and Consent Form carefully before you decide if you would like to participate. Ask as many questions as you like.

Request to participate

You are being asked to participate in this research study because you are a nursing student in a Baccalaureate degree program who would describe yourself as having a mental health concern. A mental health concern is something that affects your mood, thinking and behaviour and may or may not challenge your post-secondary experience. . Students, who self-identify as having mental health concerns, are invited to participate in this study as well as students who may have a diagnosed mental illness that affects their mood, thinking or behaviour. . .

Purpose of the Study

The purpose of this study is to understand the lived experience of nursing students with mental health concerns. It is hoped that by participation in this study you will be given an opportunity to tell you story and that the information gained will help students like yourself, faculty, administrator and support service provides to develop services and inform policies for students' nursing or otherwise with mental health concerns.

Participation

If you agree to participate you will be asked to participate in an interview, of no longer than 60 minutes, to talk and answer questions about your experience as a university student in a nursing baccalaureate program who has mental health concerns. With you consent your responses to questions in the interview will be audio-recorded and transcribed for analysis. The interview will take place at a time and place convenient to you. You will be invited to participate in a 30 minute follow up meeting to review your transcript.

613-562-5473
 613-562-5443

451 Smyth
 Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

Please indicate if you consent to having the interview audio-recorded:

- I consent to having the interview audio-recorded
 I **do not** consent to having the interview audio recorded

Risks

Your participation in this study will entail that you volunteer personal information, and this may cause you to feel somewhat vulnerable. The researcher assures you that every effort will be made to minimize these risks by ensuring that all information you provide will be kept confidential and will not affect your performance as a student. Be assured that the researcher has no influence over your academic performance or results.

There is a risk that as you explore your lived experience as a student with mental health concerns it may trigger psychological discomfort or even distress. If you experience psychological discomfort you will be referred to the University of Ottawa Counselling services. If you are psychologically distressed and this leads you to have desire to self-harm or harm another you will be escorted to the Ottawa General Hospital for mental health care.

Please note that as per the Personal Health Information Protection Act (PHIPA) and the Office of the Information and Privacy Commissioner for Ontario the researcher will be required to disclose personal health information if during the interview you make known that you are at risk of serious self-induced bodily harm or of committing harm to another person or the public.

Benefits of the Study

Your participation in this study will help the researchers to gain understanding of what it is like to be a nursing student with mental health concerns. The research findings may contribute in helping you and other nursing students with mental health concerns: be better understood by peers, faculty, administrators and support services. The research finding may also help you, and the researcher understand your experience in light of social, economic and political realities at play in the university you are attending. It is hoped that findings from the study will assist in developing policies and services for students mental health concerns in post-secondary institutions.

Do I have to participate? What alternatives do I have? If I agree now, can I change my mind and withdraw later?

Your participation in this study is voluntary. The alternative to this study is not to participate.

You may decide not to be in this study, or to be in the study now, and then change your mind later. There will be no negative consequence for not participating or from withdrawing from the study at any time.

If you withdraw your consent, your personal information will no longer be collected and all information you have already provided will be removed from the research project and destroyed.

Will I be paid for my participation or will there be any additional costs to me?

No you will not be paid for participation in this study.

Confidentiality

- All information collected during your participation in this study will be identified with a pseudonym that you will determine, and will not contain information that identifies you, such as your name, address, etc.
- The link between your pseudonym and your name and contact information will be stored securely and separate from your study records, and will not leave this campus.
- Any documents leaving the University of Ottawa will contain only your pseudonym. This includes publications or presentations resulting from this study.
- Information that identifies you will be released only if it is required by law.
- For audit purposes only, your original study records may be reviewed under the supervision of Dr. Dave Holmes, the thesis supervisor
- Research records will be kept 5 years, after this time they will be destroyed.
- The thesis student's (Carmen Hust) and supervisor are the only people to have access to the research data that is collected in this study.

Voluntary Participation

You are under no obligation to participate. If you choose to participate, you may withdraw from the study at any time without suffering any adverse consequences related to your status as a student. If you do choose to withdraw from the study, you will get to decide if your data will be used in this research project.

Who do I contact if I have any further questions?

If you have any questions about this study, please contact ----- at -----or email at -----

The University of Ottawa Research Ethics Board has reviewed this protocol. The board considers the ethical aspects of all research students at the University of Ottawa. If you have any questions about your rights as a study participant, you may contact the office at:

Office of Research Ethics

Tabaret Hall
 550 Cumberland St
 Room 154
 Ottawa, ON, Canada
 K1N 6N5
 Tel.: (613) 562-5387
 Fax.: (613) 562-5338
ethics@uottawa.ca



uOttawa

Consent Form**Institutionalized Anxiety: The lived Experience of Nursing Students with Mental Health Concerns**

Université d'Ottawa

Faculté des sciences
de la santé

École des sciences infirmières

University of Ottawa

Faculty of Health Sciences

School of Nursing

Consent to Participate in Research

- I understand that I am being asked to participate in a research study about the lived experience of nursing students' with mental health concerns.
- This study was explained to me by -----.
- I have read, or have had it read to me, each page of this Participant Informed Consent Form.
- All of my questions have been answered to my satisfaction.
- If I decide later that I would like to withdraw my participation and/or consent from the study, I can do so at any time.
- I voluntarily agree to participate in this study.
- I will be given a copy of this signed Participant Informed Consent Form.

