Perceptions and Experiences of Self-Care Among Students with Mental Health Struggles

by

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ABSTRACT

PERCEPTIONS AND EXPERIENCES OF SELF-CARE AMONG STUDENTS WITH MENTAL HEALTH STRUGGLES

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In this thesis, I explore self-care as a useful and noteworthy configuration of care among students with mental health struggles at the University of Guelph. Self-care practices are diverse and fluctuating in nature, addressing the context-dependent wellness needs of students. I demonstrate that self-initiation is an important component of effective self-care, which challenges hegemonic medical models and underscores students’ experiential health expertise. By integrating a critical disability studies perspective, I highlight the systemic, structural barriers that complicate students’ access to self-administered care, including the inconsistent provision of academic accommodations, normalized pressures of uninterrupted productivity, and overwhelming responsibilities at a difficult transitional period in the life course. I argue that self-care is an agentic act performed by post-secondary students despite and in spite of institutional challenges they face as both students and patients.
DEDICATION

To Dr. O’Brien.
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To the students who lent their voices to this project, thank you for sharing your stories of struggle and resilience with me. Your openness and honesty will continue to inspire. Thank you to Wellness Services at the University of Guelph for believing in my project and facilitating my introduction to these impressive students.

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CHAPTER 1: Reconfiguring Models of Campus Care

“You hardly see me in the sun,
My sparkle’s in the stars.
When all is dark around you,
I’m the memory of light.

- Francisco X. Stork, The Memory of Light

Students with mental health struggles are exploring new models of care on Canadian campuses, which have become sites of psychiatric disturbance where adversity and resilience are playing out in equal measure. In this thesis, I provide a nuanced account of self-care that focuses on the narratives and subjective experiences of twenty-one students with mental health struggles seeking professional care at the University of Guelph. In doing so, I have prioritized the voices of students with lived mental health experiences as a source of useful knowledge that enhances their fortitude and promotes their health expertise. This focus is all the more important given the current mental health crisis on campuses. According to a report from The Ontario Undergraduate Student Alliance, Colleges Ontario, The College Student Alliance, and The Council of Ontario Universities, which speaks for forty-five of Ontario’s colleges and universities, campus mental health is one of the most urgent issues that Ontarian educational institutions are currently facing (COOU 2017). Health care providers on campuses across the country are witnessing an influx of students struggling with their psychological wellness in rates never before seen, with issues increasing both in number and severity (Kitzrow 2009). Campus care services resultanty have difficulty keeping up with students’ wellness needs (Kitzrow 2009; Goffin 2017). More than ever, there is a need to understand the experiences of these students as they navigate various care systems, including in terms of self-administered care. While previous ethnographic studies have considered the role of self-care in the management of diabetes and weight-related illnesses among Turkish migrants (Guell 2012), Mexican Americans (Hunt et al 2001; Seligman et al. 2015), and Guatemalans (Yates-Doerr 2012), as well as in the case of ageing populations in
Russia (Chudakova 2017), and South Asian women experiencing marital distress (Snell-Rood 2015), a considerable gap exists in the anthropological literature when it comes to the consideration of self-care in mental illness, especially in the case of students who live with unique needs. Given that the discipline of anthropology has historically laid its foundational bricks using the culture concept, Janis Jenkins is astute to point out that, “persons with mental illness have been regarded as somehow lacking culture, treated sometimes as footnotes but seldom the primary subjects for ethnographies” (2015, 3). My research will treat students with mental health issues not as footnotes but as protagonists of their own experiences, highlighting their perceptions of and experiences with self-administered forms of care.

Research Goals and Questions

Inauguration into university life can mark a stressful period of adjustment and separation for many students (Nathan 2006; Blum 2010), especially for students with disabilities\(^1\) (Brinckerhoff 1996; Sitlington 2003; Ginsburg and Rapp 2013). The presence of mental health difficulties in conjunction with the already pressure-intensive nature of university life can further complicate and compromise student wellbeing. In this thesis, I argue that self-care is an important configuration of care that can enhance student mental health by flexibly and holistically addressing their psychiatric, social, and emotional worlds. In addition to managing their role as students, university-goers with mental health difficulties seeking professional care must simultaneously occupy the role of patient. As students continuously negotiate their responsibilities as both students and patients, they must navigate the conflicting demand imposed upon them by each role while also responding to structural barriers that complicate their access

\(^1\) Following the North American convention, I refer to individuals and communities living with impairments as people with disabilities rather than disabled people. This decision was also made to align the vocabulary of my research with the language used by my participants.
to care. My results demonstrate that reconciling their academic role (where students are normatively expected to have the capacity to be persistently productive) with their role as patients (where they are expected to prioritize clinical recovery above all else) leaves students in a precarious position where acts of self-care can have real consequences or real benefits when employed strategically. I argue that self-care practices are agentic acts performed *despite* and *in spite* of normalizing forces that systemically limit students’ ability to care for themselves.

While clinicians are typically perceived as the gatekeepers of mental health knowledge and treatment (Kleinman 2013), my research complicates the patient-physician distinction by highlighting the importance of agency in the lives of students as they care for themselves in various ways. I will demonstrate the importance of self-initiation on the part of student-patients as they take care of themselves. As such, a key research goal in this project is to examine the relationship between self-care and agency in post-secondary students with mental health struggles who have engaged with various forms of care, including clinical and self-administered. In order to understand the dynamics of students as actors capable of participating in their own wellbeing, I address the following questions through an investigation of their subjective experiences: *What are the self-care activities, practices, and ways of thinking adopted by students with mental health struggles that contribute to their overall wellness? How do these self-care practices work to effectively address the psychiatric wellness needs of students? And finally, what is the relationship between self-care and agency among students who identify as living with mental health struggles during their university studies?*

**Central Concepts and New Modes of Care**

While many conceptualizations of self-care exist, including the definition of self-care as personal health management outside of the clinical context (Seligman et al. 2015), the notion that
self-care involves the use of clinical therapies and alternative medicines in an at-home environment (Chudakova 2017), and power-based theorizing that frames self-care as an ethical obligation (Foucault 1990), I use participant perspectives to develop a definition of self-care that is personally meaningful to them. I have learned that for students at the University of Guelph, self-care involves practices that a person wants, rather than needs to do, that are not harmful in nature, and which result in the maintenance or improvement of personal health and wellbeing. The focus on self-care in this research was informed by Mol, Moser, and Pols’ notion of care as “everyday tinkering” (2010) as well as Seligman, Mendenhall, Valdovinos, Fernandez, and Jacobs’ concept of “hybrid self-care” (2015). These perspectives give insight into the complex, ever-shifting, socioemotional nature of self-care that shapes how and why people engage with it. Likewise, I demonstrate that my participants tinker with and explore different forms of self-care that are embodied, social, individualistic, communal, quotidian, and often a hybrid combination of the above. The forms of self-care that help students manage their mental health are context-dependent and will adjust according to a student’s in-the-moment needs.

This model of care diverges from clinical perspectives on self-care that place undue emphasis on compliance and individual responsibility (Ferzacca 2000; Seligman et al 2015). When self-care strategies were prescribed as clinical therapies to my participants, the lack of agency on the part of students rendered these forms of care ineffective. Self-initiation as an essential feature of self-care points to the importance of students as agents embedded within complex social relations of power. Sherry Ortner’s theorizing on agency (2001; 2006), which speaks to peoples’ ability to seek control and exert active influence over their lives, and which I will elaborate on in Chapter 5, is central to the experiences of students with mental health struggles. In this study, I emphasize agency to demonstrate that students with mental health
struggles are not passive recipients of care but instead are experts of their own experiences with intuitive knowledge about how to manage their wellbeing in empowering ways through self-care. By seeking agency through self-care, students challenge marginalizing assumptions about post-secondary students living with mental illness and demonstrate a new norm of neurodiversity² and resilience. At the same time, my participants are not invariably able to assert themselves as agentic actors as there are many structural and institutional barriers they need to face as students with mental health struggles.

My emphasis on self-care is not to imply in any way that students should be held solely accountable for the management of their own mental health and wellness. Quite the opposite, addressing the current mental health crisis must be a multimodal project that involves the coordinated effort of agencies across the government, medical system, education, and the community. However, further understanding of self-care will provide insight into student perseverance, their capacity as agents, and help to provide alternatives to traditional biomedical care when professional support is limited. We know that nearly thirty percent of students in Ontario who needed social or professional help for a mental health issue in 2017 did not receive the assistance they needed because they did not know of or feel comfortable accessing any resources (OSDUS 2017). Resultantly, understanding self-administered care as an avenue to daily support while also trying to change the landscape of mental health is an important task. In light of the above, my research on the subjective experiences and self-care practices of students at a Canadian university is emergent in two ways. First, research on the subjective experiences of

² Neurodiversity, commonly discussed in the domain of autism spectrum disorders, promotes the embracement of variations in neurological (as well as biological and behavioral) normalcy and advocates for replacing shame-based perceptions of atypical development with “pride” and a push for inclusivity (Cascio 2012).
mental health have been gaining increasing sight in the literature, indicating a burgeoning interest in mental health literacy. Gone are the days of psychological inquiry being the exclusive ownership of psychology, psychiatry, and neurology. The study of disability has become an interdisciplinary ontological project, with diverse voices from the social sciences contributing to important conversations about health and illness (Kasnitz and Shuttleworth 1999). Anthropology offers a unique perspective by way of ethnographic methods and the inclusion of voices of the people with lived experiences. As awareness about the mental health crisis increases, social and medical anthropological research have been singled out as potentially influential domains.

Second, this research is emergent in that it focuses on a public issue that can be constituted as a categorical emergency. The campus mental health crisis can surely be deemed a public health emergency. What role can scholars play in addressing this crisis? It is pressing not only to seek out remedies for mental illness but also to better understand the social and cultural contexts of psychological distress as well as the experiences of the people who live with it.

To this effect, the findings of my study will explore the perceptions and subjective experiences of post-secondary students with mental health struggles at an Ontario university. A major theoretical contribution of my study is its addition to the growing body of anthropological literature on self-care that explores self-administered care as a new and noteworthy configuration of care. By including a discussion on self-administered care in mental health, which has previously been understudied in the anthropological literature, I diversify the available ethnographic accounts of self-care. I focus on university students as a community of interest with uniquely positioned needs to advance our existing knowledge of student wellness and to promote their experiential health expertise. After all, the significance of having students vocalize their needs and participate in educational reform (Goode 2007), especially among those with
impairments (Cook-Sather 2006), has been noted. My research also stimulates public contributions in its focus on student mental health as a public issue with the hopes that the crisis on Canadian campuses (and beyond) can be more sensitively and competently addressed. With the help of my findings, stakeholders within the university will have a greater understanding of student-patient experiences and will have the insight to more appropriately address their mental health needs. This can be achieved by acknowledging and reforming the structural barriers that currently complicate students’ access to care within the institution of higher education, including the normalized expectation of uninterrupted productivity, student experiences of academic accommodation seeking, and student stress.

This research takes a unique approach by investigating mental health from a positive, constructive point of view. By using a critical disability studies perspective in anthropology and focusing on agency as a key theoretical concept, a critique will be provided of the reliance upon biomedical frameworks and the tendency to focus on negative experiential attributes of disability, namely stigma, in the scholarly interpretation of mental health. The field of anthropology is well positioned to tackle this research due to its ability to address complex power inequalities, to reimagine the patient-physician relationship, and most of all to give voice to people with lived experiences.

**Outline of Chapters**

In Chapter 2, I review the literature that contextualizes this study. Perspectives on caregiving are currently dominated by biomedical models (Kleinman 2013), which often neglect to address the subjective experiences of the very patients whose care they are in control of (Aderson-Fye and Floersch 2011). Patients are expected to accept the authority of medical professionals by entering “the sick role” (Parsons 1951) and prioritizing recovery above all else.
While clinical perspectives on caregiving treat self-care as an issue of compliance (Wilson et al. 1986; Hunt et al. 2001; Seligman et al. 2015), anthropological perspectives challenge the idea that patients are passive recipients of professional care and that patients cannot functionally engage in their own caregiving (Guell 2012; Yates-Doerr 2012, 2014; Seligman et al. 2015; Snell-Rood 2015; Chudakova 2017). Sherry Ortner’s theorizing on agency (2001; 2006), which speaks to peoples’ ability to seek control and exert active influence over their lives, provides a framework for understanding some of the positive outcomes of self-care.

In Chapter 3, I review the field site and the methods used in my research. I provide a rationale for Canada as a research location and for the University of Guelph as a suitable participant community. Twenty-one semi-structured, qualitative interviews were conducted with students living with self-reported mental health struggles at the University of Guelph over the summer of 2017. Participants were recruited from campus wellness services where on-campus support and accommodations are provided to students in need. The interviews address their subjective experiences as students with mental health struggles as well as their use of self-care practices. While the participants lived with and managed a wide array of mental health struggles, each of them was connected through their use of self-care as a means to achieve agency.

In Chapter 4, I interpret my discussions with students to develop a definition of self-care that is personally relevant to the participants. According to them, self-care first involves focusing on desires rather than obligations, it also involves acts that are not harmful in nature, and finally has the expected outcome of mental health maintenance or improvement. While over seventy specific self-care practices were reported by the participants, they shared the commonality of being rooted in mind-body connectedness and founded upon self-initiation. Self-care practices that are clinically imposed are rendered ineffective because they do not take patient agency into
account and they discount the fluctuating nature of self-care. Self-care strategies adjust according to students’ ever changing wellness needs, which can shift on a moment to moment basis.

In Chapter 5, I discuss how self-care can be an agentic act practiced by students in the face of disempowering assumptions about mental illness. Students become experts of their own illnesses and pragmatically learn how to find adaptive ways to manage their wellbeing. In this way, they challenge the normalized narrative of the student-patient as less capable than their peers by demonstrating resilience and continuing to achieve as post-secondary students. Although students engage with self-care to achieve wellness, agentic control is not always an option. Students face several structural barriers that prevent the practice of self-care, including unaccommodating attitudes and practices within the university, pressures placed on students to progress through studies in a way that is normatively, consistently productive, as well as a lack of free time stemming from overloaded academic and personal responsibilities.

In Chapter 6, I conclude by summarizing my arguments and highlighting the significance of my research. This study contributes to the growing body of medical anthropological work that considers self-care. While previous studies have explored self-care in relation to physical illness, my study reveals the importance of self-initiation and agentic control in the effective management of mental health among students. Additionally, student populations have been historically understudied and it is made clear in my research that this community has unique wellness needs. Beyond the academic contributions of this work, my study also makes public contributions by prioritizing the voices of students with mental health struggles so they can contribute to the discussion on how self-care shapes their subjective experiences. The university as a stakeholder will also benefit from this research, broadening the understanding of students’
support needs and experiences. I also discuss areas for future research considering certain limitations of this study.

**Personal Disclosure and Researcher Self-Care**

In an ongoing practice of reflexivity, I reflect upon and disclose my personal history with mental illness, which has galvanized me to pursue research that insistently probes for more holistic understandings of mental health and neurodiversity. I have been drawn toward student populations within the study of mental health because of my own history as a student with mental health struggles. Halfway through my high school studies in Quebec, I developed a case of anorexia that was all encompassing in my life. As secondary symptoms of this issue, I experienced bouts of depression, anxiety, and self-harm. I was certain that my status as a high-achieving student, which had been a deeply entrenched part of my private and public identity, would be compromised when I could no longer attend school on a regular basis. But an endlessly supportive program and attentive faculty members (I was fortunate enough to attend a private high school with very small enrollment rates and excellent student-teacher ratios) meant that I was compassionately accommodated. After going through the process of recovery for two years and being ‘in remission’ from my eating disorder, I relapsed during the first year of my undergraduate degree in Montreal. This time, living on my own and outside the watch of my childhood friends and family, nobody was there to hold me accountable to my health. The stresses that come along with being a first-time university student and independent adult created the perfect environment for relapse. University was so clearly a hub of emotional distress for many… how easy it was to slip through the cracks as, in my case, one of over 40,000 students! Yet, at the same time, I witnessed students resist with grit and fortitude. I am fortunate that slowly, over time, I developed strategies to promote my own health and encourage my always
ongoing recovery. These strategies incorporated a home brew of various forms of professional and self-care. Among them included reading, writing, taking baths, playing with my dog, and spending social time with significant others like friends and family. Although I may still experience fluctuations in my mental health, I now feel prepared to manage my eating disorder and its accompanying symptoms. I am proud to have overcome this part of my life and it is with these past experiences in mind that I approach my current research and make this short autobiographical account a publicly important part of my project. I include this disclosure to reduce the shame and stigma that so often surround these conversations and to elaborate on the broader context that influenced my position as a researcher and as a member, an advocate, and an ally of the community of students who have struggled with their mental health.

In this sense, I count myself among the company of social scientists who engage in insider research, where I myself belong to the community of the participants that I study. Some cases of insider anthropology result from a researcher’s life choices, as in the case of Joan Smith (2012), a teacher who conducted in-depth life history research with teachers, some of whom were former colleagues and friends. Often, a researcher’s insider status results from their cultural or ethnic identities - the literature on insider researchers within indigenous studies comes to mind (e.g., Shahbazi 2004; Wilson 2008). That being said, a number of anthropologists have previously acknowledged their own experiences with mental illness (e.g., Martin 2009; Nakamura 2013) and disability (e.g., Murphy et al. 1988; Murphy 1990; Kasnitz and Shuttleworth 2001; Denhart 2008) in studies engaging with health. My status as an insider anthropologist in the case of mental illness is unique because it is divorced from choice and is typically not attributed by culture or birth status. I relate to my participants because of a shared struggle, although I stress that there is no single “mental illness experience.” In recognizing my
emic positionality (and the assumption of partiality that sometimes accompanies this position), I also reaffirm a scrupulous dedication to rigorous, unbiased research. At the same time, I welcome the advantages that being an insider researcher imparts upon me. As Nesha Haniff, an anthropologist doing a “study of Caribbean women by a Caribbean woman” (1985, 107) discovered, being an insider to a group can incite comfort and openness from participants; it “legitimizes the role of the insider” (111) researcher and allows the researcher to treat the participants of the study as “co-researchers” (112). I maintain methodological rigour while also relating to my participants with sensitivity.

Finally, each chapter that follows, including the opening of this section, is introduced by an empowering quote about mental health resilience from different works of young adult fiction. Borrowed from the pages of The Memory of Light (Francisco X. Stork 2016), Challenger Deep (Neal Shusterman 2015), Finding Audrey (Shophia Kinsella 2015), It’s Kind of a Funny Story (Ned Vizzini 2007), All the Bright Places (Jennifer Niven 2015), and Turtles all the Way Down (John Green 2017), the passages represent a wide range of subjectivities as they relate to the experience of navigating changes in mental health during early adulthood. These quotes are selected from stories about struggle and coping (and all the complicated places in between) to complement the thoughts and utterances generously provided by the participants of this study. There are characters in these books who live with struggles including depression, addiction, schizophrenia, bipolar disorder, anxiety, and self-harm and who deal with issues like grief, isolation, guilt, and trauma. Likewise, they reflect the diversity in experience expressed by the young students I spoke to for this project. Stories are powerful and they are moving; they can teach us, touch us, provide an escape, and they can be resources we turn to in moments when we need care. I have turned to the pages of these books during times of difficulty as a means of self-
care and my hope in including them throughout this research is that they might strike a chord and inspire further readership, understanding, and healing.
CHAPTER 2: Approaches to Self-Administered and Clinical Forms of Care

“I think what I’ve realized is, life is all about climbing up, slipping down, and picking yourself up again. And it doesn’t matter if you slip down. As long as you’re kind of heading more or less upwards. That’s all you can hope for. More or less upwards.”

- Sophie Kinsella, Finding Audrey

Introduction to the Review

Though care is a fundamental aspect of humanity and is ubiquitously present in approaches to handling illness and disability (Kleinman 2012), previous studies have not fully explored the ways in which patients with mental health struggles facilitate the provision of care as actors. Discussions centered on care have been well developed in the medical anthropology literature, with major contributions focusing both on the provision and receipt of care (e.g., Cohen 2008; Jervic 2008; Taylor 2008; Kleinman 2008, 2012, 2013; Lock 2013; Buch 2014; Blum 2015). The delivery and receipt of health care, however, have been investigated largely by viewing professionals as the agents of care (Kleinman 2013). While care is often framed as being performed by either a giver or receiver in the literature, in self-care the person needing caring for occupies both roles; they personally manage their own wellbeing needs by means of self-administered care. This repositioning of patients as care providers calls for an inquiry into the content of self-care and the role that people with mental health struggles play in maintaining their own wellbeing and resilience.

The rapidly growing field of self-care studies in anthropology probes the significance of self-care by focusing on the role of patients who provide self-care in the management of physical health conditions (Donahue 1992; Hunt et al. 2001; Guell 2012; Yates-Doerr 2012; Seligman et al. 2015; Snell-Rood 2015; Chudakova 2017). Self-care benefits these groups by allowing them to make their everyday experience of illness more manageable (Guell 2012) and in one case self-care practices were even referred to as “tactics for survival” (Chudakova 2016, 78), affirming
their capacity to promote endurance in the people who practice them. Ethnographic understandings of self-care have yet to be addressed in the anthropology of mental health. I argue that as a new configuration of care, self-care is a necessary point of interest in the critical quest to understand effective and holistic mental health care strategies, especially in the case of students experiencing mental distress.

In the following review, I will first provide an overview of self-care as a currently emerging research topic in the discipline. As a generally understudied phenomenon, medical anthropology scholars have started engaging with the concept of self-care (Donahue 1992; Hunt et al. 2001; Guell 2012; Yates-Doerr 2012; Seligman et al. 2015; Snell-Rood 2015; Chudakova 2017) with the aim of questioning the patient-physician relationship, calling attention to structural forces that limit patients’ ability to tend to their wellness, and challenging ideologies of normalcy. The forces of structural stigma at play in the lives of those with mental health struggles (Evans-Lacko et al. 2012) become clear especially when integrated with a critical disability studies perspective. I will contrast self-care with forms of traditional, biomedical care in the treatment of mental health. Clinical discourses reduce patient self-care to compliance, where the effectiveness of self-care is evaluated according to the extent to which patients observe medical guidelines (Seligman et al. 2015). These clinical interactions are founded upon assumptions of biological normalcy (Ablon 1992; Zimmerman 2000; Davis 2013; Fullagar 2013), where cognitive states of mental illness are pathologized and considered abnormal and aberrant, in need of curing. Next in this review of the literature, I discuss new and exciting perspectives on self-care that lie outside of medical models. Patients are increasingly being viewed as capable of achieving actor-status within structures of stigma through acts of self-care (Guell 2012) and “tinkering” with models of care that fit into their everyday lives (Mol et al.
Self-care is likewise being considered a “hybrid” form of care (Seligman et al. 2015) that includes the social and emotional worlds of patients on top of their physical health. I also consider the ways in which medical models and self-care models of health can be compatible (Yates-Doerr 2012; Myers 2015) rather than contradictory, especially in the context of mind-body connectedness (Scheper-Hughes and Lock 1987). I end with a consideration of Ortner’s (2001; 2006) theorizing about agency and its centrality in discussions on self-care among marginalized groups.

Here I should note that I refer to the participants of my study and the community that they belong to as “people with mental health struggles” rather than “mentally ill people” for two reasons. First, when asked about the terminology they use to speak about their mental health status, the participants of my study overwhelmingly referred to their various diagnoses and states of being as mental health struggles or issues rather than mental illnesses. Second, participants emphasize that their mental health status is but one element of their multifaceted identities. While the phrasing “mentally ill person” positions a diagnosis as the central detail of person’s identity, the term “person with mental health struggle” appropriately appends an implied uncoupling between the diagnosis and the person as a whole.

**Definition of self-care**

While care in general is an empirically understudied phenomenon (Kleinman 2013), self-care has likewise not been established as a single conceptual term in the literature on mental health or within the public consciousness (Segall and Goldstein 1989; Chudakova 2017). As the concept has grown in popularity, ideas about self-care vary across and within disciplines, with anthropology being identified as a key discipline in the discussion on self-care and personal health management (Wilkinson and Whitehead 2009; Guell 2012). Within medical anthropology,
self-care, “broadly refer[s] to preventative health behaviors and management of illness by individuals outside of the clinical sphere” (Seligman et al. 2015, 64). Other variations of this definition exist, such as Chudakova’s (2017) interpretation, which is focused on at-home patient use of clinical treatments and traditional medicine. For the two above interpretations, there is an implication that self-care is performed to cope with or manage health adversity. Many other conceptualizations of self-care within medical anthropology reference, are informed by, or challenge Foucault’s (1990) concept of “the care of the self” (Chudakova 2017; Guell 2012; Yates-Doerr 2012; 2014), where taking care of oneself is presented as a lifelong moral project. Comprehensively, self-care refers to the practices that people engage with in order to care for themselves both physically and socially (Guell 2012; Seligman et al. 2015; Chudakova 2017).

**Medical Anthropology and Mental Health**

An anthropological approach to the lived experiences of people with mental health struggles is important given that within the past couple of decades, the social sciences have been increasingly alienated from meaningful participation in the world of mental health research related to the current zeitgeist where biological psychiatry reigns supreme (Kleinman 2012; Whitley 2014; Jenkins 2015; Rosso Buckton 2015). The depreciation for ‘soft’ science perspectives on mental health and the reality that mental health research is dominated by neuroscientific projects (Jenkins 2015) is part of a phenomenon that Whitley (2014) describes as the shift from a bio-psycho-social to a bio-bio-bio framework of psychiatry, which threatens the development of holistic understandings of mental health. Moreover, it jeopardizes the centrality of care as a key goal in clinical practice (Kleinman 2012). A primary goal of medical anthropology, especially in the sub-interest of mental health, is to challenge biomedical perspectives on mental health and caregiving (Whitley 2014). This includes problematizing not
only the relationship between patients and physicians but also questioning the latter’s perspective, “as an incontrovertible point of departure” (Hunt et al. 2001, 347). Additionally, medical anthropologists continue to call into question the distinction between labels of ‘normal’ and ‘abnormal’ that are so often placed on people who are suffering, in particular among individuals with mental health struggles (Kleinman 2012).

The genesis of medical anthropology and its interest in mental health can be attributed to William Caudill’s pioneering works in psychiatry (1952, 1954, 1956, 1961) that investigated experiences of mental illness from an anthropological perspective for the first time (his “undercover” work at the Yale Psychiatric Institute from 1952 is now infamous). Caudill’s body of work is reflective of early trends in the anthropology of mental health in that many studies investigated clinical and institutional contexts (e.g., Caudill 1952; Barrett 1954, 1956, 1961; 1996; Goffman 1961; Metzl 2009), which would set in motion the ever-present goal in medical anthropology of psychiatric critique. Psychiatry is criticized as a practice and a system, with Fabrega Jr. contributing to a discussion on the incongruity between psychiatry’s goal of addressing individual patient health and its concurrent need to satisfy institutional requirements (1993).

Other formative works adopted an antithetical approach and investigated mental health and illness from outside of the institutional context. Schep-Pe-Hughes’ book (1979) on the experience of schizophrenia in a small Ireland village at this point almost needs no introduction. Sue Estroff’s influential studies on community mental health services (1981) are focused on the issues of deinstitutionalization rather than the abuses that took (and take) place within the walls of ‘mental hospitals.’ Estroff’s work often focuses on the problem of chronicity (Estroff and Lamb 1985; Estroff 1993) and tackles important questions of identity politics including how
chronic schizophrenic identities are produced through social contexts. The sociocultural nature of mental illness was a key discovery in this area, revealing that diagnostic criteria, symptomology, and outcomes differ cross-culturally (Kleinman 1987). That the determinants of psychiatric illness are not solely biological but also deeply cultural (e.g., Kleinman 1987; Jenkins 1996, 2015; Kirmayer and Corin 1998; Helman 2000; Jenkins and Barrett 2012; Luhrmann and Marrow 2016) gave further credibility to the central role that anthropologists can play in furthering understandings on mental health. The cultural nature of psychopathology has been well documented. To illustrate, experiences and outcomes of schizophrenia have continuously been proven to be more positive in ‘non-Western’ countries than in North America and Europe (Luhrmann and Marrow 2016). Fewer patients cite negative socioemotional experiences of schizophrenia in India than in the America, for example, because of cultural differences like the longevity of familial support systems, because health care providers do not make diagnosis a focus of clinical encounters, and because shame and judgment are not associate with labelling.

Bringing us into the newer age of research, Rob Whitley has outlined the three foci for the medical anthropology on mental health in light of the current “era of biological psychiatry” (2014, 499). First, the field must continue to critically evaluate psychiatric knowledge and practice. Second, anthropologists must elucidate the contexts that produce, “suffering and healing regarding emotional distress/mental health” (Whitley 2014, 501). Third, and perhaps the biggest change from times passed, anthropologists must serve as agents of change, no longer merely discussing psychological phenomena from the comfort of the Ivory Tower but instead participating in public action to improve the lives of people with mental illness through solution-based actions and discourses.
Integrating Critical Perspectives from Disability Studies

A disability studies perspective within anthropology calls into question the notions of normalcy that we take for granted and emphasizes the role that non-disabled (or neurotypical) individuals have in creating adversity in the lives of people with disabilities. This theoretical approach frames disability as socially constructed and interprets it by scrutinizing the barriers that prevent societal inclusion for individuals with disabilities (Kasnitz and Shuttleworth 2001; Ginsburg and Rapp 2013; Liasidou 2014) rather than focusing on the presumed shortcomings of people with impairment or illness. The disability studies literature illuminates the structural forces of exclusion and stigmatization that students with mental health struggles face at university. Stigmatization is a structural issue (Link and Phelan 2001; Corrigan et al. 2005; Hatzenbuehler and Link 2013) that affects members of marginalized groups including people with mental illness (Evans-Lacko et al. 2012). Akin to structural racism, structural stigmatization cannot be reduced to individual attitudes and beliefs. Rather, it is a profoundly social phenomenon upheld by, “society-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized” (Hatzenbuehler and Link 2013, 2). For university students with mental illness, these social and structural forces play out within post-secondary institutions. Disability perspectives move away from individualized perspectives on stigma that do not fully capture its all-encompassing nature and instead stress its structural characteristics. Anthropology, especially when combined with insight from critical disability studies, offers a unique and valuable perspective because it provides nuanced information on the experiences of students with mental health struggles that the ‘hard’ sciences sometimes cannot. Self-care in this context is a method of wellness seeking in the face of
structural stigma and an agentic act despite the structural barriers to mental health that students will encounter during their studies.

**Clinical Care**

After having reviewed the literature on self-care, in this section I provide an overview of clinical care as an alternative form of support in the treatment of mental illness. This includes a discussion on the forms and philosophies of medical treatment as well as a critical deliberation of professional mental health practitioners as agents of care. My aim here is not to present the framework of clinical care as categorically oppositional to self-care. Instead, my goal is to critically analyze certain shortcomings and missteps in the clinical care process to inform how self-care might offer functionally unique avenues toward wellness.

**Clinical Care: Professionals as Agents**

If self-care involves maintaining personal wellbeing by caring for oneself, then clinical care can be framed as its conceptual counterpart. Traditional, clinical health provisions currently claim hegemonic authority over health care initiatives (Kleinman 2013). Clinical care, which is typically biomedically informed, endorses specific forms of treatment in mental health care. In the case of mental illness, pharmaceuticals, counselling, psychiatric support, and behavioral therapy are among the possible proscribed therapies. Doctors and other clinicians are presumed to hold the accurate knowledge needed to help cure and guide people toward recovery. As gatekeepers of wellness, professional health care providers use biomedical and psychiatric knowledge to shape contemporary conceptions of wellness, pathology, as well as mental health and illness (Kessler 1990; Martin 1991; Fausto-Sterling 2000). Clinicians are the purveyors of knowledge and resultanty the holders of great power, both physical and symbolic (Foucault
1982). It follows that patients are not seen as agents with the appropriate proficiency or competence to manage their own mental health.

There is a tendency in biomedically-grounded studies to assume the constant suffering of people with mental illness by describing them as “sufferers” and “victims” (Atkinson 1993). This type of language supports the notion that people with mental health issues do not have the capacity to help themselves, that professional care is necessary for adaptive functioning, and that a person’s psychiatric difficulties are at the core of their identity until they are ‘cured’ (Zimmerman 2000). This epidemiological framework emphasizes the control and reduction of mental illness, which positions the people who live with them as deficient, in need of change, or somehow ‘less than.’ Because the literature uses quantitative data sets and neurological knowledge, these studies also neglect to address the subjective experiences of the ‘patients’ themselves (Aderson-Fye and Floersch 2011), which further supports the idea that physicians are the sole overseers of health and that patients are not agents in control of their wellness or of representations of their experiences of sickness. Patients under the clinical gaze enter the “sick role” (Parsons 1951), where patients are perceived to become unproductive members of society with deviance that needs curing. But sickness can be broken down into two subcategories: illness and disease. These two interpretations of health have been mapped onto Pike’s (1954) categories of emic and etic. Illness has been conceptualized as emic, in other words as culturally specific and locally variable. The emic perspective is bound by subjectivity and sees cross-cultural differences in the experiences of disease (Good 1977, 1981), as demonstrated by irregular “explanatory models” (Kleinman 1978). Disease on the other hand has been conceptualized as etic. Unlike illness, disease is more universally stable and is focused on biological reductionism. Etic perspectives do not account for cross-culturally variable experiences of sickness (Kleinman
The disease model does not work in cultural discussions centered on illness and is not translatable to transcultural psychiatry (Helman 1984).

The focus on a disease model rather than an illness model of sickness plays out not only in research but also in practice by way of the linear path that the clinician takes in treating mental illness: diagnosis followed by intervention with the ultimate goal of remedying the patient of their illness. Mental health can fluctuate, meaning a person may not occupy the distinctive category of well or unwell at any given time (Jack.org 2017). But the goals of patients are not always to rid themselves of their “illnesses” and may not even view themselves as ill in the first place. For example, Nakamura (2013) writes that many of the Japanese participants she came to know with schizophrenia did not consider themselves victims and their disability is simply an adaptive part of their identity. Similarly, In Luhrmann and Marrow’s (2016) edited volume of cross-cultural studies on schizophrenia, one chapter (Luhrmann and Padmavati 2016) reviews the case of Sita, a young Indian woman experiencing episodes of screaming and hearing voices. While her case of schizophrenia would be considered quite clinically severe, her impairment was limited; Sita cared for her children and her household, had artistic hobbies, and held a stable job. When she described the stresses in her life she explained how difficult it was to be a new bride, to take care of children, to have ailing family members… her schizophrenia was described as a challenge only secondarily. Jenkins describes in her book based on thirty years of cross-cultural ethnographic research into mental illness that diagnoses are social categories ascribed to subjective experiences that exist on a continuum from ordinary to “extraordinary” (2015), rather than concrete and stable realities that are always debilitating. Nevertheless, the goal of clinical care is often to eliminate the mental illness altogether, ignoring the spectrum of experience. This corrective mindset that focuses on ‘cure’ rather than ‘cope’ disregards the oscillating nature of
mental health. Here I should note that medical anthropology has at times been subject to the same criticism of focusing on a corrective mindset (Whyte and Ingstad 1995; Shuttleworth 2004), which is why an integrated perspective with critical disability studies is valuable and much needed.

**Self-Care as a Form of Compliance**

Clinical discussions on self-care underscore the importance of patient compliance in treatment, though this compliance is confined to medical models. Biomedical models of care often equate self-care with compliance (Wilson et al 1986; Seligman et al. 2015) where patients are obliged to follow professionally mandated care plans. In this sense, “self-care is measured in terms of the extent to which patient behaviors coincide with medical recommendations” (Seligman et al. 2015, 71). In Hunt et al.’s 2001 discussion about the perspectives of self-care among low income Mexican-Americans in South Texas with Type II diabetes and their health care providers, it is revealed that clinicians typically interpret a lack of patient self-care as noncompliance or a failure to understand the needs of their condition. In cases where blood glucose levels were not improving in patients, physicians believed patients were being noncompliant. Patients tell a very different story when it comes to their personal wellness regimens. The Mexican-Americans had a plethora of knowledge regarding diabetes management, including an understanding of the importance of diet, exercise, and health monitoring. Instead, numerous barriers existed that prevented the practice of self-care. One interviewee said that because of the need to take care of her family, including an unwell husband, she lacked the time and resources to monitor and regulate her own health. Another participant revealed that their job did not afford the appropriate breaks and mealtimes that would be needed for a person with diabetes to effectively manage their health. Doctors also recommended dietary plans that were
expensive, inaccessible, and culturally incompatible- yet the patient was still to blame for a lack of physical improvement. When self-care is reduced to compliance by professionals, it is devalued and the patients who practice it are recognized as ignorant. In this sense, clinicians maintain a sense of power, authority, and expertise over their patients.

**Biology, Normalcy, and Stigma**

Clinical perspectives on mental health and illness have rendered certain types of bodies and minds “normal,” while consequently stigmatizing certain others. Erving Goffman’s (1963) sociological, symbolic interactionist concept of stigma describes how some social actors, including people with disabilities and pathologies, are denied social acceptance because of perceived public abnormality. According to this groundbreaking work, a person can be stigmatized because of an unusual physical trait (examples related to mental illness include low BMI from an eating disorder, poor hygiene, or self-harm scars), an outlying personal trait (such as dependency on disability benefits or an inability to attend school due to mental distress), or a group trait (having a family member that died by suicide or belonging to a student support group for mental illness, for example). While Goffman’s stigma concept is still very significant and widely used, it has been critiqued on the grounds that it ignores the empowerment of people with impairments and disabilities and does not properly address power imbalances or systemic injustice (Anspach 1979; Hahn 1984; Frank 1988; Shuttleworth 2004). We know from studies on disability and impairment that people with physical and developmental disabilities experience social stigma and isolation, causing deeply entrenched inequalities, including people with deafness (Becker 1980; Preston 1994), cognitive impairments (Braga 1996; Denhart 2008; Eagan and Guiliano 2009), intellectual delays (Edgerton 1993), senescence (Herskovitz and Mittiness
1994), and the likes. The result of stigma is social alienation and the disempowerment of the targeted individuals or groups.

Stigmatizing attitudes and perceptions are partially created by and continuously reinforced by structural and institutional knowledge arrangements. Since the goal of clinical treatment is to remedy people of their mental illness (in other words it is ‘cure’ rather than ‘care’ oriented), perfect mental health is framed as the prototypical and normal ideal. Disability scholar Joan Ablon documents the social disqualification of people with apparent disabilities whose bodies do not conform to the framework of bodily normalcy that clinicians have created. In much the same way that people with visible markers of physical or developmental disabilities are often ostracized, so are people whose mental health might be considered atypical. People with no disability or with positive mental health are assumed to have normal ability, while their pathologized counterparts are framed as lacking in ability. However, in disability studies, disability is understood as something exterior to the person with the impairment. It is socially and environmentally constructed and creates a hierarchy of normalcy informed by power relations. While numerous studies that focus on mental health and disability use ‘stigma’ as a key concept (e.g., Ablon 1981, 1984, 1999; Edgerton 1993; Mitteness 1994; Burnard et al. 2006; Eagan and Giuliano 2009; Bonnington and Rose 2014; Corrigan and Fong 2014), previous anthropological studies have yet to explicitly investigate self-care as an expression of agency leading to resilience in the face of stigmatization.

**Transitional Troubles in Higher Education**

Here I should note that clinical settings are not the only institutional contexts that perpetuate stigmatizing ideology; educational settings can do this as well. Stigma can have negative impacts and outcomes for student mental health and is a significant barrier to wellness
and support. It is well documented that disclosure of disability in university settings is a frightening task rife with potential social repercussions (Hartman-Hall, Haaga 2002; Denhart’s 2008; Barnard-Brak et al. 2010) because transgressions of the “normal” calls students’ capabilities into question. The fear of stigma is one reason university students struggling with their mental health may not reach out for help or access campus wellness services (Corrigan et al. 2015). There are also stigmatizing attitudes that exist within the institution that demote the wellbeing of students in and out of the classroom. A 2002 study from the Southern United States found that many university professors believe that mentally ill students should not be allowed to attend post-secondary programs (Becker et al. 2002). They cited safety concerns and discomfort as the reasons that mentally ill students should not be allowed to study at their institutions. These beliefs and attitudes are reminiscent of the conditions present during the 1960s, when some students were prevented from accessing education because of mental illness and disability, which contributed to the onset of the Disability Rights Movement. With the support of clinical knowledge and attitudes in higher education, psychiatric and developmental disability continue to be the cause of expulsion from university programs (Barga 1996; Becker et el. 2002).

The transition from secondary to post-secondary education has been noted as a particularly turbulent period in the life-course, especially among students with disabilities (Brinckerhoff 1996; Sitlington 2003; Ginsburg and Rapp 2013). This transitional phase sees students figuring out the, “business of achieving adulthood while taking advantage of their opportunities to remain children” (Blum 2010, 91). Surely, vignettes of parties and social clubs, drinking and gossiping come to mind in the construction of the archetypal university student. But ethnographies of post-secondary life demonstrate that students juggle very adult concerns. Anthropologist and professor Rebekah Nathan posed undercover as an undergraduate student
and learned that student concerns include the need to hold down a job to pay for enrollment, difficulty finding community, spending precious free time pursuing activities that will make impressive resumes, having trouble staying in shape, and many others (Nathan 2006).