Signatures

Participant's Name (Please print.)

Participant's Signature

Date

Investigator Statement

I carefully explained to the research participant the nature of the above research study. To the best of my knowledge, the research participant signing this consent form understands the nature, demands, risks and benefits involved in participating in this study.

Name of Investigator (Please print.)

Signature of Investigator

Date

☎ 613-562-5473

📠 613-562-5443

451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca**Consent Form**



Université d'Ottawa
 Faculté des sciences
 de la santé
 École des sciences infirmières
 University of Ottawa
 Faculty of Health Sciences
 School of Nursing

Appendix D

Formulaire de consentement

L'anxiété institutionnalisée : L'expérience vécue d'étudiant-es en sciences infirmières avec des préoccupations de santé mentale

Directeur de thèse :

Chercheuse principale :

Votre participation à cette étude est volontaire. Veuillez lire attentivement le présent document avant de décider si vous désirez y participer. Vous pouvez poser autant de questions que vous le voulez.

Demande de participation

Nous vous demandons si vous désirez participer à cette étude parce que vous êtes inscrit-e à un programme de baccalauréat en sciences infirmières et vous vous décriez comme ayant des préoccupations de santé mentale. Une préoccupation de santé mentale signifie une condition qui a une influence sur votre humeur, vos pensées et votre comportement et qui peut rendre plus difficile votre expérience de formation secondaire ou pas. Les étudiant-es qui s'identifient comme ayant des préoccupations en santé mentale, ainsi que ceux et celles ayant reçu un diagnostic de maladie mentale ou de dépendance, sont invité-es à participer à cette étude.

Objectif de la recherche

L'objectif de cette recherche est de comprendre l'expérience vécue d'étudiants en sciences infirmières avec des préoccupations de santé mentale. Nous espérons que votre participation à cette étude vous permettra de parler de vos expériences et que les informations recueillies aideront les étudiant-es comme vous, le corps professoral, le personnel administratif et les fournisseurs de services de soutien à comprendre vos expériences et élaborer des services tout en informant les politiques sur les étudiant-es, en sciences infirmières ou autres disciplines, avec des préoccupations de santé mentale.

☎ 613-562-5473

📠 613-562-5443

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www.uOttawa.ca

Bienfaits

En participant à cette étude, vous aiderez la chercheuse à mieux comprendre l'expérience des étudiant-es en sciences infirmières avec des préoccupations de santé mentale. Les résultats de cette recherche pourraient contribuer à ce que vous et d'autres étudiant-es en sciences infirmières avec des préoccupations de santé mentale puissent être mieux compris-es par vos collègues, le corps professoral, le personnel administratif et les services de soutien. Les conclusions de recherche pourraient également permettre à vous et à la chercheuse de comprendre vos expériences dans le contexte des réalités sociales, économiques et politiques de l'université à laquelle vous assistez. Nous espérons que les résultats de cette étude contribueront à l'élaboration de politiques et de services offerts aux étudiant-es avec des préoccupations de santé mentale dans les établissements postsecondaires.

Dois-je participer? Quelles sont mes options? Si je consens maintenant, puis-je changer d'avis et me retirer par la suite?

Votre participation à cette étude est volontaire. Vous avez l'option de ne pas y participer.

Vous pouvez décider de ne pas participer à cette étude ou d'y participer maintenant et de changer d'avis plus tard. Ne pas participer à l'étude ou vous en retirer à tout moment n'entraînera aucune conséquence négative pour vous.

Si vous retirez votre consentement, vos renseignements personnels ne seront plus recueillis et toute information fournie jusqu'au moment où vous vous êtes retiré-e sera supprimée de l'étude et détruite.

Serai-je compensé-e financièrement pour ma participation? Y a-t-il des coûts associés à ma participation?

Vous ne recevrez aucune compensation financière pour votre participation. Aucun coût supplémentaire lié à votre participation à cette étude n'est prévu.