Among the most salient stressors students face is the pressure to succeed academically. Blum’s (2010) account of plagiarism in a selective American college demonstrates that the preoccupation with future career success played a large role in students increasingly turning to academically dishonest practices. But data shows that even students at elite colleges with promising career prospects suffer in the form of addiction, self-harm, disordered eating, as well as depressive and anxiety disorders because of pressures placed on students to be perfect (Levine 2008). Students with impairments must navigate these planes of success and failure, having their perceived disabilities reinforced through the venture of education (Varenne and McDermott 1998; Schuelka 2018).

**Emerging Perspectives on Self-Care**

In contrast to the marginal status given to self-care in the literature on clinical care, several relatively recent studies in anthropology have made self-care their primary focus (Guell 2012; Yates-Doerr 2012, 2014; Seligman et al. 2015; Snell-Rood 2015; Chudakova 2017). However, nearly all the existing studies focus on the role of self-care in the management of chronic physical illness and largely ignore the role of self-care in mental health. Consequently, I turn to anthropological literature situated within the context of physical health management to glean important insight into ethnographic knowledge on self-care. First, the existing works question the assumption that patients are passive receivers of professional care. Second, certain structural forces limit the level of their engagement in self-care. Third, patients still develop their self-care strategies as actors, though their capacity to care may be diminished due to economic,
social, or political constraints. Fourth, these self-care practices may promote physical as well as socio-emotional wellbeing. These important takeaways can be extracted from this literature, which are presented in the following two subsections:

1) Acting Within the Structure

First, within the medical anthropology literature, self-care problematizes the patient-physician relationship. Healing and wellness regimens are typically dominated by clinical care recommendations (Kleinman 2012). These are often taken as given even though they are not always compatible with patient needs, sometimes rendering them ineffective (Guell 2012, Seligman 2015). Caring for oneself, then, is written about in the anthropological literature as an often-necessary supplementation (and in some cases, alternative) to standard clinical care in that it can be practiced collectively or independently and it can be manipulated to fit neatly into the ever-changing circumstances of a person’s life. For example, Guell (2012) discusses self-care in the context of diabetes management, specifically how Turkish migrants in Berlin living with diabetes negotiate self-care in the face of an oppressive medical system. The participants of this study were recruited at self-help groups, where Turkish Berliners collectively sought out knowledge on self-care in a context where clinical information was inaccessible, difficult to understand, and incompatible with the unique needs of this population. Since migrant patients were treated by doctors as incapable of having the knowledge to effectively manage their diabetes (the power imbalance between patient and physician is made startlingly clear), and therefore left in the dark, patients had to adaptively assume the role of experts and, “become their own caregiver[s]” (518). This article expertly describes how patients innovatively and sometimes collectively manage their diabetes by caring for themselves in ways that suit their lives and personal contexts, rather than in ways that are necessarily clinically proscribed. This so called
“tinkering” (Mol et al. 2010, 14) allows patients to discover health management tools that creatively fit into their everyday worlds. Guell makes the important distinction between, “caring for yourself as opposed to being cared for” (520), which lies at the heart of the distinction between self and clinical care. In this sense, the literature highlights patients as actors with the ability to develop their own care plans even as they face structural factors that limit their ability to practice self-care such as poverty or a lack of cultural competence. By tinkering with innovative and intuitive forms of care, patients act within these limiting structures.

2) Addressing the Socioemotional Worlds of ‘Patients’

Second, the literature alludes to the fact that self-care is a multifaceted form of wellness management which, as opposed to the bio-centric forms of treatment provided in clinical settings, includes the social and emotional words of people in need of care. A 2015 medical anthropology article by Seligman et al. discusses how different forms of care play out in the role of diabetes management in North America. This reading offers an interpretation of self-care that is more complex and nuanced than a patient’s ability (or lack thereof) to manage the physical symptoms of their illness. For the low-income Mexican-American participants of this study, maintaining their wellness was discovered to be a holistic process beyond the monitoring of blood glucose levels, the maintenance of healthy diet, and the administration of drugs. Self-care here was described as a mixture of practices that are not only physical but also social and emotional. This complex reimagining of self-care was termed “hybrid self-care” by Seligman et al (2015, 64). The Mexican-American interviewees stated that attending to personal emotional needs and maintaining interpersonal relationships with significant others like friends and family are important forms of self-care, even though they might not directly impact the measurable biomarkers of diabetes. The centrality of hybrid practices for the participants casts doubt upon
the clinical definitions of self-care, which are often solely preoccupied with accountability for physical wellbeing. Patients as actors craft personalized care practices that include the nurturance of relational and affective states. Since the worlds of patients do not solely revolve around their physical wellness, patients learn to care for themselves in ways that lie outside of the clinical scope. Self-care practices are diverse and their value lies largely in their ability to address not only physical but also social and emotional wellbeing.

**Clinical and Self-Care Combined: Care at the Intersection**

Some recent studies reconsider the relationship between self-care and clinical care to imagine ways in which these strategies complement one another. Biomedical forms of care are framed as physical and empirical while self-care can also be social and emotional. While it is valuable to consider them each in turn, the epistemological distinction is misguided and the relationship between clinical care and self-care is intimate and entangled. Yates-Doerr (2012) has been keen to point out that these are not competing methods but complimentary approaches to care. Her study at a weight and nutrition clinic in Guatemala exemplifies this. During the clinical encounters she observed, the nutritionists and clinicians adopted the first-person plural “we” in their discussions of patient wellness plans, making care a, “relational and transmissible practice” (136). By saying “we’ll do it bit by bit” (146) rather than *you’ll* do it bit by bit with respect to helping patients manage their weight-related illness, nutritionists make care and treatment a process that involves both the self-care of the patient as well as the professional support of the physician. In this respect, the power imbalances are minimized to give shared responsibility of agency and care among patient and physician.

In another ethnographic study, Neely Laurenzo Myers (2015) investigates a mental health treatment center in the United States. This treatment center is operated by clinicians in
collaboration with the individuals who are seeking treatment, where both parties negotiate a care plan that each can feel comfortable with. By participating in the cultivation of their own mental health and repudiating the disempowering nature of recovery-driven programs, these patients were able to achieve empowerment. Myers’ research demonstrates that when people with mental health issues can seek agency and partake in self-care rather than be forced to recover in ways that are proscribed and out of their control, they can achieve positive outcomes. There is a need for similar ethnographic perspectives on self-care practices as they relate to student mental health, which can sensitively situate the needs of students embedded in university campus settings (Anderson-Frye and Floersch 2011).

**Mind-Body Connectedness**

The dichotomization of the body and the mind in health and wellness has been an ongoing trend in medical anthropology, the social and physical sciences, and beyond. Nancy Scheper-Hughes and Margaret Lock (1987) challenge the dualistic, Cartesian division of body and mind. Scheper-Hughes and Lock calls the division between body and mind a “biological fallacy” that is epistemologically pervasive in biomedicine (Scheper-Hughes and Lock 1987, 6). An associated dualism between body/mind is that of real/unreal, suggesting that components of the body have more legitimacy than their cognitive counterparts. In other words, mental illness is typically perceived as something other than physical pathology. Mental illness exists in the mind of the sufferer; physical ailment takes a toll on the corporal self. This commonly held belief is applied to people living with mental illness. The mind-body distinction has been criticized because it fails to address the way that bodies with impairments live in and interact with the world, which is produced through social engagement (Hughes and Patterson 1997).
Findings from Seligman’s (2015) study of hybrid self-care reflect this phenomenon of mind-body connectedness. The Mexican-American participants of this study spoke about how they drew associations between emotional stressors and diabetic onset/outcomes. The author describes how one participant attributed the onset of her diabetes with the grief caused by the loss of a child to SIDS. Others felt that their diabetes had worsened because of domestic violence trauma. In addition to participants feeling that their emotional distress impacted their diabetes, diabetes equally impacted their emotional states. Participants considered emotional regulation and social harmony important parts of self-care in the treatment of their diabetes. This suggests an intrinsic connection between body and mind, between physical and psychological states.

Further support for the centrality of mind-body connectedness is the extensive literature citing comorbidity between poor physical and mental health (Von Korff et al. 2009). An ethnographic study of self-care is necessary because it will begin to fill these gaps and make clear the connection between self and clinical care and how they play out in the body and the mind.

Despite the above contributions, however, these studies focus on physical illness rather than mental health issues. In particular, diabetes and weight-related physical illnesses have been the focal point of most anthropological studies on self-care. These forms of pathology are of interest because of the inherent role that self-care plays in managing symptomology, such as controlled diet and exercise as well as the administration of medicine and vaccines like insulin. Since the causality of weight-related illnesses such as diabetes can (however inappropriately and superficially) be attributed to a lack of self-control in patients, they are often held personally responsible for their illness and, by extension, for their personal care (Montoya 2007; Yates-Doerr 2012; Seligman et al. 2015). Mental health and illness is nearly impossible to quantify in the same way that diabetes management can be measured through specific biomarkers such as
blood glucose levels. Mental health care and management rely instead on patient self-reports and patient knowledge. Resultantly, including the perspectives of students with lived experiences is necessary in better understanding the landscape of campus mental health.

Agency

Though several recent studies have focused on patients’ engagement in self-care as actors, the concept of agency has not been utilized fully in the literature on self-care. In what capacity do people with mental health struggles have the ability to exert agency when managing their illness? And what role does agency play in the expression of clinical and self-care? When a focus is placed on curing ‘sufferers’ of their illnesses, as is typical in the biomedical framework, narratives of patient agency typically take a back seat. For this reason, an in-depth anthropological study about the self-care practices employed in higher education that contribute to student agency is necessary. Agency, or the ability to exert control and influence in a person’s life, is a central but mostly unexplored facet of student self-care. Sherry Ortner’s theorizing on agency (2001; 2006) is well-suited to the needs of this project. Ortner describes agency as, “the forms of power that people have at their disposal, their ability to act on their own behalf, influence other people and events, and maintain some kind of control in their own lives” (2006, 143). This definition of agency places it firmly within the social sphere. People exist within and are not only made by their social circumstances but they also make up the social world (think Bourdieu’s concept of habitus, 2000). In this capacity, they are actors or agents. Every actor is embedded within social relations that are historically, culturally, and socially contingent and which impact a person’s ability to act in the world. Ortner describes two ways that the sociality of agency plays itself out. First, people have positive social relationships with significant others. Social embeddedness with others such as family, friends, peers, and allies constitute relations of
support. Conversely, “the agent is always enmeshed within relations of power, inequality, and competition” (2006, 131), and here of course, stigma comes to mind. In other words, the same person can simultaneously occupy social roles of equality and inequality. While certain people and groups wield power, there are others who are inevitably powerless. Ortner makes it clear that agency cannot be appropriately discussed without addressing the social power and the inequality of its distribution.

Ortner’s theorizing is oppositional to what Ratner (2000) calls and criticizes the “individualistic view of agency (413),” which does not take broader social structures and constraints into account in its conceptualization of agents’ ability to act in the world. Ratner critiques the ideas of scholars like Jerome Bruner (1982) and Jaan Valsiner’s (1998) individualistic concepts of agency. These scholars reject the idea that agency takes place on a societal scale and that it can incite resistance, instead proposing a vision of agency that is enacted through individual behaviors and meaning-making. The individualistic view of agency is limited (Wertsch 1993) and does not have a space for discussions on resistance and social movement and so instead Ratner argues for a “cultural conception of agency” that takes into account the broader social context in which actors exist (2000, 421).

Ortner reminds us that even the powerless and dominated have the capacity to exert agency and have control on the world around them. This form of resistance plays out in varying degrees. Resistance is not always enacted, especially not always in intentional or obvious ways, and it certainly does not always have the capacity to create real social change. But, “subordinated actors are never wholly drained of agency except perhaps in fairy tales” (2006, 149). Ortner identifies slavery, colonialism, and racism as meaningful targets of study for how people achieve fulfillment and meaning in life despite the impact of hegemonic forces. I propose that structural
stigmatization in the case of people with mental illness is also a suitable and important area of study in this regard — in fact people with disabilities have been identified by Davis as an understudied community negatively affected by societal norms the in his book chapter *Disability, the Missing Term in the Race, Class, Gender Triad* (1995). I also recognize that agency has problematically been equated with resistance in the literature (Ahearn 2001) and so I recognize that agency can be achieved by and for projects of resistance but agency is not resistance in and of itself.

Recent lay articles written by online journalists and activists have already identified self-care as an act of agency and social resistance (Harris 2017; Trombetta 2018). The magazine *The Political Anthropologist* has even published an article titled, “Community Resistance in a Neoliberal Post-Truth Era: Is Self Care Becoming a Radical Political Act?” (Clennon 2016). Certain printed publications have touched upon this idea as well. For example, O’Reilly has identified self-care as an act of agency for women in the case of violent gender domination (2017). A nursing article evaluates the effectiveness of a program developed for patients with prostate cancer to promote their self-care and agency, where the program was shown to significantly improve quality of life (Kim 2011). Within schools specifically, it has been suggested that student agency is, “most readily evidenced by the presence of student resistance” (Miron and Lauria 1998, 198-190). However, these resources have touched upon the interconnectedness between self-care, agency, and mental health only as a secondary consideration. A further investigation would enrich the growing literature on self-care by highlighting students’ ability to resist and seek resilience within structures of marginality.
Who Benefits the Most from Self-Care?

The existing ethnographic research on self-care tends to focus on the ways in which people in marginalized communities attempt to manage their illness when their access to clinical care is limited due to their migration, age, or socioeconomic status. Self-care has been recognized as a particularly important practice among socially vulnerable populations (Donahue 1992; Guell 2012; Seligman et al. 2015). This is evidenced by studies that compassionately tackle self-care in communities such as migrant families (Guell 2012), low income immigrants (Seligman et al. 2015), women facing domestic abuse (Snell-Rood 2015), disenfranchised elderly populations (Chudakove 2017), and the poor in developing countries (Donahue 1992). This intersectional approach to the study of self-care implies that multiple axes of marginality such as ill-health and migrant status, for example, complicate traditional biomedical treatment. Given that self-care among marginalized communities has been notably identified as an area of significance, including conversations about mental health becomes even more critical. People with mental illness face marginalization and stigmatization that impedes their agency (e.g. Bonnington and Rose 2014; Whitley and Campbell 2014), making them fitting candidates for research on self-care in this context. Students with impairments face social marginalization at a difficult transitional period (Nathan 2006; Blum 2010; Ginsburg and Rapp 2013). Although it is certain that self-care practices among people with chronic illness have been garnering increasing attention in the literature, few anthropological accounts of self-care and mental illness have been produced despite the knowledge that self-care can be particularly effective amongst marginal people.
Conclusion

Self-care is a new configuration of care that is deserving of worthwhile attention, especially in gaining new understandings about student mental health. Self-care can be an effective tool in managing psychological wellness because tinkering (Mol et al. 2010) with new and creative ways to deal with struggle can be compatible with the lives of the people in need. Unlike biomedical forms of treatment, self-care also takes the social and emotional worlds of people into account (Seligman et al. 2015), which holistically addresses the entirety of the person including their subjective experiences outside of their capacity as patients. Since marginalized communities have been identified as gaining particular benefit from practicing self-care within the anthropological literature (Donahue 1992; Guell 2012; Seligman et al 2015; Chudakova 2017), it is remarkable that the heavily stigmatized community of people with mental health struggles has not yet been given analytical attention in ethnographic discussions on self-care in medical anthropology or critical disability studies.

Traditional, clinical health provisions have claimed hegemonic authority over mental health care (Kleinman 2012; Whitley 2014; Rosso Buckton 2015). Clinicians have the power to normalize and stigmatize different cognitive states of being (Ablon 1992; Zimmerman 2000; Fullagar 2013), which can be disempowering and can also prevent people, in particular students, from accessing care in the first place (Corrigan et al. 2015). Although many studies focus on stigma, this research will demonstrate that the stigma concept is only tertiary to the experiences of students with mental health issues who find ways to persevere and challenge dominant narratives about mental illness and the people who live with them. Often times, self-care practices are based on informal or lay knowledge as opposed to traditional clinical care. Since self-care as it relates to mental health has been undertheorized in the ethnographic literature, no
clear anthropological definition of self-care in the management of mental illness has been established. Further investigation of self-care in mental health is therefore important in imbuing this avenue toward wellness with conceptual as well as theoretical strength and clarity.

Self-care may be a valuable supplementation - rather than alternative - to clinical care because these approaches can be compatible (Yates-Doerr 2012; Myers 2015). Mind-body connectedness in mental health will prove particularly important in my upcoming analysis, which will show the value of integrating forms of traditional and self-care. As well, the topic of agency has proven to be a critical concept in the discussion of self-care among students at the University of Guelph. Their interaction with, adoption of, and simultaneous rejection of biomedical models of illness demonstrate that students are active participants in managing their personal wellbeing through choice. With these bodies of literature in mind going forward, I move onto my next chapter in which I discuss my chosen field site and research methodologies.
CHAPTER 3: Field Site and Methodology

“And when the abyss looks into you – and it will – may you look back unflinching.”
- Neal Shusterman, Challenger Deep

In this chapter, I first provide a rationale for Canada as a location of importance in my research, as well as the University of Guelph as a specific site of interest. Next, I discuss the recruitment of participants and interviews as a primary method of data collection. I conducted twenty-one semi-structured, qualitative interviews with seventeen undergraduate and four graduate students addressing the subjective experiences of students with self-reported mental health struggles. All participants were registered students at the University of Guelph. Interviewees were recruited through an e-mail to members of campus wellness services. The interviews lasted on average slightly over an hour and a half (≈ 95 minutes). Following this, I discuss the difficulty of rapport-building during short-term anthropological research as well as the strategies I used to combat this obstacle, including an ice-breaking activity and my personal mental health disclosure. Finally, I conclude this chapter with discussions on the ethical considerations and limitations of my study.

Contextualizing my Research Site

Valuable insights regarding disability and mental health in university-aged individuals have been collected globally, in particular in the United States, using survey and statistical knowledge on rates and distribution of mental illness (e.g., AUCCCD), ethnographic knowledge about colleges as sites of mental health issues (e.g., Anderson-Fye and Floersch 2001), and psychology studies related to the perception of students with disabilities using academic accommodations (e.g., Eagan et al. 2009). However, the subjective experiences of Canadian students with mental health challenges have not been made a priority in the North American
literature. Canada’s universal health insurance program and our two-tiered health care system contrast with the limited public health care available in the United States. Tuition costs are generally lower in Canada and most Canadian universities are public institutions. Though this project is not a comparative study, I contend that a focus on a Canadian university enriches the literature on student mental health in North America as many previous studies were conducted at American colleges.

In Canada, staggering statistics support the pressing need for national mental health research. According to the Mental Health Commission of Canada, 20% of Canadians live with mental illness, which is slightly higher than the national incident rate in the United States (NSDUH 2014). This statistic likely under-represents the number of Canadians living with mental health issues due to a reluctance to self-report mental illness and disclose a diagnosis. Moreover, Canadian university students are even more likely to be living with mental illness than the national average (Becker et al. 2002). Mental illness is an especially critical issue among young Canadians since suicide is the leading health-related cause of death among fifteen to thirty-four year olds (STATCAN 2015).

High rates of student suicide within Canada is particularly salient in the province of Ontario. A document by the Center for Addiction and Mental Health reported on the mental health and wellbeing of students in Ontario between 1991 and 2015 and findings reveal the startling reality of youth suicide in Ontario. The document reports that in 2015, twelve percent of students in Ontario in grades seven to twelve had seriously considered suicide that year, which equates to roughly 113,500 individuals (CAMH 2015). Additionally, three percent of students from that same group had attempted suicide that year, meaning that around 27,000 high school students in Ontario attempted to take their own life in 2015. Both suicidal ideation and suicide
attempts among young Ontarians are on the rise. The National College Health Assessment from Spring 2016 further contextualizes this grim trend in the postsecondary context. Results from this national survey demonstrate that in Ontario, nearly half of students have experienced feelings of depression at some point within the previous year and just over half of students felt anxiety intense enough that it overwhelmed them (NCHA 2016). Once again, these percentages are up from previous years. Despite a growing number of students reporting experiences of depression, wellness departments across Canada experience ongoing difficulties meeting the mental health needs of students, often through no fault of their own (Pfeffer 2016). Greater numbers of students with increasingly severe issues mean that wellness services at universities are chronically overcrowded and underfunded (Kitzrow 2009). Wait-list times for appointments with campus mental health professionals can exceed a month (Goffin 2017). At Ryerson university in Toronto for example, while students in “crisis” are sometimes seen within the week and “priority” students are typically seen within three weeks, “routine” students who need ongoing care consistently wait between three to six months for therapy (Arnold et al. 2015). Outside of the campus context, Ontarians still struggle to get timely mental health care. A 2017 study from the CMAJ revealed that the majority of Ontario patients discharged from intake emergency visits following suicide attempts will not be seen by a psychiatrist within six months (Rudoler et al. 2017). This study also reveals that patients visiting the ER for other critical mental health concerns similarly will not receive a follow-up appointment within the month after discharge.3 As a writer for the Globe and Mail puts it, “that’s like showing up in emergency with a heart

3 Surely, some of these patients slip through the cracks because they themselves cancel or never schedule follow-up appointments and so these rates cannot be solely attributed to shortcomings in the professional health care system. Still, there is a broad failure to deliver timely and accessible mental health care in the province and many patients wind up unwillingly neglected within the system.
attack and not seeing a cardiologist after you leave” (Anderssen 2017). Within the university, more qualified mental health specialists can also be difficult to access. A survey of fifty American universities, both private and public, reveals that appointment times for psychiatrists can greatly exceed those of counsellors (Thieklin 2017). Canada’s two-tier mental health care system further estranges patients from accessing more specialized professionals like psychiatrists, who are not always employed on campus health services (Thieklin 2017).

Resultantly, there has been an increasing pressure for research and transparency related to mental health issues on Ontario campuses. The City of Guelph was a particularly suitable and appropriate site to conduct this research because it is a university town whose residents are already exposed to conversations and current issues about mental health.

**The University of Guelph**

Data collection for this study took place in the city of Guelph, by all accounts a university town, in Southwestern Ontario. The University of Guelph (UoG) is distinguished as a community-centric, socially conscious campus. Visibly promoted on the homepage of the institution’s website are promises of its, “safe campuses and welcoming, supportive culture” (https://www.uoguelph.ca/about.html). Within Ontario, Guelph has colloquially been singled out as the ‘granola campus’ because of its infamously progressive attitudes. The social awareness that Guelph is known for extends to its promotion of diversity and social inclusivity for students with disabilities and mental illness, although the policies and attitudes championed on campus are by no means flawless.

The University of Guelph houses a number of mental health initiatives on its campus. Many of these are peer initiatives organized by student advocates enrolled at the university. A student-run chapter of the national mental health charity Jack.org was established in 2015; its
members organize events on campus that aim to start conversations about mental health among students with the goal of reducing stigma. During a recent campaign from this student charity called ‘Let’s Taco ‘Bout It,’ a public stand was set up in the lobby of the campus’ arts building where tacos were sold to students as they were given information on mental health literacy. A separate event organized by the group Art with Impact staged a film screening workshop that invited students to congregate and watch a film that touched on mental health with meaningful discussions on empowerment and personal story sharing that followed. This event combined art, entertainment, and education to reduce the stigmatizing and isolating effects of having a mental illness in university. Other students still have independently organized poster presentations and art displays in public campus spaces that have focused on student mental health and wellness. These types of student organized events and activities encourage public engagement from peers, exposing students to the need for mental health awareness.

In addition to youth-lead movements on campus, specialized offices within the university espouse a commitment to the promotion of diversity and mental health. The university’s Wellness Services, which have offices that are conveniently located in the central student building, have two branches that cater to the needs of students with special educational and psychological needs, including students with mental illness and mental health struggles. Counselling Services (CS) is a resource that, in addition to offering programs focused on personal and professional development, consists of mental health professionals who meet with students that may be having mental health difficulties during their studies. This service operates assorted programs including crisis walk-in hours, regular one-on-one therapy sessions, as well as group workshops. CS is an inclusive and safe space for students to address mental health needs and to learn about additional resources on and off campus. In addition to Counselling Services,
Student Accessibility Services (SAS), “helps students who experience disabilities with full and equitable participation in academic life [and] strives towards creating a barrier-free environment where all students can achieve their potential” (https://wellness.uoguelph.ca/accessibility/). This service can recommend and organize accommodations for students with disabilities who may need particular academic support because of an impairment. When a student lives with a mental illness that can impact their ability to perform as a student, SAS can help this student claim their right to accommodation when appropriate. Both CS and SAS functionally deliver institutional acknowledgement of and support for students experiencing mental health struggles. However, student mental health on campus continues to be a pressing and persistent issue due to inadequate funding despite popular and institutional push for change. The CS website offers alternative resources for students during long wait-times but alternative professional help can often be costly and difficult to access. The timeliness of this research within Guelph is also evidenced by several mental health related tragedies that occurred within the university’s community leading up to the realization of this project. Between September 2016 and February 2017, four students studying at the University of Guelph died as a result of suicide. Although these suicides have been heavily reported in the media, currently there exists no comprehensive or systematic reporting of student suicide rates in Canada, partially because occupation (or student status) is not recorded in coroner reports. Additionally, the cause of death for students who die by suicide while at home or outside of campus residences will not be deemed student suicides. Consequently, it is difficult to compare the suicide rate at Guelph to the broader Canadian context. That being said, journalistic, anecdotal, and testimonial sources claim that the four students who died by suicide at the University of Guelph was anomalously high. Given this
situation, an in-depth study of students’ subjective experiences and the management of their wellness via self-care is needed.

**Recruitment**

To recruit participants with mental health struggles, communication with SAS and CS began months in advance of the interviews, in the spring of 2017. Wellness Services at the University of Guelph saw the value of my project, expressed their interest in the insights my project was aiming to gather, and were eager to help with the recruitment of participants. Originally, the term “psychiatric disability” was used throughout the recruitment documents but upon reflection and consultation with various student groups and the campus wellness services, it became apparent that most people with mental health struggles do not identify as living with a disability, therefore making the term “psychiatric disability” inappropriate. I made the linguistic choice to emphasized the category of “mental health struggle” and used “psychiatric disability” only sparingly, when contextualizing the study within the broader literature of disability studies. Once the documents were approved by the university’s research ethics office and the wellness services, an e-mail was sent out to members of their online list serves explaining the purpose of the research and providing contact information should any students wish to find out more information about voluntarily participating in an interview. Recruitment for interviewees took place at the beginning of the summer of 2017.

**Participants**

I sought out students currently enrolled at the University of Guelph to voluntarily participate in a semi-structured interview about their self-care strategies as students with, “self-reported mental health struggles or psychiatric disabilities.” I did not recruit participants based on a single diagnostic category and students with a wide range of mental health struggles were
invited to participate. This “cross-impairment-disability” approach is common in critical
disability studies research (Shuttleworth 2000; Kasnitz and Shuttleworth 2001). Two students
misunderstood the purpose of the study as being therapeutic in nature so these individuals were
turned away. Additionally, two students living with non-psychiatric disabilities responded to the
call and were similarly not suitable candidates for the interviews. In the end, twenty-one students
were interviewed between June and September of 2018. See Appendix A for a breakdown of
participants.

A call for participants was distributed via e-mail from certain student support services at
UoG to their members. These services include SAS, which provides registered students with
academic accommodations and directs students to appropriate sources of support, as well as CS,
which offers support to students struggling with managing their mental health and their broader
university lives. As such, the participants in this study were all active members of Student
Wellness Services. This avenue of recruitment through campus services was beneficial in that
students using these services have previously acknowledged their wellness needs and are actively
seeking to manage their psychological distress through therapy or accommodations. As members
of these services, students have already been in a position where they have needed to disclose
information about their university life and their psychological wellbeing to relative strangers.
Since frequenting these services requires that students have disclosed information about their
health and wellness in the past, they had prior experience speaking about topics that may be
deemed sensitive or vulnerable. Many students came forward with requests to participate and
were open and comfortable during interviews. Every informant indicating that the research
interview was not their first time speaking about their mental health and wellness in depth. Later
in this chapter, I outline other methods of rapport-building that aided in this process. Whereas
campus wellness agencies may require that students disclose their diagnoses to receive counseling aid or academic accommodations, I should note that this study at no point requested the disclosure of a diagnosis or details about specific mental illness from participants. One student who was recruited through the wellness services recommended the interview opportunity to a friend, who was then interviewed as well through snowball sampling.

Participation in the study was strictly on a voluntary basis. Individuals had the choice to participate in the study or not by contacting me of their own volition. There are some limitations that can emerge from this kind of self-selected participation, including a potential skew of the participant pool to reflect people who would be comfortable with participating in research. Personal mental health often lives within the public imaginary as a topic that is private, stigmatized, and even taboo. The prospect of speaking about their mental health to an unknown researcher would for many students seem a daunting and intimidating affair. I expected that the students I spoke to for this project would be individuals who were already open and vocal about their mental health in their everyday lives, since they were candid enough to reveal their status as a student with a mental health struggle and request an interview in the first place. My suspicions were confirmed when I learned that most of the students I interviewed considered themselves mental health advocates in a variety of capacities, which is commonly seen in studies where participants live with some sort of impairment or disability (Ablon 2002). Consequently, the students who may be most burdened by stigma and feelings of shame were likely discouraged from volunteering their time and resultantly excluded from this study. A second limitation of this recruitment strategy is that only summer students or permanently local Guelph students could conveniently participate, as fieldwork was conducted over the summer months. Nevertheless, many of the students who responded to the call for participants did so with enthusiasm and
urgency, indicating that mental health knowledge is a meaningful issue for students, who were willing to sacrifice precious time to meet for an interview.

**Interviews**

In an attempt to ensure the comfort of the informants in this study, private and discreet interview locations were offered. In addition to the graduate student office (which is reserved by individual graduate students for specific time slots, providing a private meeting space), locations on and near campus were suggested. When members of student wellness services are witnessed entering the offices of accessibility and counseling services, these students can become targets of stigma. As such, options for neutral public spaces (coffee shops, communal university campus spots) as well as neutral private spaces (my student office, rented library room) were used during all interviews.

During the interviews, three categories of questions were addressed. First, interviewees were asked about their experiences as a student with a mental health struggle. This category of questioning included some broad, open-ended questions such as how the students define themselves as people and how they would define their mental health status. Other questions addressed issues of *if* and *how* being a student has positively or negatively affected students’ mental health and if their mental health has ever affected their ability to perform as a student. Other questions in this section were more removed from academic life and inquired about a variety of issues related to disclosure, including who the informant has disclosed their mental health status to in the past, what factors affected those decisions, and the way that mental health is spoken about in their peer groups. Second, students were questioned about the practices they employ to engage in self-care and empowerment. During this time, informants were asked about the activities, hobbies, and frames of thought that give them positive feelings. They were asked
about which techniques had been effective or ineffective in improving their mental health. Personal experiences of empowerment and self-care were also collected. As well, I asked each student for their personal definition of self-care and empowerment to develop definitions that are meaningful for this population, as there is currently little literary consensus about the definition of these concepts in the study of mental health (Wilkinson and Whitehead 2008). Third, the interview questions focused on how empowerment and self-care practices affect students’ identities and their sense of agency. Here, I asked to what extent students felt that their disability or mental illness was central to their identity. I also questioned what elements of their lives students felt they had or lacked control over, including any barriers to their control. I also collected stories about when using an empowerment practice led to a feeling of personal control. These interview question themes produced ethnographic insight into the experiences of students living with mental illness as well as how they cope with any perceived struggle through self-care and empowerment practices. No interview questions directly addressed negative or stigmatizing experiences; these topics came up organically through the personal narratives of students. The line of questioning appears to have been relevant and of consequence to the students as every interviewee requested a summary of the study’s findings containing aggregate results from the research. Interviews lasted between forty-five minutes to two hours, with most interviews lasting around an hour and a half. Every participant consented to being recorded throughout the duration of the interview on an audio recording device. See Appendix B for a table outlining some of the key interview questions.

The number of interviewees (21) was partially determined with theoretical data saturation points in mind. When using non-probabilistic sampling in qualitative interviews, it can be difficult to establish standards for sample size based on data saturation. When Guest et al (2006)
tested data saturation in their study that comprised of sixty in-depth qualitative interviews with West African sex-workers, they reached the saturation point after twelve interviews. In a codebook with 109 distinct codes, nearly three quarters of their codes were present in the first six transcripts (94% of the thirty-six high-frequency codes were present) and nearly every code was present in the first twelve transcripts. They also discovered that themes which appeared central within the first few transcripts maintained this status of importance once coding was completed. Of course, six to twelve interviews certainly cannot be touted as a universal numerical saturation point. More recently, Constantinou et al. (2017) suggest that simply going through transcripts to find a saturation point can provide erroneous assumptions about data saturation, called order-induced error. Instead, using their Comparative Method for Themes Saturation (CoMeTS), they recommend reordering transcripts a number of times during the coding process, only then can saturation be conclusively determined.

In general, interviews are an appropriate study design method for reaching data saturation (Fusch and Lawrence 2015). I asked every participant the same question in the same order, which can aid with the saturation of the data and the replicability of the study (Fusch and Lawrence 2015). The questions were also targeted and specific, avoiding vagueness. When interviewees share similar characteristics, as is the case in my research, variability decreases to an even greater extent. Finally, the coded transcripts were reviewed several times in different orders according to the CoMeTS method and the saturation point remained around the eight interview mark. In my study, some of the broad themes (e.g. the existence of barriers to self-care, self-care as an expression of agency) were detected after three or four interviews. Similarly, some of the important coding themes (e.g. definitions of self-care, self-care as a hybrid practice, the benefits of self-care, feelings toward clinical care) were identified within the first few transcripts and all of the key coding themes (definition of self-care
(SC), types of effective SC practices, types of ineffective SC practices, SC as a social practice, SC as a physical practice, benefits of SC, how SC makes a person feel, factors that prevent the practice of SC, disclosure of mental health status to other person, how mental health issues impact identity, mind-body connectedness, perception of mental illness as a disability, negative opinions about professional care, positive opinion about professional care) emerged after ten interviews were coded. The additional eleven interviews added richness and depth to the data, even though saturation had been achieved.

Following each interview, the audio recording was transcribed into a word processing document and the audio file deleted. Transcripts were then coded on a variety of measures. Types of self-care and empowerment practices were coded as well as interviewees’ definitions of these practices. A chart that provides a sample of the codebook (outlining major coding themes and a sample of corresponding codes) used for this project can be found in Appendix C.

These coding categories have been developed for this study to capture the broad range of wellness needs and expressions of agency among Canadian students in post-secondary education. The interpersonal and institutional barriers that prevent effective practice of self-care were unexpected codes of significance given that my interview questions focused on the benefits and positive experiences of self-care. Student experiences of agency as well as the language used to describe feelings of agency and control were also coded for this project.

**Rapport-Building**

A significant challenge of short-term anthropological research is the impact that time limitations can have on rapport-building. Typically, researchers can devote months simply to building familiar relationships with informants. In the context of a Master’s thesis, this was an impossibility. I met and interviewed participants within the same day, during the only interview I
would conduct with each student. Since students are typically very busy and are already sacrificing their time to speak with me, I could spend no more than a few minutes engaging in rapport-building before moving into the interview questions. I worried that the short duration of these interactions might result in participant discomfort and a reluctance to open up, which would limit the depth of results. Not only might it limit the depth of the data collected, it might create an ethically ambiguous situation where participants feel uncomfortable and unprepared to share information that may be sensitive. I tried using methods that would counteract this limitation. One small strategy that I used to create a casual and open research environment was allowing interviewees to choose their pseudonym rather than choosing one for them. Many of the interviewees seemed excited by this idea and had fun choosing names that they thought sounded nice, that represented characters from their favorite books, and that had personal significance to them. This was an ice-breaking activity that successfully allowed me to connect with the informants.

More significantly, I practiced a strategy that I call ‘mutual disclosure.’ When going through the interview questions, I am asking informants to disclose information about their personal mental health history and their present mental health status. This type of information can be difficult to disclose, especially to a researcher with a recording device and a clipboard of note paper. For this reason, before going through the informed consent process at the very beginning of each interview, I would disclose information about my personal mental health history and would reveal my personal reasons for being interested in the topic of mental health in an effort to create a sense of trust and solidarity between me and the informants. I chose to put myself in an uncomfortable position before asking the same of the students I was interviewing, a strategy that helps build rapport in interviews with students with impairments (Denhart 2008).
Specifically, I spoke about how I began experiencing a number of mental health issues at the age of thirteen, when I would begin a many year long battle with depression, anxiety, and eating disorders. I was fortunate enough to attend a very small high school where I was not only accommodated, but supported while I was in and out of treatment. The reason for my interest in university students is because of the difficulties I faced during a relapse in the first year of my undergraduate degree at McGill University and the difficulties I faced in seeking support at the time. I recognized the need for more transparency regarding the needs and experiences of students with mental health struggles, which has informed my current research interests. I practiced this mutual disclosure hoping to ensure my participants that I was positioned to understand, interpret, and represent their experiences with care and sensitivity. The response to my disclosure by informants was overwhelmingly positive. Students thanked me for opening up, said that it “broke the ice,” and Tiranah said that as a result of the mutual disclosure she felt, “comfortable to talk about [their] stuff without coming off as crazy.”

The inclusion of my positionality in my thesis is also done with the intention of reducing the shame and stigma that so pervasively still surrounds conversations about mental health and to promote the knowledge that individuals living with mental illness can still thrive and succeed. The practice of including representations of impairment and disability by people with impairments and disabilities is being increasingly advocated by leading voices in the field of disability studies such as Devva Kasnitz, who was the President of the Society for Disability Studies for 28 years and who is a disabled scholar herself. Other anthropologists have put this method into practice include Robert Murphy, who became paraplegic during his career as a professor of anthropology at Columbia University and who changed the direction of his research to focus on an anthropology of paralysis following his impairment (Murphy et al. 1988; Murphy...
Emily Martin’s 2009 ethnography, which tackles the complicated nature of public and clinical perceptions of depression and mania in bipolar disorder, is also partially autoethnographic as she considers her own experiences with the disorder. Another instance of this method in practice is when Karen Nakamura divulged her status as a disabled scholar by disclosing her diagnosis of major depressive disorder to both the readers of her 2013 ethnography and during fieldwork to her informants. There are also scholars whose experience of having family members with disabilities has informed their research into disability studies; such is the case with New York University’s Rayna Rapp and Faye Ginsburg who produce “entangled ethnographies” (Ginsburn and Rapp 2013). In this research, disclosing my history as a student with a psychiatric disability is important in delivering an emic insight into student mental health and was also valuable in building rapport with interviewees under constrained circumstances.

**Ethical Considerations**

There is a supposition that individuals living with mental health issues may be at increased vulnerability to emotional distress due to preexisting psychological health conditions. In addition, mental illness is a sensitive subject in Canadian society. As a result, there was potential for minimal psychological and social risks in this study. Additionally, revealing details about their personal lives to an unknown researcher could have caused mild discomfort. Although potentially triggering questions were avoided as the focus of this study is self-care and agency, there was a possibility that informants might ruminate on feelings or experiences related to their mental health, which could have caused mild sadness or anxiety. Measures were therefore taken to promote the comfort of participants and to offset the possibility of psychological distress and the loss of status. No interview questions directly addressed negative or stigmatizing experiences. Rather, questions related to self-care, empowerment, and university
life were focused on. Participants were also told during the informed consent process and reminded throughout the interview that they could answer questions in any way they liked, that they could pass on any question they were uncomfortable answering, and that they could drop out of the interview at any time and have their data removed without any consequences to themselves or the outcome of the study.

Three participants became visibly emotional during the interviews. When this happened, students were reminded that they did not need to give any more detail about the topics that had made them emotional (and that they had the option to end their participation in the study with absolutely no harm to them, myself, or the success of the study). At the same time, they were encouraged to take a moment to gather their thoughts and continue with the interview in a way that they felt comfortable with. In all three cases, students reassured me of their comfort and insisted on continuing with the discussion. It seems as though even though the study’s focus was on self-care and the positive aspects of mental health, including emotional and difficult-to-tell stories was also important for participants. One student, speaking about the suicide attempt of a family member, needed to take a moment to gather her thoughts. Two other students began to tear up when speaking about estrangement from family members and past feelings of loneliness, respectively. These sensitive topics came up when students were describing when and in response to what they turn to self-care practices. All three of these students insisted that they wanted to continue the interview, with Sadie saying,

“no, the reason I’m crying is the reason I want to be doing this. People need to talk about mental health stuff and I want to be the one talking about this. I get a little emotional thinking about that time in my life but I’m really okay, really. Like, this is good for me and I want to make a difference.”
For these three participants, participating in the project and lending their voice to the study was personally important and I supported the participants’ choice to continue with the interview.