Confidentialité

- Tout renseignement recueilli au cours de votre participation à cette étude sera associé à un pseudonyme de votre choix; aucun renseignement pouvant servir à vous identifier, comme votre nom, adresse, etc., ne sera inclus.
- L'association entre votre pseudonyme et votre nom et vos coordonnées sera enregistrée, en lieu sûr, dans un dossier sans lien à votre dossier scolaire qui demeurera toujours sur le campus.
- Tout document transporté à l'extérieur du campus de l'Université d'Ottawa ne portera que votre pseudonyme. Cela s'applique aux publications et aux conférences basées sur cette étude.
- Aucun renseignement vous identifiant ne sera dévoilé, sauf si la loi l'exige.
- Aux fins de vérification seulement, votre dossier scolaire original peut être consulté sous la supervision de Dave Holmes, directeur de cette thèse.
- Les données de recherche seront entreposées pendant 5 ans, après quoi elles seront détruites.
- L'étudiante menant cette recherche (Carmen Hust) et le directeur sont les seules personnes ayant accès aux données de recherche recueillies pendant cette étude.

Participation volontaire

Votre participation n'est aucunement obligatoire. Si vous décidez d'y participer, vous pouvez vous retirer de l'étude à tout moment sans engendrer aucune conséquence négative pour votre statut d'étudiant-e. Si vous décidez de vous retirer de l'étude, vous pouvez décider si vos données seront incluses dans l'étude ou pas.

Avec qui devrais-je communiquer si j'ai d'autres questions?

Pour toute question au sujet de cette étude, veuillez communiquer avec ----- au -----, ou par courriel à l'adresse suivante : -----

Ce protocole a été révisé par le Conseil d'éthique en recherche de l'Université d'Ottawa. Ce conseil évalue la dimension éthique de toute recherche menée par les étudiant-es de l'Université d'Ottawa.

Pour toute question liée à vos droits en tant que participant-e à cette étude, veuillez communiquer avec nos bureaux aux coordonnées suivantes :

Bureau d'éthique et d'intégrité de la recherche

Pavillon Tabaret
550, rue Cumberland
Pièce 154
Ottawa (ON) Canada
K1N 6N5
Tél. : (613) 562-5387
Télec. : (613) 562-5338
ethics@uottawa.ca



uOttawa

Formulaire de consentement

Université d'Ottawa

Faculté des sciences
de la santé

École des sciences infirmières

University of Ottawa

Faculty of Health Sciences

School of Nursing

L'anxiété institutionnalisée : L'expérience vécue d'étudiant-es en sciences infirmières avec des préoccupations de santé mentale

Consentement à la participation à la recherche

- Je comprends qu'on me demande de participer à une recherche sur l'expérience vécue d'étudiant-es en sciences infirmières avec des préoccupations de santé mentale.
- ----- m'a expliqué en quoi consiste cette étude.
- J'ai pris connaissance de chacune des pages de ce formulaire de consentement à l'intention du/de la participant-e.
- Toutes mes questions ont été répondues de manière satisfaisante.
- Si je décide au cours de l'étude que je ne désire plus participer ou que je veux retirer mon consentement, il me sera possible de le faire en tout temps.
- Je consens volontairement à participer à cette étude.
- Je recevrai une copie signée de ce formulaire de consentement.

Signatures

Nom du/de la participant-e

(lettres d'imprimerie)

Signature du/de la participant-e

Date

Énoncé de la chercheuse

J'ai expliqué soigneusement au/à la participant-e en quoi consiste cette étude. Au mieux de mes connaissances, le/la participant-e dont la signature est apposée ci-dessus reconnaît la nature, les exigences, les risques et les bienfaits associés à sa participation à cette étude.

Nom de la chercheuse

(lettres d'imprimerie)

Signature de la chercheuse

Date

☎ 613-562-5473

📠 613-562-5443

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Appendix E

Are you a nursing student who struggles with mental health concerns, mental illness and or addiction?

We are interested in learning more about your experience and hope you will consider participating in a qualitative research study.

Purpose of the Study

The purpose of this study is to understand the lived experience of nursing students with mental health concerns, mental illness and or addiction who are enrolled in the BScN at the University of Ottawa.

Participation

If you agree to participate you will be asked to participate in an interview, of no longer than 60 minutes, where you will be invited to talk, and answer questions about your experience as a university student at the university of Ottawa in a nursing baccalaureate program.

**If you are interested in participating
or have any further questions please contact:**

Appendix F

Êtes-vous étudiant-e en sciences infirmières? Êtes-vous aux prises avec des préoccupations de santé mentale, une maladie mentale ou une dépendance?

Nous aimerions mieux connaître vos expériences et espérons que vous serez intéressé-e à participer à une recherche qualitative.

Objectif de la recherche

L'objectif de cette recherche est de comprendre l'expérience vécue d'étudiant-es en sciences infirmières avec des préoccupations de santé mentale, des maladies mentales ou des dépendances.

Participation

Si vous acceptez de participer à cette étude, nous vous demanderons de participer à une entrevue d'un maximum de 60 minutes pendant laquelle nous vous inviterons à parler et à répondre à des questions sur votre expérience d'étudiant-e avec des préoccupations de santé mentale qui est inscrit-e au programme de baccalauréat en sciences infirmières à l'Université d'Ottawa.

**Si vous aimeriez participer
pour plus de renseignements,
veuillez communiquer avec**