**Limitations of the Study**

In addition to the limitations mentioned above (the exclusion of students who were unwilling to voluntarily disclose their status as a student with a mental health struggle and the inclusion of summer students only), there was another limitation to this project, namely the use of qualitative interviews as the singular method of data collection. The option to conduct participant-observation during on-campus therapy sessions was explored with campus wellness services for this project. The complexity of this arrangement, especially given the strict time constraints of Master’s research, made this option too challenging to organize. Although this option was explored, the observation element of my project was not actualized. It is complicated to gain access to patients in clinical settings as privacy and confidentiality are priorities among these services. Methodologically, participant-observation would have enriched my data by allowing me the opportunity to observe students speak about mental health and self-care in a non-research or group setting. Surely, this is an option that can be explored for another project where time limitations are not as constrained.

Although the opportunity for participant-observation as a method of data collection did not work out for my study, I was privy to pseudo-observational opportunities during interviews with students. For more than one participant, spending time relaxing in coffee shops and having good conversations were described forms of self-care. In meeting interviewees in casual settings (about half of my interviews took place in various coffee shops on and around campus) and chatting about student experiences over coffee and tea, I participated in acts self-care alongside
the students I spoke to. Elizabeth, who writes her favorite empowering quotes in a pocket book that she can look back on when she is feeling down even granted me the intimate opportunity to look through the book with her. She pulled the little journal out of her bag during our interview, smiling as she thumbed through it and showing me some of her favorite quotes. While I may not have engaged in formal participant-observation, at the end of the day, I witnessed self-care in action.

Now that I have outlined my methodological framework, I proceed into my analysis of data. This includes a discussion of what self-care means for students at the University of Guelph, what types of self-care practices deliver effective mental health management for this group, and how students engage with various types of self-administered care in context-dependent ways. I make an argument for the prioritization of student wellness expertise as I frame self-care as an agentic act performed in the face of normalizing forces that limit students’ access to care.
Post-secondary students with mental health struggles describe an understanding of self-care that attempts to balance desires with obligations, and that is oriented toward the maintenance or promotion of personal wellbeing. The forms of self-care performed by students are diverse and fluctuating in nature, including acts that are embodied, individualistic, social, and quotidian. Despite the wide-ranging nature of self-care practices among university students, it is apparent that mind-body connectedness is an important facet of effectively caring for oneself. Clinical therapies often do not prioritize patient empowerment, which results in a discrepancy between professional health care recommendations and the improvised forms of care that can improve health in practice (Hunt et al. 2001; Seligman et al. 2015). I will demonstrate that when clinicians prescribe self-care strategies, the imposition of clinical authority and the absence of personal autonomy among students can result in ineffective mental health self-care. This problematization of the patient-physical relationship, which is entrenched within hegemonic power dynamics, demonstrates that clinical care recommendations are not always compatible with student needs and that self-initiation is an important feature of self-care.

Definitions of Self-Care

When asked how they would describe self-care, most students with self-reported mental health struggles paused in thought. Self-care has recently become a trendy buzzword. Posters can be found on campus noticeboards that encourage students to practice self-care with flyers that boast catchy text such as, ‘Self Care Isn’t Selfish!’ A popular trend on the video streaming
platform YouTube called ‘Self Care Sunday’ has hundreds of people uploading videos where they broadcast and share their self-care routines, often to be viewed by thousands of young people.\(^4\) Students revealed that despite having heard the term float around in conversational, therapeutic, and online spaces, few had ever considered its precise meaning, let alone developed a definition that was personally meaningful for them. This is reflective of current research on self-care, where a single conceptual definition has not been established in the literature. As the term has recently grown in popularity, ideas about self-care also vary across fields of study, with anthropology being identified as a key discipline in the discussion on self-care and personal health management (Wilkinson and Whitehead 2009). Here I establish a definition of self-care that is created with the perspectives of the students I interviewed in mind. After some thought, most students agreed: self-care involves acting upon and doing things that you want to do, not that you need to do.

The relationship between desires and obligations among university students must be examined by considering their life course transition. For many students, university marks the first time they will be living away from home and with this comes an enormous amount of independence and responsibility all at once. Students need to manage their coursework and lecture attendance while also feeding themselves, maintaining a living space, building social networks, sometimes holding down a part-time job - often all for the first time - which can result in feelings of helplessness, solitude, and being overwhelmed (Nathan 2006; Blum 2010, Council

\(^4\) The ‘Self Care Sunday’ trend, while promoting useful strategies for improvised care, is also profoundly linked to consumerism. Content creators partner with brands and endorse specific products to their viewers using language and terminology coopted from discourses on self-care and mental health movements. The corporatization of health care has been well documented (e.g., Mol 2008; Kleinman 2012; Sandel 2013) and here we see that self-administered forms of care are not exempt from the market model.
of Ontario Universities 2017). It is worth questioning what circumstances exist among the
demographic of university students that might make them susceptible to psychological distress.
After all, seventy-five percent of diagnosable mental health disorders will first surface in people
between the ages of eighteen to twenty-four (Kessler et al. 2005). Although many high school
graduates will begin working rather than pursuing post-secondary studies, this critical period of
life between eighteen and twenty-four is also the prime age that Canadians pursuing post-
secondary education will typically be entering college, university, and early graduate studies. My
participants’ accounts will illustrate the competitive, stressful experiences of postsecondary
education and how it factors into their mental health. Students said that the list of ‘things’ that
need to be accomplished in any given day can seem overwhelming, especially with the added
complication of mental health issues. Therefore, it is no surprise that self-care involves a
distancing from the needs and a focus on the wants.

High-achieving Master’s student Sarah describes how devoting all her time and energy to
the demands of schoolwork and the needs of others has “ran her dry” in the past, contributing to
long bouts of clinical depression and anxiety and ultimately resulting in a suicide attempt.
Although Sarah sought treatment and has found stability in her life, her mental health still
experiences ups and downs and she has come to believe in the importance of practicing self-care
in her daily life to maintain her wellbeing outside of treatment, and said,

“Self-care is making sure you set aside time for doing things that you want to do. Not
necessarily things that somebody else wants or that your significant other wants or doing
your schoolwork or any of the things you ‘should’ be doing. It’s like no, time for
YOU is important because if you don’t take care of yourself then you won’t be able to do
any of those other things.”

So while students hold themselves accountable to life’s obligations, not depriving oneself
of desires is an important component of self-care leading to balanced wellness. Students
elaborated upon further parameters qualifying their definition of self-care. While taking care of oneself involves doing “things” that you want and not necessarily need to do, sometimes the things that a person wants to do can be self-defeating, which would be in direct opposition to the desired outcomes of self-care. As such, students elucidated that self-care involves acts that make you not only happy but also healthy. Health here is achieved by avoiding environments and practices that, while possibly enticing, are electively harmful. If the ‘things’ that an individual wants to do, rather than needs to do, are destructive or self-injurious in nature, they do not fall within the confines of self-care.

Elizabeth and Katie both battled issues with substance abuse during the early years of their undergraduate degrees. At the time, these women thought they were effectively tending to their mental health by escaping negative emotions with the use of drugs and alcohol. Now that both are proudly living sober lives, they have realized that taking drugs and alcohol was a maladaptive form of self-care. They said,

Katie: “I was horrible essentially at dealing with stress and depression. I binge drank, that was an issue. I would binge drink a lot to try and just like forget about it. So, I guess technically that was my coping mechanism. And then just crawling into bed. Yeah, I would just crawl into bed with my big comforter, my pillows, turn on my TV because that’s the easiest way to distract my mind is with TV- both the visual and the audio stimulation. And then just drank so that I would numb the feelings. But that obviously wasn’t working for me.”

Elizabeth: “My first night of university I went to the hospital because I drank too much and I had to do a couple sessions with an addictions counsellor. It didn’t really hit me at the time I was like, ‘I don’t have a problem,’ […] Now after going to AA I know how to remind myself every day that I’m an alcoholic and not to go back there. I know how to listen to my body and give it what it really needs to be okay.”

Finally, the objective of self-care is not always to achieve optimal health and happiness. As Jamie and a number of students implied, when an individual experiences a dip in their mental health, a quick-fix for perfect mental health is not usually possible,
“It’s just that there’s this expectation that as soon as you seek help or take your happiness into your own hands or try to... find some sort of plan to be better, whatever that means... that you should feel better right away. But there’s no ‘cure’ for what I have. If I wake up feeling anxious or depressed, there’s pretty much nothing I can do that will make me feel like fa la la la la I’m on top of the world, especially not, you know, permanently. Opium, maybe? (laughs) But no, ya, kidding aside, there are things I can do to take control to a certain extent but I’m not going to read a book or play soccer and suddenly feel perfect.”

Practicing self-care, especially if a person is struggling or in crisis, will likely not result in optimal wellbeing. Maddison described the purpose of self-care as, “just keeping your head above water.” In other words, while the goal of self-care might be to achieve optimal health and happiness, even small improvements or the maintenance of mental health can be an important feature of caring for oneself. Taking all the above into account, the following is a definition of self-care that holds meaning for university students with mental health struggles: Self-care involves practices that a person wants, rather than needs to do, that are not harmful in nature, and which result in the maintenance or improvement of personal health and wellbeing.

**Agentic Acts: Self-Care Strategies that Work**

If self-care involves pursuing personal health by doing things that you want to do, not things that you need to do, then what exactly are those ‘things’ that can benefit a person’s wellbeing? Throughout the twenty-one conducted interviews, more than seventy specific activities, hobbies, and pursuits were mentioned as self-care strategies. The diversity in self-care practices include acts that are artistic, athletic, hygienic, entertaining, self-reflective, activistic, among many others. Some of the described self-care practices can be categorized as either embodied or social activities, both individualistic and collectivistic, although the boundary separating these many forms of care will be blurred in the upcoming discussion. Additionally, the exact content of self-care practices may shift daily. Sometimes effective care practices
change according to a participant’s situation or state of mind. In some contexts, even everyday activities like taking a shower or getting dressed can amount to self-care. Despite the wide range of self-care practices discussed by participants, they are all self-initiated acts.

  **Physical Engagement**

  Almost all the self-care strategies that were described by students during interviews were active and embodied in nature. By this I mean that students care for themselves by engaging in practices and activities that involve movement and physicality within the individual body. Although these activities require physical engagement, it will become clear that the benefits of these activities are born from strong mind-body integrations. Most popular self-care strategies practiced by students required that the participant move, act, or interact with the world around them using their body. Some involve large amounts of energy expenditure while others require finer, more localized gestures.

  Self-care sometimes requires embodiment in an obvious, all-encompassing way. Embodiment is the process by which humans occupy and use their physical body, not only materially but also socially (Horton and Barker 2010). Care itself is an embodied experience that has been described as, “more verb than noun” (Kleinman 2015, 240), denoting the performative, physical nature of acts of caring. Exercise was often described as the most effective method of maintaining or improving mental health. Many students were members of the campus gym and so could practice self-care conveniently on campus. The types of exercise that each student preferred performing at the gym were varied: while Petra lifts weights at the gym every day, Marcy takes a weekly contemporary dance class, and Tiranah likes cardio activity like running on the treadmill. Other students fit exercise into their schedules outside of the gym, like Omar, who chooses to walk to and from campus rather than take the bus. Grace began taking a boxing
fitness class at the campus gym a year ago to help with an autoimmune disease that causes
muscle soreness. To her surprise, it also inadvertently helped with her depressive thoughts. She
said, “when I am boxing, I feel focused and in control. I feel… I feel not carefree but I feel like
I’m not worried about something and I’m very, like, present in my body and I’m very aware of
myself in, like, a positive way.”

The embodiment of self-care is other times subtler and requires the use of a single part of
a student’s body. Massive energy expenditure is not the only requirement for effective self-care.
Some students invested their time in subtle tactile activities involving the fine motor use of their
hands. Four students played video games to calm their negative thoughts and feelings. Sarah
planned tea and coloring parties for herself and her friends, where they drink tea and draw in
finely detailed adult coloring books. Two musically inclined students play their instruments of
choice, guitar and viola, to practice self-care. Marcus, a student as well as a violist, said this of
his time spent playing his instrument,

“I know the classic cheesy line is like, *music saved my life*, but for me it’s actually true. I
know it’s so overplayed but I mean it is true so I’m not going to not say it. Music didn’t –
music isn’t the only thing that saved my life but honestly it’s a part of it. And not even
listening to music, well there’s that too, but actually mostly just playing the viola. I was
one of those kids whose parents forced them into playing the piano when I was young
and… nope. That’s all I can say. That didn’t work out for me, I did not like it at all and I
would pretend that I was practicing but I was just watching TV in the basement. My
parents were probably like, ‘he practices all the time but isn’t getting any better…
something fishy is going on here’ (laughs). But ya anyway I picked up the viola in high
school and kind of fell in love with it so ya that’s what I do.

*Loa: And how do you feel when you are playing the viola?*

“Good question… I need to think about that for a second. Honestly, I’m just thinking of
more cheesy things to say. But no. I feel kind of at peace? Viola is a really technical
instrument. Do you know about it? Basically you have to concentrate on so many things
at once. There’s the fingering that has to be just right, including placement and pressure,
the bowing, again it has to be at the right angle and with the right pressure, the arm
movement, placement of my chin, it goes on. So how can I think about anything else
when I’m thinking about all that? I’m concerned about making like… beautiful music.
And it’s coming from me. Like I need to do all these things to make sounds that are actually beautiful so if my mind is elsewhere I’m going nowhere fast. I need to be delicate with the instrument and that forces my thoughts to be delicate if that makes sense. Does that answer the question? Yah, so I just feel at peace.”

While Marcus attends one-on-one therapy sessions that he says do help him, he attributes the termination of his crisis mode with music therapy done on an ad-hoc, self-care basis. He recognizes that the embodiment of creating beautiful sounds impacts his mindfulness and thoughts, allowing them to be “delicate.” Importantly, the self-initiated viola playing worked as a means of improving wellbeing while the piano playing, which was imposed upon him by his parents, did not.

Alycia became observably excited when talking about her love for baking and called it her “moment of happiness.” While not requiring someone to break a sweat, activities like baking and instrument playing are still very much centrally located in the body with the mixing of batter and the strumming of strings. Students are seeking resolution to psychological distress by integrating approaches to care that are both bodily and cognitive. When Alycia is baking, she describes how following a recipe keeps her focused. She then ‘performs’ that recipe physically when she prepares the dish, which in turn alleviates thoughts and feelings of anxiety. This level of activity often requires someone to engage their body while also engaging their mind.

This finding harkens back to Scheper-Hughes and Lock’s concept of the mindful body (1987), which challenges the pervasive assumption of a mind-body dualism. They explain that this, “Cartesian legacy to clinical medicine and to the natural and social sciences [fails] to conceptualize a ‘mindful’ causation of somatic states” (1987, 9). In much the same way, student descriptions of physical activity that relieve psychological pain call into question the misleading assumption that separates the body from the mind. Especially in discourses related to health and medicine, pathology is interpreted as existing in either the physical body or the less tangible
mind. The term ‘mental illness’ etymologically means ‘illness of the mind,’ while ‘mental health’ likewise indicates ‘healthy of mind.’ The resulting implication is that mental health struggles exist singularly within the psyche of an individual, which ignores the important role of a mind-body unity in the understanding and management of mental illness. Mind-body connectedness is also the framework that guides the interaction between people with impairments and the physical, social world around them (Hughes and Patterson 1997). The experiences of the university students I spoke to suggest that in the management of mental health, the mindful body (or the embodied mind) belongs to a dialogical process where the body and mind work in a unified way during times of self-care. Petra’s penchant for working out perfectly exemplifies this mind-body connectedness. When asked how she feels when she is exercising, she said,

“How does it feel when I’m working out? Well this morning I worked out at 5:00am because I had an early class so I feel a little tired (laughs). I get out of bed and I’m like, ‘I’m so tired I don’t want to do this,’ but then I get there and I’m like, ‘oh! I know why I did this! I feel so goood!’ I don’t know! Just the energy it gives me, I feel like when you break a sweat you’re like not dirty but just like you’re just letting everything go, letting bad energy go and just I don’t know it just makes me feel good. And honestly it makes me feel less angry, which is usually an issue for me.”

The hybridity (Seligman 2015) of this practice and its combination of the cognitive and the physical through mind-body integration (Schepeter-Hughed and Lock 1987) are important features of student self-care. The integration of bodily movement and mindfulness is what translates into effective self-care. These physical engagements are helpful in addressing mental health needs because of the ways that physicality impacts the mind. The idea that physical activity is central for mental wellbeing is not a novel idea (Carless and Douglas 2010). My findings suggest that these activities are more diverse than what is typically considered a physical activity—students do not need to run marathons to practice embodied self-care!
Furthermore, students indicate that their self-care practices are important because they are self-initiated agentic acts, rather than something that is imposed upon them by professionals, which I will further elaborate upon later in this chapter.

It is important to note that embodied self-care requires certain skills in movement and assumes the ability of the participant. Over a quarter of my interviewed students reported a comorbidity between physical and mental health issues, which meant that some students were limited in their physical capabilities. Sarah was in a car accident that resulted in tissue damage, which temporarily prevented her from exercising. She said that her mental health suffered significantly while she was unable to be active. For Tiranah, her physical limitations resulted from symptoms of her mental illness. Tiranah used to be a runner, which was a force for good in her life, but had to stop doing cardio exercise for a time because of weakness and physical complications from an eating disorder. Once again, a person’s embodied experience including physical limitations shapes the unique and adaptive ways that each individual subjectively experiences their mental health as well as how they use physical activities as self-care.

**Individual and Collective Activities**

While embodiment is a common feature of self-care, so are a range of individual and collective practices, with much overlap between each of these categories. Although the “self” in self-care implies that self-care is a solo practice, this is not necessarily the case, as my findings illustrate. About half of the students emphasized that their mental health suffers when they are not being social, including Sarah who said,

“Trying to make sure that you actually go and see friends and talk to people [is helpful]. I mean that for me it’s really hard because I have a fair degree of social anxiety but I always feel so much better when I do it. My fiancé is really helpful with that aspect of it mostly just by saying, ‘did you talk to one of your friends? Did you set up a time to see them?’ It’s stressful but it helps.”
The beginning of university life marks a sudden social restructuring for students. Many young adults move away from home for postsecondary education, which means a shakeup of familial and friendship relationships. Even within the university itself, large class sizes and student populations in the tens of thousands can be a jarring change from secondary school. Nearly half of the students I interviewed had also lived on campus residences for at least one year, which presents a particular, often intense social environment. Katie’s commentary about the evolution of her friendships throughout her time in university illustrates that being social does not automatically become effective self-care. Her former friendships, which she identified as socially maladjusted, contributed to a lack of self-care. Once she moved on from those relationships and developed new, healthier friendships, she was able to care for herself by spending time with them. She said,

“A lot of my friends from undergrad have drifted apart from me. I refuse to- I refuse to binge drink and go out partying and do that destructive behaviour anymore but they still want to do it. Back then I totally said no a bunch of times to going out only for my friends to like pressure me into doing it and then I would be sick and hung-over and not doing work and feel even more anxious. So, uh it’s a huge difference with my friends now as a master’s student. I might get a couple of drinks but we socialize and we release stress in a healthy way. Like going out to dinner and just kind of ranting about your day, or playing sports together. It’s healthy.”

Often, embodied and social activities go hand in hand. Marcy enjoys taking dance classes not only because of the freedom of movement it provides her but also because of its social element. She likes learning and performing the choreography with the other students. Similarly, Cornelius sings in a choir because he enjoys the artistic expression and because it provides a temporary distraction from the intense pressures of being a student. At the same time, being a member of the choir allows his to care for himself because of the strong friendship bonds he has formed with his choir group.
One standout case is Petra, a student who experienced a mental health crisis in her first year of university. Following a suicide attempt two months into her first semester, she was stigmatized as a someone who was unstable, a “basket case,” and desperate for attention. After being ostracized from her friendship group, Petra was forced to move out of her campus residence and find a new social network for support, which satisfied her need for physical and social care. When asked about this transitional time in her life Petra responded,

“Yah, so when this whole situation happened I was, I didn’t want to have like a pity party for myself. I’m like, ‘screw this, I am better than this, I’m not letting this get to me.’ So I joined a gym. I’m like a gym rat now- I work out every single day, I have since first year so three years now every day consistently. So I’ve made so many gym friends so now it’s like the gym is my second home, it’s like a family to me. I know everyone there, it’s the same people, I’ve made so many friends. So the gym is definitely something that has helped me and something that brings me pleasure and I don’t do it because I hate my body or because like I hate myself, I do it because I love myself and I want to like, have something in my day that always like is positive and gives me good energy for my day.”

Here, we see that self-care can be at the same time embodied (physically exercising the body), collectivistic (spending time with peers at the gym), and individualistic (working out individually). The social nature of embodiment and self-care has been well documented in the anthropological literature. Numerous ethnographic texts describe the relational aspects of self-care upon which the ability to practice it are hinged (Guell 2012; Yates-Doerr 2012; Seligman et al. 2015; Snell-Rood 2015). Importantly, the ability to practice effective self-care has been shown to be partially dependent on the presence of positive social relationships. Snell-Rood (2015) outlines a case in which married women in Delhi, India respond to marital conflict and domestic disturbances with a refusal or inability to eat. These wives demonstrate difficulty caring for their own nutritional and dietary needs when their marriages are suffering from tension and abuse. Their ability to care for themselves, even by taking care of basic needs such as eating, is compromised by the fragile gender politics that affect wives in Delhi slums. Self-care suffers
when negative social events affect people’s lives and my participants describe how they must tolerate stressors produced from the university as an institution and from their mental health struggles. This will be relevant in the discussion on self-care among university students, many of whom experience a restructuring of their social selves when they begin post-secondary studies.

**The Fluctuation of Wellness and Adjustment**

Another way that participants engaged in self-care was by performing acts that might, to many, seem mundane and quotidian. Especially for students who may be struggling with their mental health in more severe ways, practicing everyday activities that are seemingly trivial can hold great significance. Carter, who lives with social and situational anxiety, spoke about how she sometimes “lives under a rock.” For her, simply partaking in everyday activities is part of her self-care repertoire, explaining,

“It’s so easy to slip into the routine of not taking care of yourself at all. You know after a week of not taking care of yourself you have that morning where you’re like, ‘I’m eating breakfast today and I’m putting on an actual pair of pants and not just sweatpants and I’m brushing my hair and leaving the house.’ Those things can change the course of that downward spiral. And I’ve had friends who don’t necessarily understand mental illness and I’ve mentioned to them in outright just excitement being like, ‘guys I left the house today!’ and they’re like, ‘okay…’ and I’m like, ‘no you don’t get it, I haven’t left the house for five days, this is great!’”

For students like Carter, everyday activities like preparing a simple meal or getting dressed in the morning are agentic accomplishments that reflect a reclamation of personal control over wellness. They are imbued with meaning and represent a self-initiated jumping over of hurdles during a time when managing the commonplace can be a challenge. Carter’s triumphant response to feeding and clothing herself is cause for both celebration and concern. Knowing that Carter is making the grades to stand out in her elite post-secondary program but is at the same time unable to care for herself in simple ways suggests that students are under immense pressure to succeed in their post-secondary programs of study. Still, everyday care must be recognized as
an achievement when mental illness produces devitalizing effects on the body and mind.

Elizabeth pointed out that effective self-care strategies can be banal and they are also contextual and change over time depending on a person’s needs when she disclosed,

“Self-care is different every day. Some days it’s literally getting up, taking a shower, and then perhaps making your bed and lying in your bed all day. Like that’s really good self-care when I’m in a really bad place. Like for instance last time I was in a bad place, really bad place, was February and it was literally my self-care was seeing my therapist twice in that week binging on Netflix and eating pizza. Recently my self-care when I had a rough weekend a couple weekends ago it was I went to yoga and it triggered emotions in me and I literally spent forty-five minutes on my mat in the middle of class crying. For me, I’m like I handled that brilliantly, that was what I needed that day.”

As the above examples illustrate, effective self-care practices include embodied acts that rely on mind-body integration, individual and collective practices, and even everyday activities that may seem trivial to others. See Appendix D for a chart outlining all of the described effective self-care practices for reference. The messiness of self-care and the many forms it can take reflects its transformative, shifting nature; as such, there is no single formulaic blueprint to effective self-care. Despite the diversity of practices discussed by participants, they are all agentic, self-initiated acts that stem from care.

Self-Care Strategies That do not Work

As mentioned, the self-care practices that will work for any individual are unique and can change depending on the context and the person’s life circumstances. Identifying self-care practices that effectively promote psychological wellness is a process of discovery and adjustment. Naturally, the interviewed students have sampled a litany of self-care tactics, some of which have been more helpful than others. Students mentioned activities that they had tried in the past that either did not help to improve their mental health or that were unenjoyable. Many of the responses by students involved activities that are centred on introspection. Practices that students found disagreeable included meditation, taking deep breaths, repeating affirmations, and
thinking about, “what’s the worst thing that could happen?”

Tiranah: “One [therapist] literally told me to just look in the mirror and just… like compliment myself? That’s so awkward and weird. And also not that I hate myself or anything but I would probably have to lie to myself. Like, ‘oh Tiranah you’re so pretty and smart and amazing.’ If I thought all those things I probably wouldn’t have needed a therapist in the first place. Like I’m not going to trick my brain into liking myself.”

Hudson: “It’s hard to explain but everyone says that when you feel a full-on panic attack coming on over something that doesn’t matter, or at least ‘shouldn’t’ (makes air quotes) matter, you have to ask yourself the question, ‘what’s the worst that could happen?’ Are you kidding me? No. No. That’s literally the worst thing I could possibly do for myself. […] There was this one time where I was late for an assignment and I couldn’t submit it on dropbox because I didn’t realize that it was due at 5:00pm and not midnight or something like that. And I started to full on freak out thinking that I would get the five percent late penalty or whatever it is. Can you imagine if I had tried to picture the worst thing that could happen? Well then I’d be freaking out about failing the class, the whole year, needing to retake courses, maybe not graduating… why would people tell me to think about the worst thing that could happen? I get it in principle but just… no.”

Six of my participants indicated that journaling is an ineffective means of self-care.

Alycia and Grace, who both attempted journaling for a time upon the recommendation of mental health professionals, did not experience benefits from the practice.

Alycia: “Journaling! I personally get nothing out of it. I think just because, me, I’m writing down bad things and then I’m like, now there’s a record of it (laughs) so it doesn’t help to alleviate it off of my mind and then there’s a record of it so for my mindset it was not a good strategy.”

Grace: “Uh I used to, I have like a therapist who told me to like journal a lot but I find that um like the physical activities are like, or activities around creating things are a lot more effective for me than writing? Like about my feelings. Like there’s certain instances where journaling is good for me but as a whole I prefer to like, to expend energy as the like mental health release thing.”

Certainly, this is not to say that any of the above recommended practices cannot be effective means of self-care. Journaling, repeating affirmations in the mirror, and playing the ‘worst thing that can happen’ game might be strategies that restore wellness to some students.

More likely, the young students mentioned above have unfavorable opinions about introspective activities as a form of mental health management because these specific practices were imposed
upon them rather than self-selected. In each case, the introspective act was recommended by a mental health specialist, and in one case recommended by a significant other. Keeping a diary or maintaining a thought journal might have alleviated the symptoms of Alycia’s or Grace’s mental illness had this been an activity that these students already took pleasure in as a personal activity or hobby rather than imposed by a clinical figure.

The above examples suggest that professional recommendations are not always suitable or effective in practice, especially when the therapeutic suggestions are imposed. It seems as though introspective practices are commonly suggested forms of self-administered care by mental health practitioners. Without taking into account the wants and needs of student-patients (recall that self-care for students involves acts that they want to do), imposed self-care recommendations get added to the list of things that a student needs to do. The incompatibility between clinical recommendations and student needs is not surprising since I observe that self-care has been underexplored in the psychological literature on mental health. A simple search for the term ‘self-care’ in academic psychology, psychiatry, and nursing journals will reveal that there are more publications addressing the self-care of health practitioners than of their patients. It is clear that while self-care appears to be a popular term, the research has only become emergently prevalent within the recent past and definite clinical standards of self-care have yet to be comprehensively established. What I saw happening in the meantime in university was that students with mental health struggles were using strategies that were not suggested by professionals. Instead, they use lay-knowledge and personal intuition to develop personalized care strategies that can effectively be carried out outside of the clinical environment.
Discussion and Conclusion: Self-Care and Mental Health

The existing medical anthropology literature focuses largely on the practice of self-care within the framework of physical symptomology including diabetes management (Hunt et al 2001; Guell 2012; Seligman et al 2015) senescence (Chudakova 2017), weight-related illnesses (Yates-Doerr 2012), and pharmaceutical use in response to common physical symptoms like colds and headaches (Donahue 1992). What of self-care and mental health? It is clear both from the existing literature and from my added contribution that the forms of care which constitute self-care are diverse and multifaceted. For example, while over seventy specific self-care practices were mentioned by students, they fulfilled care needs that were embodied, social, individual, collective, as well as quotidian.

Self-care as an emerging analytical topic in medical anthropology offers new perspectives on care that are not captured or prioritized in the clinical agenda. In their anthropological study on selfhood and self-care among diabetes patients in Mexico, Seligman et al (2015) suggest that self-care is, “simultaneously social, emotional, and physical” (63). For the low-income Mexicans in this study, caring for their families was an important form of self-care, even though it did not resolve clinical outcomes of diabetes according to a traditionally biomedical standpoint. Seligman calls this “hybrid” self-care, which attends to elements of health related to emotion and sociality. As the findings of my study illustrate, my participants engage in this hybrid self-care. Self-care in the context of health management is clearly versatile and complex; it goes beyond addressing and resolving the clinical symptoms of illness. This hybrid form of self-care is especially relevant in discussions of mental health, where wellness is largely dependent on emotion and sociality. The participants of this study discussed the importance of embodied, individual, and collective acts of self-care as contributing to their wellness. The
students that I spoke to confirmed that for them, sociality is also an important component of effective self-care in the management of mental health and illness. Not only are positive social relationships necessary for the practice of self-care, actively engaging in social encounters can itself be a form of self-administered care. The hybridity of self-care (Seligman et al 2015) with its encompassment of the physical, social, and emotional worlds of students is what makes caring for the self a unique and meaningful wellness practice outside of professional care. Similarly, students’ ability to tinker (Mol et al. 2010) with forms of self-care that fit into their everyday lives makes it a practical form of care in the lives of students.

Many of the care practices performed by the participants of this study were simultaneously embodied and collective, at the same time fulfilling needs that were physical and social. This points to the discovered importance of mind-body connectedness in the execution of effective self-care. The intimate connection between body and mind disrupts biological categories (Scheper-Hughes and Lock 1987) and for the students of this study allowed for more holistic approached to mental health.

I posit that when acts of self-care are clinically imposed upon students, they feel structurally and institutionally disempowered. When these care practices are acted upon, the disempowerment translates directly into ineffective self-care. Rather than being an issue of compliance, the students at the University of Guelph exert agency in choosing which care methods to make use of, whether they be clinically recommended or improvised and intuitive. Consequently, in order to achieve the desired effects of wellness maintenance or improvement, acts of self-care must unquestionably be self-initiated. Self-care as a valuable alternative or supplementation to clinical care, which can be incompatible with patient needs or difficult to
access, has previously been discussed (Guell 2012). Yet the explicit focus on the self-initiation of care acts has not been a point of focus before now.

Conclusion

Throughout the twenty-one interviews, students produced a definition of self-care hinged upon acting on desires in ways that are health-oriented and with the goal of maintaining or improving personal psychological wellbeing. By prioritizing their needs and setting aside obligations, my findings show that practicing self-care despite the many student pressures and obligations can allow students to demonstrate resilience. Participants’ discussions also highlighted that mind-body connectedness and self-initiation are fundamental to effective student self-care.

Although previous studies have considered some aspects of the link between self-care, health, and wellness, the relationship between caring for the self and mental health specifically has been under-investigated. More specifically, self-care and the subjective experiences of self-care practices have not been considered anthropologically among university students in Ontario. My findings begin to shed light on this issue but continued research is needed to further our understanding of alternate forms of care and their impact on student wellness in the Canadian context. The fluctuating nature of wellness and adjustment among students makes this topic rich and complex, certainly in need of more systematic theorizing.

While the discussion has thus far been largely definitional, fleshing out the basics of what self-administered care is and how students at the University of Guelph practice it, in the following chapter I dig deeper into this concept of self-care by considering its relationship to agency. My participants, in their capacity as both students and patients, can seek and achieve agency through acts of self-care. While caring for the self can be an empowering avenue for
university students in the face of hurdles they face in their academic and clinical lives a profusion of disempowering structural barriers exists that complicate their access to care. I will demonstrate how students tactically negotiate the decision to include forms of self-administered care into their wellness regimens in ways that are context-dependent and that can have real life positive consequences.
CHAPTER 5: The Agency of Care

“Do whatever it takes to remind myself that I’m still here and have a say.”
- Jennifer Nivan, All the Bright Places

Self-care is an agentic act exercised in the face of disempowering assumptions about students with mental health struggles. In the context of self-administered care, students can become experts of their own illnesses and regain control of the care process throughout their recovery. By caring for themselves in various ways, students dispute the normalized narrative of the sick role and demonstrate their potential beyond their capacity as ‘patients’ passively going through the clinical care system. While students engage with self-care as an agentic form of empowerment, several social and institutional barriers exist that prevent students from effectively caring for themselves during their studies. These include complicated access to academic accommodations for students with mental health struggles despite these accommodations being codified in human rights and campus wellness policies, assumptions and expectations of a ‘normal’ scholastic trajectory founded upon uninterrupted productivity, and a lack of free time resulting from academic responsibilities. In this chapter, I will examine students’ self-care practices by analyzing the relationship between their agency and the structures that limit their practice of self-care.

Self-care: An Agentic Act

A definition of self-care that is meaningful for the university students I spoke to who live with mental health issues has been established: self-care involves practices that a person wants, rather than needs to do, that are not harmful in nature, and which result in the maintenance or improvement of personal health and wellbeing. Self-care is performed through a variety of practices, including physical and social activities, which are often developed through lay knowledge and sometimes contradict formal biomedical perspectives.
There is one more important feature of self-care that became evident throughout my interviews with students: self-care can be an expression of agency. According to Ortner’s (2001; 2006) theorizing, people, as agents, act within and have the ability to transform the social relations in which each person is embedded. These social relations exist within complex systems of power, which are strongly affected by and reproduced through instances of inequality. Ortner’s broad definition of agency highlights, “the forms of power people have at their disposal, their ability to act on their own behalf, influence other people and events, and maintain some kind of control in their own lives” (2001, 78). While most agency scholars agree that agency is a universal capacity innate to all humans (Taylor 1985; Sewell 1992; Duranti 2004; Ortner 2006), Ortner emphasizes how it is also contextually embedded within cultures and histories wherein forces of domination, oppression, and resistance are at play. Here, the concept of agency is significant in the context of university students with mental health issues, who have been subject to unequal power relations on a number of fronts. For example, students are sometimes disempowered by the system of clinical care that fails to recognize student-patients’ knowledge and agency in managing their mental health. Due to inconsistent policies and practices regarding academic accommodations for mental illness beyond the SAS, students struggle to navigate the complicated and often unclear accommodation system.⁵ Although students know how to practice self-care, there are barriers that sometimes prevent them from caring from themselves. The time-costly responsibilities of being a student leaves them with little time to practice self-care and

⁵ While Student Accessibility Services absolutely recognizes cases of mental illness as legitimate cause for academic accommodation, individual professors provide student support in ways that are inconsistent (with some cases of students relaying that their accommodation was not recognized altogether), indicating a need for clearer policies and practices. The role of educators in discouraging academic accommodations among students with disabilities has been widely cited (e.g., Hill 1996; Hartman-Hall and Haaga 2002; Barnard-Brak 2010).
feelings of selfishness when free time is spent caring for themselves. However, students continuously stress their resilience and achievements, which highlights their subjective capacity as actors. Their expressions of agency challenge the disempowering ideas and arrangements at a postsecondary institution.

What follows is a discussion about the ways in which caring for themselves allows students to seek and exert agency as patients, as students, and as experts of their own illness given that the existing ethnographic literature on self-care and mental health has yet to explicitly identify agency as a key concept of research interest.

Students as ‘Patient Agents’

Students occupy a number of roles during their studies. They are students, they can be sisters or brothers, sons or daughters, athletes, artists, activists, and the likes. For students with mental health struggles, however, they also most likely occupy the role of a patient. Medical discourses dominantly shape the ways in which health and pathology are conceptualized. Although psychology and psychiatry are younger than the medical sciences, knowledge produced in these fields still guides the ways the public thinks and feels about mental health. In a more practical sense, people place their trust in mental health professionals to treat mental illness by following their guidelines for therapies and treatments. According to the concept of the sick role (Parsons 1951), it is often thought that a person who is unwell is obliged to actively work toward recovering wellness by accepting the authority of medical professionals. Part of “being sick” is prioritizing recovery because in the meantime those who are sick are not considered to be part of the educational institution (or society at large) resulting from a perceived lack of “normal” functioning. Of course, in the context of mental health, the pressure to be well does not
account for a wide range of mental health experiences—neurotypicality alone is normalized and students are expected to have unwaveringly positive mental health that does not fluctuate.

Typically, young adults with mental illness who seek treatment are stripped of much of their autonomy throughout the treatment process as patients under the care of mental and physical health practitioners. When I went through the mental health care system in my adolescence, a typical day of treatment might look something like this:

8:30 am: wake up, staying in my bedroom on best rest
11:00am: get blood tests to check my levels
1:00pm: attend an appointment at the youth psychiatric clinic
4:00pm: drive an hour to attend an art therapy session
6:00pm: eat dinner under parental supervision
8:00pm: work on the CBT ‘homework’ assigned by my therapist
11:00pm: take medication before going to bed

I always acted in the role of a patient. Even at home, I was constrained by the proscriptions and prescriptions of my doctors. However, students with mental health struggles have obligations as patients as well as students, though clinicians prioritize their roles as patients. Katie addressed how the power of clinicians’ control impacts her as a student-patient seeking treatment for chronic mental health problems. When recalling a personal anecdote of powerlessness during an interaction she had with a mental health counselor, Katie described,

“One time I was having a really bad day and [my usual counselor] wasn’t available so I went to go see another counsellor and I essentially just like broke down crying. At that session she was like, ‘you need to go see a doctor because I’m concerned for your safety,’ and that’s when she picked up the phone, called the doctor, booked me an
appointment for the same day, without my permission. I started to protest because I had a really big data collection appointment that day but she was like, ‘you need to make this a priority’ so I had to cut things short for my project. But I’m like… this could have easily been avoided if she had just been like, ‘does 2:00 work for you? No? Okay let’s do 4:00.’ It’s not that I was attempting to get out of treatment it was like… I still have a life, I’m a student... I still have a life. It was, uh, not good and I just don’t take well to people doing things that affect me without consulting me. So it was like I’m the patient here, I get to decide what kind of treatment I do or do not receive and how I receive it and I felt like I was being treated like a child. I understand it’s because they were concerned about my safety but ya, no, you don’t just book doctor’s appointments for people without checking to see that they can even make it. It’s just I was exhibiting signs that made her think that I wasn’t capable right? Of making decisions for myself. But I had no intention of doing something bad to myself.”

Katie later went on to explain that while she occasionally still checks in with mental health professionals, she has preferred to find ways of managing her mental health on her own. Students with mental illness, like Katie, have their autonomy revoked when they are treated as helpless and incapable of participating in important decisions about their health by their doctors, who are the active and powerful decision-makers when it comes to health and wellness. She was able to reclaim a certain amount of autonomic agency by resisting the influence of dominant neurological standards of therapy to incorporate self-care practices that she knew were better suited her preferences and lifestyle.

In contrast to the clinical care system that gives power and authority to a clinician, by implementing self-care practices, young adults can reassert a sense of agency and participate in the decision making and caregiving process as patient-agents. People with mental health issues can act as agents within and outside of a therapeutic setting when they take their care into their own hands. The concept of control, which is a fundamental element of agency, was central to many of the discussion I had with students. Taking control of one’s life, health, and schoolwork were concerns that nearly every student expressed, including Alycia. Of the role that control plays in her everyday life Alycia said,
“Control is an important word with depression because there is [sic] two sides of your brain like some instances I can control my actions when I’m in an okay mind state so I can go out for a walk, I can reach out to friends. That I can feel in control of. Or making myself study, that I can usually control. However, if I get to a bad low, I don’t have any control over what happens. Or at least that’s how I feel.”

To reassert control, Alycia has a personal care plan that she turns to, which involves regular visits with a mental health counsellor as well as a toolkit of self-care practices, such as walking her dog. Ortner (2006) has given much attention to the forms of resistance that groups enact in response to domination — namely instances of colonialism and racism. Stigma is another crucial area to explore in terms of agency as resistance, in this case through avenues of self-care. By studying students and the ways they care for themselves, I offer an alternative perspective of the ‘patient’ in a time when much of the research on mental health refers to people as patients and takes place within a clinical setting, which limits the possibility of empowering accounts of people with mental health struggles.

Although self-care is an important expression of agency, it does not necessarily follow that students reject clinical care. Each student I spoke to was a current member of a wellness service at the University of Guelph where they had received or were receiving ongoing mental health treatment in a clinical capacity. Rather than deny the importance of clinical care, students challenge the framework of care proscribed and prescribed by professionals and were critical of clinical interactions. Students, as patient-agents, include both clinical and self-care in their wellness toolkits and make use of different strategies and resources depending on the circumstances and the availability of professional care. Taking on the role of the patient-agent also grants young people the agency to care for themselves when professional care is difficult or expensive to access. This benefit is particularly salient for student populations. While every student I spoke to reported that the wellness services on campus were very helpful (one student
even saying, “I don’t think I’d be alive today if it wasn’t for resources on campus”), wait times for appointments can be lengthy. This is true of university wellness services across Ontario, where waiting times to see campus mental health practitioners can be longer than a month (Goffin 2017). About this, the president of the Ontario University and College Health Association Meg Houghton has said, “I don’t want to be too hyperbolic, but the truth is, lives are at stake” (Pfeffer 2016, CBC.ca). When asked where they go or what they do when formal mental health services are not available, Mannard confirmed this concern by revealing,

“Like if I’m feeling like I’m in crisis mode, and I call [mental health services] when I don’t have an appointment, the secretary will usually say that they have an opening for me… in two weeks. You don’t have any appointments for the next two weeks? Great, well guess what, I could be dead in two weeks. […] That’s when I need to cool myself off or else something really bad could happen, I can’t just go to the emerg [emergency room] every single time things get really bad. So I’ll need to call my girlfriend or even go on a walk to get out of my head and be around people or else I don’t know. And I’m here talking to you now so it’s worked so far!”

Mannard is talking about self-care as a matter of life or death. What he is saying is: either I find a way to care for myself when institutional help is unavailable, or I fear that I may hurt myself. This is a powerful testament to the force that self-care can have in the lives of students. Self-care can have the ability to save lives, which makes it all the more worrisome that there are barriers preventing its practice. Beyond the ability to seek self-care outside of treatment, it can also provide students with an avenue toward resilience, to act as agents of their own wellbeing, and directors of their own care. In this way, they may challenge the sick role that has been imposed upon them.

The Patient Expert

The anthropological studies on self-care practices, which mostly focus on type-II diabetes, provide useful insights into the agency of students in managing daily care. Hunt et al. (2001) have made a compelling case for integrating patient knowledge with clinical perspectives
that commonly devalue self-care and patient expertise. They point out that the self-administered care practices of patients living with chronic illness are often clinically criticized as incorrect or harmful. Conversely, physician perspectives fall within biomedical models, which are taken for granted. However, Hunt et al. (2001) problematize the hegemonic narrative of “doctor as expert” to include the voices of patients in the case of type II diabetes. Physician strategies are very “clinically driven,” but the recommendations of doctors do not always work for every patient’s lifestyle and personal circumstances. A patient’s life is always changing, even down to daily routines and responsibilities. This is why Hunt et al. (2001) write that self-care can be effective because of its flexibility; namely how it can be tailored and altered to suit the moment-to-moment needs of patients. This leads me back to Seligman’s (2015) study on diabetes and the concept of hybrid self-care that integrates physician recommendations with patient knowledge, which includes their emotional and social needs. My participants’ use of self-care fits into this model; they engage in self-care in ways that are flexible and well-suited to their daily lives. Maddison said,

“Going to therapy takes over an hour because I have to get there, get home, and actually do the session. Listening to a song takes one minute and taking a bath takes twenty minutes. That’s kind of nice. But still, I go to my appointments every week. But I couldn’t do that every day.”

Similarly, Hudson said, “It’s nice being on a [sporting] team at school because it’s right on campus. Like I can go from class and BAM! I’m on the field letting everything go.” Previous studies on self-care in physical health provide useful perspectives on patient expertise and for the purposes of a clinician helping patients to manage type II diabetes, specific markers can be measured to assess the extent to which self-care has been effectively carried out (Hunt et al 2001). If a patient is doing what they ‘should,’ their glucose levels would be within a healthy range, they would have good limb circulation, and so on. However, measuring the effectiveness
of self-care in the case of mental health becomes much more complicated. The symptoms of mental illness are largely internal, governed by thoughts, feelings, and emotions. Whereas it is sometimes possible to measure the effectiveness of self-care in physical health according to established standards, this is not always possible for mental health. Within the patient-physician interaction, from the get go there is a reliance upon patient perspectives to describe the type and severity of patient symptoms. Mental illness diagnoses are decided by professionals not based on blood test results or scans but on patient self-reports, though this is not always emphasized in the clinical care system. The participants of this study made note of their expertise and sometimes challenged clinicians’ knowledge. Speaking about the sometimes complicated process of reconciling the perspectives of her mental health practitioners and her instinctual knowledge about care as someone who has lived with anxiety and depression for about five years, Liu mused,

“It’s hard. Because I have been with counsellors where I was really pissed off with the advice they gave and with stringing me along but maybe it’s just me being hyper sensitive… or did they not handle that correctly? Because it’s hard because like I’m not the professional. That's the difficulty with the power difference. I don’t know what the correct way of handling this situation is. I have to trust that they do. And that they do it correctly. But like it like doesn’t take a psychologist to see how to release stress in a healthy way. It’s pretty intuitive. So what do I do?”

This quote reveals that sometimes Liu trusted her own knowledge as the expert of her illness above the advice of professionals. Hudson, who expressed his disapproval of the ‘what’s the worst thing that could happen’ method of anxiety reduction recommended by mental health care providers, also expressed his patient expertise when he asserted,

“I know that when I’m about to have an attack the best thing for me to do is, kind of the only thing that will really do anything even if it’s not much is just to, is to break the routine. Say I’m freaking out over school then I need to stop whatever I’m doing and get out. Or not get out for sure but stop doing work and go get a bite to eat or put on music or
something. It doesn’t get stuff done but I’ll tell you that, I mean that works a lot better than thinking of all the worst possible outcomes and making myself even more anxiety ridden.”

Participants sometimes questioned the superiority of doctors’ knowledge on managing their mental wellbeing. Doctors have expertise and technical knowledge that most lay-people do not but when it comes to individualized self-care plans in people struggling with their mental health, doctors do not always know best. Does it not then make sense to include the patient as an active participant in the care process as well, particularly in the case of mental health? These participants’ statements show that they empower themselves by asserting that they possess knowledge and resources to, along with professional help, care for themselves as patient-experts (and by extension, as patient-agents).

This concept of the patient as an expert of their own health management has recently been further explored (Wilkinson and Whitehead 2009). Through the lived experience of existing with the illness, a person establishes a certain amount of expertise on their own illness (Milson 2001; Bodenheimer 2002; Wilson et al. 2007), which can guide the forms of care that ‘patients’ gravitate toward. Ramsundar (2018) discusses people with type 2 diabetes in South Trinidad as biological citizens who, in the face of skepticism about biomedical care, use, “historical knowledges about food that are not necessarily informed by diabetes-centric meal plans and suggestions by doctors, but what historical knowledges and advice arises from the community” (96). Patients and patient communities develop their own expert lay-knowledge about health and wellness, which warrant continued consideration. There are potential risks involved with this frame of mind, however. In the literature on illnesses such as diabetes, where people with the disease must chronically manage their own health, when patients do not care for their illness in ways deemed appropriate by biomedical standards, these patients are viewed as noncompliant and partially at fault for their own ill-health (Seligman et al. 2015). It might be a slippery slope to endorse a plan that relies so heavily on self-care when it comes to mental
illness because if patients showed no signs of improvement, they might be considered at fault. If the full burden and responsibility of good mental health is placed on the person who is struggling, this will lead to further issues of stigmatization. Nevertheless, my research indicates that patient expertise in self-care should be acknowledged with the goal of problematizing patient disempowerment resulting from the overemphasis on the legitimacy and influence of clinical knowledges and forms of care.

**Structural Forces that Disempower Students with Mental Health Struggles**

Participants frequently made comparisons between physical and mental health to challenge the limited recognition given to mental health challenges as legitimate reasons for accommodations by some instructors. Comparisons between depressive episodes and cancer, for example, were drawn with the sentiment that both types of illness cause real pain and distress, even though the latter may be measurable and testable to a greater extent. Students typically compared physical pain with psychological pain after sharing personal experiences where their mental health struggle was not taken seriously by certain friends, family members, and professors. This attribution between physical and psychological symptoms has been observed cross-culturally, notably in India where described feelings of “stress” and “tension” are idiomatically employed to put words to symptoms of physical ill-health (and other times, tension is believed to be the cause of the medical issue itself among Indians) (Weaver 2014; 2017). In my research, these types of comparisons were employed strategically with the aim of legitimizing the reality of student struggles and psychological distress. Some students sounded defeated when speaking about these issues, appearing tense and frustrated by the barriers they have faced to being taken seriously and achieving agency, including Katie who vented,

“So the hard part is it’s not like a broken arm where you go from being fine to being in ridiculous amounts of pain… the pain just kind of slowly, gradually adds on and the next
thing you know, your whole world is just pain. But that’s your normal. Which is a horrible way to live! In constant pain.”

Katie’s quote provides an alternative interpretation of pain, one which is not bodily but instead psychosomatic, psychiatric, and emotional. The following quotes from Omar and Sadie, both undergraduate students, demonstrate how students felt the need to give credibility to this pain and its accompanying difficulties in response to feelings of stigma and powerlessness in the school environment.

Omar: “I mean it’s just kind of a big joke. Do you know how much the school would be on my side if I had cancer or something? I mean sorry but I would be able to take time off without worrying about my transcript being completely ruined, I could… I don’t know get an extension if I had an appointment or something like that. I’d have cancer, yah, but I’d have support. But tell people here you have bipolar disorder? No, you may as well be a leprechaun. Like I mean they look at you like you’re making it up and your problems are make believe. But if someone with cancer has troubles you don’ think I do too?”

Sadie: “Honestly, I’m one of the lucky ones. Because I have my nerve problem. I have a doctor’s note for that so I can use that as an excuse whenever I’m having a bad day mentally and need a bit of a break. Is that bad to say? You can bet I’m not going to tell a prof that I’m having a bad day and need some extra help… like haha sure you are.”

These comments point to the bureaucratic hoops that students with mental health struggles sometimes need to jump through to have their struggles legitimized and cared for, a recurring issue that I heard about from students. When their peers have physical health stressors they are accommodated but when students seek similar accommodation for mental health stressors their efforts do not always achieve the same results. While Student Accessibility Services grants accommodations to students with mental health struggles and gives cases of mental illness the same amount of sensitive consideration as cases of physical illness, accommodations for mental health difficulties are not always recognized by individual professors in ways that are consistent (Lehman, Davies, and Laurin 2000; Hartman-Hall and Haaga 2002; Hindes and Mather 2007; Barnard-Brak 2010). While many of my participants cited
positive interactions with professors in seeking support for their circumstances, about a quarter of them had also been refused accommodating support from individual professors (these were students who had already been granted academic accommodations by SAS), indicating a dangerous discrepancy between policy and practice. The refusal of equitable leniencies for students struggling internally is reflective of a broader cultural issue, one that propagates a widespread myth that psychiatric issues are less toilsome than physical illness. When this misconception is enacted within the university at large, students suffer. Jamie revealed,

“When you’ve read your course outline and it says, ‘there will be accommodations for compassionate reasons’ and you message your professor [about mental illness] and they say, ‘well to me that’s not a compassionate reason.’ It’s like… wait, what, wait I was told by the other part of the university, by student wellness services, that I would be accommodated! So it’s kind of weird. It’s more like there’s a great push for a place to go when you need help but the professors and program advisors and counsellors and just the faculty in general don’t seem to be matching the stride of the wellness offices because they just… it's kind of like here we’ll throw you to SAS but I’m not going to do anything about it when you show up to class.”

Experiences like Jamie’s are actually a violation of human rights according to the Ontario Human Rights Commission (OHRC). According to the OHRC, it is the role and responsibility of post-secondary institutions to,

“ensure that their facilities and services are accessible, that appropriate, effective and dignified accommodation processes are in place, and that students who require accommodations because of their disabilities are accommodated to the point of undue hardship. Under the Ontarians with Disabilities Act, they are also required to complete an accessibility plan. Educators at the post-secondary level are responsible for participating in the accommodation process (including the provision of specific accommodations), being knowledgeable about and sensitive to disability issues, and maintaining student confidentiality [my emphasis added].”

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6 This also falsely dichotomizes mental and physical illness, the body and the mind are so often perceived as mutually exclusive entities (Scheper-Hughes and Lock 1987). In reality, mental illness can take a toll on the physical body as well (and vice-versa).

7 In OHRC documents on academic accommodations mental illnesses are included under the umbrella term “disability.”
Students with mental health struggles must be counted among those with legitimate struggles deserving of accommodation in accordance with the OHRC and every post-secondary educator should be well-versed in the accommodation process, including who is eligible for accommodation and the types of accommodations that can be offered. Not only must universities deliver appropriate accommodations to students with mental health difficulties, they must do so in a way that is non-discriminatory. In 2016 an addendum was added to the OHRC policies stating that students are no longer required to disclose a DSM diagnosis to receive an accommodation; medical documentation that confirms mental illness without specific diagnosis is enough. Still, accommodations granted by Student Accessibility Services are not always recognized as legitimate by individual instructors. Therefore, narratives that compare physical to mental health were a form of resistance against the institutional beliefs that their problems were not worthy of support and that mental health difficulties are not medical conditions deserving of accommodation. As my participants’ accounts illustrate, in many cases, students navigate their academic lives without academic support and accommodation for their problems. This results in more stressors, further time constraints, and a decreased ability to practice self-care.

**The Assumption of Normalcy: Barriers to Self-Care**

Although the students I spoke to described in detail dozens of self-care practices that have effectively stabilized and improved their mental health (Chapter 4), many of these same individuals report rarely engaging in these activities. Several barriers exist that prevent students from regularly performing self-care practices, namely a lack of time and a societal pressure to be productive. Although this might seem self-sabotaging, self-destructive, and noncompliant, a refusal or inability to practice self-care has been observed among other communities. One ethnographic example is the study by Hunt et al. (2001), which demonstrates that the barriers
that can interfere with caring for oneself take on many forms. The Mexican American immigrants of this study faced monetary, social, and environmental constraints that prevented them from effectively managing the physical symptoms of their diabetes. In my study of university students with mental health struggles, social and institutional constraints limited their practice of self-care.

Although every student described several self-care strategies that have benefitted them in the past, there are three significant barriers to student self-care. The limited recognition given to mental illness as a legitimate concern deserving of academic accommodation by some professors as discussed above is surely a barrier to self-care. When students are not accommodated for their mental health issues, a butterfly effect occurs where they must focus all their resources on academic work and forego self-care.

Second, academic responsibilities do not leave students with enough time to practice self-care. Self-care is dependent upon having enough time to practice it, making time a fundamental element of mental health. Students with mental health struggles know how to practice effective self-care to promote their psychological wellbeing but they consistently communicate that academic responsibilities do not leave them with enough time to care for themselves. The normative institutional expectation imposed upon students is that they will productively progress through post-secondary studies in a way that is continuous and uninterrupted, which does not account for students who may have diverse wellness needs. Since forgoing schoolwork and related responsibilities (volunteering to improve resumes in the face of competitive job markets, holding down jobs to pay for tuition, etc.) have immediate, tangible consequences that jeopardize this normative progression through studies, self-care is sacrificed before schoolwork is. When describing the workload of university, Sarah said,
“I do find that occasionally, um, schoolwork can sometimes take a lot out of me and that I just don’t have any energy left to do anything else. And it means that I don’t have as much time to do the things I need to do to take care of myself like seeing friends or getting enough exercise or eating properly. Or getting enough sleep. Like all of these things are important for both physical and mental health but they are one of the first things I stop doing if I’m super stressed.”

Students said that practicing self-care gives them feelings of control, especially over negative or harmful thoughts and emotions. These self-care practices were often spoken about longingly and in the past tense because of an inability to engage in these hobbies, activities, and daily routines when school saps them of time and energy. Cornelius talked about an activity that used to improve his mental health but that he has since halted because of the busy pandemonium in his life. He has decided not to partake in this activity again until after he finishes his current undergraduate degree as well as his planned future master’s and PhD degrees. He said,

“One thing I really liked toward the end of high school was writing, writing short stories, characters, and I haven’t done that because I don’t have always as much time as I would like as an undergrad student. But that’s something I would love to get back into maybe after my undergrad or after I’m done being a student like ten years down the road.”

Third, not only do students feel like they are lacking time but when they do have time, self-care remains low on the list of priorities because of guilty feelings resulting from a societal and institutional pressure to be productive. Conversations about time management for university students often focus on how to get through dozens of readings a month, how to juggle multiple exams in a week, and how to avoid procrastinating on assignments. This time management advice is offered during orientation events, setting the expectations for a student’s time in higher education, and are continuously reinforced throughout a student’s academic career. The message is loud and clear: to achieve success, managing schoolwork is to be prioritized above all else. While this type of time management information can be important, it overlooks a student’s need to manage their scholastic responsibilities with other important factors such as their personal
health, both mental and physical. With the small amount of free time that overloaded students do have, they must choose how to spend that time. As Omar said, “always more reading, more editing, more writing, more volunteering, more working can be done.” This seems to suggest a social preoccupation that is far-reaching beyond the university: the idea that in order to be truly and fully productive, a person must work herself to the bone. This “ideology of achievement” (Demerath 2009) is damaging to student wellbeing and identity-formation; the competitive school environment correlates a student’s worth with their capacity to produce.

It is no surprise that recent literature on self-care typically mentions the contemporary climate of neoliberalism (Yates-Doerr 2012; Seligman et al. 2015; Chudakova 2017), given that ideas of productivity and personal responsibility are central to both discussions. If a student chooses to spend their down time by practicing self-care, they feel guilty because they are being unproductive. Almost every student reported feeling guilty and selfish for devoting valuable temporal resources to the activities and hobbies that fall under the category of self-care, even when their mental health benefitted from it. The reasoning behind the feelings of guilt is that their time could or should have been better spent being productive. Productive, in this case, means devoting time to school and resume building. When discussing the pressure to prioritize schoolwork over self-care (or as she calls it, coping mechanisms), Carter said,

“Sometimes I need to just put things down and go for a swim, go for a run, go get coffee with someone. Now, being in university, there’s that stress like I cannot take the hour to calm down. Because if I use this hour for calming down, that’s an hour later that I’m not sleeping because this [schoolwork] needs to get done. So I think as much as I’ve still hung onto using my coping mechanisms I don’t necessarily take the time to reach for them when I’m at school.”

What’s more, the notion that student mental health should be sacrificed in the name of academic success has become normalized. Katie described how the lack of balance between schoolwork and self-care has become a pervasive issue that is socially sanctioned, saying,
“This mentality that being stressed out of your mind, pulling all-nighters, binge drinking, getting high off Adderall, and just like working yourself to a burnout stage… that’s cool. Like that is the expectation and if you are not completely exhausted and stressed out of your mind, you’re not working hard enough or you don’t have enough to do.”

Since students are ‘normally’ assumed to be continuously productive in an ongoing and uninterrupted fashion, students struggling with their mental health are structurally set up to fail. Either they must do away with valuable, necessary self-care to keep up with the normal academic trajectory and in doing so put their mental health at greater risk or they must be marginalized for deviating from the norm of productivity. Davis (2013) discusses the power of norms in the making of disability and explains that, “the ‘problem’ is not the person with disabilities; the problem is in the way that normalcy is construction to create the ‘problem’ of the disabled person” (3). In this case, the normative trajectory of the academic career can be disabling for students with mental health struggles, especially when they deviate from these norms. Agents must always act within and confront structural relations (Ortner 2006) and here we see that students as patient-agents are limited by the structural constraints within the university.

Despite these structural constraints, students do sometimes make a choice to care for themselves. Sarah’s advice to all students sums up student perspectives of self-care nicely and demonstrates how self-care can be a form of resistance and an expression of agency. She said,

“It doesn’t matter that oh, well I only have a week to complete this essay. Yah, that’s all well and good but if you try and cut out time for yourself, you will eventually crash and burn. It might not be this week, it might not be this month, it might not be this year, but it will happen eventually. You are important, take care of yourself.

In this way, the participants of my study challenged the constructs of normalized productivity at a postsecondary institution and asserted the importance of their self-care and management of wellbeing as patient-experts.
Defying The Odds

Although the exertion of agency among my participants is constrained by the structural barriers within the university, students are still actively determined and high achieving. Participants reiterated a shared narrative that emphasized their ability to practice self-care and to succeed *despite* and *in spite* of the barriers that discourage the practice of self-care. Resiliency is a core facet of their identities and subjective experiences, which challenges the stereotype of students with mental health issues as less capable and less dedicated students. Hudson describes how sport as a form of self-care reassured him of his abilities not only as an individual with psychiatric struggles but also as a capable student when he said,

“You know once… at one point I had this idea that something was wrong with my brain. Like maybe I’m disabled and actually that means that I can’t be the person or student that I want to be… and actually that I need to be. But now I think, ‘no!’ I’ve found ways that actually make me, what’s the opposite of disabled? Able! I’ve found ways that actually make me able to do what I need to do. That’s where the being an athlete part comes in. Like I’m not talking about actual [physical] disability but if my brain was broken then I wouldn’t be able to get my body to move. So I focused on that and thought about it and it makes me feel better and not as anxious about my anxiety. Soccer and lacrosse too. […] And after a game you think I’d be tired as… you think I’d need to pass you on the spot but no! I go home and that’s actually when I read and study.”

In this upcoming discussion, I emphasize student agency largely through my participants’ resistance of normalizing views about students with mental illness, and here I tread lightly. Fraser (1992) describes the complicated role of resistance in discourses on marginalized people in the case of feminist theory: on the one hand, proponents of feminist theory want to document and corroborate the marginalization of women and their subjugation by patriarchal authority, in doing so *under*emphasizing capacities for resistance. On the other, they want to encourage modes of feminist activism and advocacy, in doing so *over*emphasizing resistance as a plausible option for real change. While there are harms in embellishing or fetishizing the capacity for agency, one does a disservice by failing to recognize efforts of resilience as well (Jenkins 2015).
I find myself cemented in this same tug-of-war struggle; at the same time needing to validate the real struggle of my participants but all the while wanting to demonstrate their capacities as agents of resistance. I leave this note here in recognition that agent-lead social change is no easy feat (Ratner 2000), even though I learned of small triumphs of resistance from each student that I spoke to.

**Proving People Wrong**

The students that spoke with me said that the people they interact with in their social circles have certain expectations of them as young people with mental illness. More specifically, people have expectations of them specifically as students with mental health struggles. They believed that when people learned of their diagnosis, they were viewed as less capable students or students who were looking for an “easy out,” regardless of their actual academic performance. For example, students felt like they were not taken seriously when they spoke about their mental health struggles, like their mental illness was not legitimized. This in turn guided students’ decision to disclose their diagnosis to staff and faculty at the university. Petra said,

“Two days before an assignment is due I can’t message a professor like, ‘hey look, I’m not having a good day. Like I’m 75% done my essay but today is just a really bad day, I can’t finish the other 25%, can I have an extra day?’ They’d be like, ‘screw you, everyone is just gonna say that.’ They just wouldn’t do that so for me, when I’m feeling like I’m not coping and I have something that’s due like relatively soon and I still have to work on it then I just get like overwhelmed because I’m like… I have to do this. If I don’t do this I’m gonna fail.”

Em, who has chosen to disclose her diagnosis to select people in her social circle as a student, elicited a different reaction. People treat her with a sort of fragility and inherent, all-encompassing inability. She said, “do you know how many times I’ve had people ask me in the most patronizing way, like, ‘sweetie, honey, Em, don’t you think that you should take time off, time for yourself, what with everything you have going on right now?’ It gets old.”
The concerns expressed by students are not only supported by their narrative accounts but are also supported by the literature. Research demonstrates that stigmatizing narratives are commonplace toward postsecondary students with mental illness. A psychiatry study from 2002 explored the attitudes and perceptions of university students and faculty about psychiatric disability (Becker et al.). Although this is not a particularly recent study, it reveals that as early as fifteen years ago, fewer than 50% of faculty at a large American university were comfortable dealing with students who live with mental illness. In this study, the cited discomfort has led to 42% of faculty believing that students should not be eligible for benefits that accommodate their mental illness, even when policies and laws are in place that require this, and that students with mental illness do not belong in post-secondary programs. This article even reveals that psychiatric disability has resulted in student expulsion, regardless of academic performance. Though this is an American study, the findings seem to be translatable to the Ontario context I observed. There are institutional prejudices that exclude students with mental health issues from feeling belongingness on post-secondary campuses. They are viewed as less capable and less effort-driven than their neurotypical peers. Self-administered care can allow students to confront and challenge these assumptions in addition to promoting their long-term productivity and resilience.

Students have the knowledge that their status as people with mental illness compromises their social capital in educational milieus. Consequently, when students have the opportunity to defy the expectations placed upon them, this can sometimes be an agentic form of resistance. Simply succeeding by successfully caring for themselves plays against type in the minds of others. Carter lives with social anxiety that disrupts her day to day life. At the same time, she is in a renowned program at the University of Guelph that is highly exclusive and demanding. She
reflected upon what others think of this false dichotomy, explaining,

“You know I’ve had it personally from people in my life who are like, ‘oh how can you want to be a vet if you can’t socially interact with people?’ and I’m like… just because I struggle with that now doesn't mean that ten years down the road I’m not going to be able to do it. And the fact that you're telling me that I can’t just means I’m gonna do it, dammit! I mean if you’re going to say that then fine, I’m upset, but now I’m gonna do even better. And I’m already doing fantastically so there!”

In Carter’s case, which is also true for many of the other participants, student self-care is a performance of agency that confronts and challenges negative assumptions about students with mental illness. Other students, including Liu, similarly discussed how self-care has the dual role of addressing wellness while also functioning as an agentic act of resistance that allows them to assert their intellectual competence, saying,

“Oh this is actually a funny story that I totally forgot about before. So I was retaking this midterm for a random history class that I was taking it because I missed it the first time around. The prof knew that I missed it because of my depression and all that because I e-mailed her the day of the test being like, ‘this is not going to happen for me.’ And ever since then I felt like she maybe treated me differently… not different maybe just that she expected more of me and she would always ask me more questions in class? And it made a difference because it was a seminar course. Anyway when I went to go retake the midterm in her office as a joke to myself I showed up in my full cheer costume and holding a Harry Potter book. Like hell ya, look at me, you think I don’t have my “S” together but I’m a high intensity athlete and I was reading for pleasure!”

Importantly, for Liu, cheerleading and reading as forms of self-care did not only function as ways to stick it to the man (or the history prof, in this case). She went on to say that cheering and reading did eventually help her get back on track with her studying and her coursework. Liu needed to take time off to care for herself during her mid-term exams and this decision resulted in negative reputational repercussions. Still, the rewards of making the difficult decision to defer her exam eventually paid off when she felt well enough to take the delayed mid-term, all the while with a good sense of humor. So students weight the benefits and drawbacks of taking time off from school to care for themselves and will sometimes do so when it is deemed necessary...
and it helps. My participants sometimes chose to act on self-care while other times foregoing caring for themselves, both of these decisions having real world consequences.

Most of the students I interviewed distinguished themselves as high achieving students. Moreover, several of them were majoring in challenging, highly demanding programs, including animal science, chemistry, psychology, and biological engineering. That they were able to maintain high academic standing despite their mental health issues was a source of pride for many, including Petra, saying,

“I’m trying to get into law school too so my grades matter. It’s not like I’ll just take a 60, I need 80s, 90s, I’m not just trying to get average grades. I'm trying to exceed that. I am exceeding that. So it’s difficult for me when if I feel like I’m not coping because then I’m not able to do my things I need to do or be productive.”

Later, Petra describes what she calls her “take that attitude.” This is essentially the feeling of empowerment and satisfaction she gets when she is able to defy all of the odds and be well enough not only to pass at school but to achieve grades that make her a top contender for law school. The “take that attitude” is also a feature of Petra’s home life, where she can prove her siblings wrong, who often call her a “psycho.” Petra, Carter, and their peers work to question the stereotypical view that students with mental health challenges are “less capable.” By proving people wrong and defying the odds, this study’s participants offered alternative constructs of psychiatric struggle.

Discussion and Conclusion: Self-Care as an Avenue Toward Agency

For students with mental health struggles at the University of Guelph, acts of self-care are expressions of agency performed in the face of the university and the medical system as institutions that frequently prevent student patients from caring for themselves. Through the enterprise of agency, although not always explicit or realized, students seek control within their lives. Still, each actor is also constrained by the power relations within which they are embedded.
(Ortner 2001, 2006). We see that this is the case with my participants, who are entrenched within structures that promote marginalizing views of people with mental health issues, namely that they are unworthy and less capable until such a time that they can be ‘cured’ of their aberrant illness. Of course, the systemic stigma and marginalization that they are often subjected to cannot easily be dismantled through individual acts of agency. Rather, students resist on a smaller scale by performing self-care as acts of agency, which rewrites the narrative of the student with mental illness; rather than being perceived as incapable, fragile, or deviant, expressing agency through self-care allows students to demonstrate control and prove their worth. In this way, they are rejecting the sick role (Parsons 1951) and expressing their resilience.

The idea of patients as experts of their own illness has been explored in the existing literature (Hunt et al. 2001; Milson 2001; Bodenheimer 2002; Wilson 2007 Wilkinson and Whitehead 2009) although rarely in the context of mental health. Since patients have the lived experiences, their histories inform a unique knowledge about their health, one that is not often recognized in clinical settings. My participants assert their expertise by exerting agency through acts of self-care, which can address their wellness needs in ways that are flexible and well suited to their daily lives. They integrate clinical and self-care perspectives, having the control to choose both or either in the creation of personalized care plans informed by their status as patient-experts.

**Conclusion**

Although my results demonstrate that self-care is an important act of agency for students with mental health issues, it is still concerning that there are institutional barriers preventing the performance of self-care, including a limited access to academic accommodation and pressures to succeed and be productive, which do not always leave students with the time or ability to care
for themselves. Among my participants, a high value is placed on productivity. The student identity that has been normalized is one in which a student can continually sustain productivity. When mental health struggles cause a student to deviate from this course, they can be marginalized. An internalization of this ‘normal’ commitment to productivity means that students often do not take the time to practice the self-care that is necessary.
CHAPTER 6: Conclusion

“Your now is not your forever.”
– John Green, Turtles all the Way Down

Summary of Arguments

For students with mental health struggles at the university of Guelph, self-care practices involve acts that students want, rather than need to do. They are adaptive, health-oriented acts performed in the interest of mental health maintenance or improvement. Students reported a wide array of self-care practices that were embodied, social, individualistic, collectivistic, and rooted in the everyday. Self-care was clearly shown to encompass a range of activities and practices although they all had one critical feature in common; they were guided by self-initiation. When my participants followed clinically recommended self-care regiments, which were imposed upon them and not necessarily in line with their own wants or interests, they reported no improvement in wellness. As experts of their own subjective experiences, students experientially have the intuitive knowledge that allows them to holistically address their mental health needs through agentic acts of self-care.

Self-care can be an agentic act that allowed the students I spoke with to remodel the normative perception of young people with mental health struggles. When post-secondary students have mental illnesses, the clinical care system treats them as patients first and students second (if at all). They are expected to passively accept their role as patients and prioritize their recovery above all else. This paints a picture of students with mental health struggles as less capable, more fragile, and deviating from the ‘normal’ student until such a time as they are “cured.” This linear perspective of recovery disregards the oscillating nature of mental health and the range of neurodiversity experienced among university students. Importantly, it also fails to
take into account the capacity of students as actors and vehicles of control. Comparatively, treating them as students first and patients second would likely produce similarly adverse effects. My participants are already burdened by academic pressures to be productive and high achieving in their roles as students. Instead, I call for a healthier balancing between the roles of patient and student in settings of higher education.

Despite the empowerment that students can exert as patient-agents and patient-experts, they are not always able to exert agency as there are structural barriers in place that can have consequences when broken. Complicated access to accommodations, the normalized pressure to be productive, and the time costs associated with being a university student can prevent students from practicing self-care. Students must delicately negotiate their paradoxical roles as both students and patients in the ongoing quest for mental health. Still, students seek out avenues for agency and take control of their wellness in empowering ways through self-care. As Mannard alluded to earlier, self-care has the power to save lives.

The expertise of patients in understanding and managing their own wellbeing has already been observed in the literature (Milson 2001; Bodenheimer 2002; Wilson et al. 2007; Wilkinson and Whitehead 2009), especially in discourses on diabetes. Diabetes management involves consistent self-care where food, exercise, and blood glucose levels must constantly be monitored and adjusted by the patient. When the wellbeing of patients with diabetes does not improve according to biomedical markers of health, patients are viewed as noncompliant and personally responsible for their ill-health (Seligman et al. 2015). By extension, we must be careful in mental health research on self-care not to automatically blame people struggling with their mental health for a decline, stagnation, or lack of improvement in their wellness. If a student includes self-care in their wellness regimen this does not mean that they should be held solely responsible for their
wellbeing. Still, my study demonstrates that patients’ expertise and self-care strategies need acknowledgement to challenge the disempowering barriers set forth in clinical and educational contexts.

**Significance of the Study**

**Academic Contributions**

This study is contributing to an anthropology of self-care, an increasingly noteworthy area of research that seeks to understand self-care as a new configuration of care. My research provides insight into an important new line of inquiry in the anthropology of self-care. While self-care among individuals with physical conditions and chronic illnesses have been explored ethnographically (Guell 2012; Yates-Doerr 2012, 2014; Seligman et al. 2015; Snell-Rood 2015; Chudakova 2017), mental health has been largely disregarded in the medical anthropology literature on self-care. As an important component of overall wellness, mental health has notably been understudied in anthropological discussions on care, care giving, and care receiving. In this study, a definition of self-care that is relevant to university students was developed, which is a meaningful contribution given the conceptual ambiguity that sometimes surrounds discussions about self-care. Although self-care as a concept has notoriously been devoid of definitional clarity (Segal and Goldstein 1989; Wilkinson and Whitehead 2008; Chudakova 2017), there are trends in the literature regarding previous conceptualizations of self-care. In clinical settings, self-care is intimately linked with matters of compliance (Wilson et al 1986; Seligman et al. 2015), where a failure to improve patient health by caring for the self is attributed to noncompliant attitudes and behaviors. This perspective devalues self-care as a potential avenue toward empowerment and reduces it to the ability (or inability) to abide by professionally proscribed methods of caring for the self. Anthropological studies (eg: Hunt et al 2001; Seligman...
et al. 2015) problematize this perspective by including patient perspectives that speak to the importance of self-care as a means to wellness in the face of clinical care systems that do not always understand a patient’s needs and which place an emphasis on personal responsibility and clinical control. I contend that self-care is a valuable configuration of care that offers university students with mental health struggles the opportunity to seek agency in the face of clinical and structural forces that limit their wellness in their capacity as both patients and students.

Additionally, my discovery that student self-care is an agentic act heavily reliant upon self-initiation contributes new knowledge to this area of study. The finding that agency is intimately related to self-care among post-secondary students broadens our understanding of what it means to care for oneself and how it is related to agentic control and wellness. Previous anthropological studies have discussed self-care in various ways. Self-care can be a relational process in the clinical setting where, in the context of diabetes, nutritionists share the responsibility and burden of recovery with their patients (Yates-Doerr 2012). Alternatively, self-care among pensioner communities in Russia is collectively practiced as an alternative to clinical care in a context where elderly individuals have complicated access to professional care (Chudakova 2017). My discovery that self-care is less effective and disempowering when it is clinically imposed and when it is not necessarily in line with a person’s own wants or interests is also an important contribution to the anthropology of self-care. This further problematizes the patient-physician relationship that is already a focus of interest in the literature.

More broadly, my study also contributes to the anthropology of mental health by focusing on students with mental health struggles as a specific community of interest. University students are uniquely positioned in their experiences of mental health management because of particular challenges they face as a community. After high school, young adults who choose to continue
onto post-secondary education typically inherit a large amount of autonomy. At this time, students will often live away from family for the first time and need to manage their social and health issues independently. When managing their mental health on their own, students are not always able to receive satisfactory or timely professional care at the university due to inadequate funding for on-campus wellness services that result in these services being understaffed and overbooked. This need for supportive care and accommodation that is not always accessible comes at a time when a student’s social life is being restructured, when they are learning to cope on their own, and when they are facing fierce academic competition. These structural factors deeply shape post-secondary students’ subjective experiences of living with mental health struggles and the types of care they engage with. At the same time, there are ongoing discourses that deliberate the extent to which universities as educational institutions are responsible for the mental health support of their students. Pressures to walk the line between teaching and treatment have opened dialogues about the hand that universities should play in providing therapies on campus versus referring students to off-campus resources. Since post-secondary institutions have a role to play in producing the conditions that foster mental distress in the first place, these conversations are rooted in ethical and moral considerations of the burden to care.

By implementing a critical disability studies perspective in my examination of the subjective experiences of student mental health and self-care, this study highlights the external factors that create “disabling” and challenging barriers to wellness for students. This approach problematizes biomedical and medical anthropology perspectives on mental illness. The participants I interviewed expressed a desire to override hegemonic biomedical and psychiatric perspectives on mental illness. Students disagreed with the clinical portrayal of mental health struggles and the people who live with them. My participants disagreed with this notion that,
because of their diagnoses, they were somehow less capable than their peers and incapable of effective decision-making. They felt forced into the sick role by the clinicians they saw, in a limbo where their value hinged on recovery. At the same time, the university expected them to prioritize their role as students and not patients. Given the situated connection between normalcy and productivity (Davis 2013), when my interviewees failed to be productive students or patients, they were relegated to the role of the abnormal. The disability studies perspective helps to disentangle the paradoxical forces at play, both of which are hinged on the powerful ideology of normalcy; on the one hand the normalized expectation of productivity among students and on the other the clinical pressure to prioritize recovery.

**Public Contributions**

A significant stakeholder community in this research is the population of post-secondary students who struggle with their mental health. The voices of young people with mental health struggles are not often heard, whether it be due to stigma, fear of disclosure, or the belief that people with mental illness are vulnerable and unreliable. This project prioritizes the voices of students with lived experiences and provides them with an outlet to share their expert insight on how caregiving works in their lives and works to shape their identities. This study demonstrates how students with mental health struggles achieve agency in higher education through self-care practices. The limited attention paid to agency in the literature does a disservice to students with mental health struggles by failing to address their experiences of resilience. By highlighting students as having the ability to be capable, high-performing, and intuitive, the findings of my project combat the negative assumptions about student mental illness that can be so marginalizing. On a small scale, I will deliver the findings from this study to Student Wellness Services and Accessibility Services so that they may work with the university to better address
the wellness needs of students. I also intend to explore other outreach and advocacy options that will reach a wider lay audience- both addressing the structural barriers that complicate access to care and promoting student resilience to combat the stigma-centric discourses on student mental health. Student mental health is a topic that is both conceptually complex and politically charged; this study gives voice to individual students in an effort to reveal the structures that make it so.

The university as an institution will also benefit from these research findings. For post-secondary schools right now, ethnographic research in the area of mental health is imperative and it is critical. Calling the current Canadian landscape of mental health a crisis, in particular among young Ontario students, is in no way an overstatement. Canadian students are facing increasingly proliferative and complex mental health challenges. A comprehensive report from four organizations (The Ontario Undergraduate Student Alliance, Colleges Ontario, The College Student Alliance, The Council of Ontario Universities), which speaks for forty-five of Ontario’s colleges and universities, claims that campus mental health is one of the most urgent issues that Ontarian educational institutions are currently facing (COOU 2017). While this tells us that the situation is critical in Ontario, the National College Health Assessment (NCHA 2016) indicates that the situation is not vastly different across Canada with students all over the country experiencing distress (although further research is needed in other provinces and territories in the country).

In light of the above, the results from this study may be used to inform the development of a set of guidelines by governing bodies on Canadian campuses to better manage the needs of students with mental health struggles. The data will allow for the creation of innovative strategies to better accommodate students, to promote their wellbeing, and to make university campuses more inclusive spaces. This can be done by addressing the structural barriers currently
in place that prevent students from practicing self-care. Namely, ensuring that all university employees are well-versed in accommodation best practices will help align practice with policy. The reality of accommodation for students with mental illness must be more in line with the discussed human rights standards outlined by the OHRC, which will greatly improve campus wellness by allowing students the opportunity to care for themselves when needed.

People in positions such as student council members and directors of student wellness services will understand the subjective experiences of the students attending their universities more holistically and will be more well-equipped to create a healthier learning environment for students. This will need to include an attitudinal change that accepts neurodiversity and no longer promotes the idea that uninterrupted productivity is the only ‘normal’ and accepted way to be a successful student.

**Future Research**

While I have begun to explore student self-care and its connection to agency, further exploration of this topic is still necessary going forward. Future research might continue to probe this notion of the patient-agent and explore how patient-agents might also be able to act as student-agents. Medical anthropology is an area well-suited to addressing the subjective experiences of self-care in people struggling with their mental health. The exploration of agency through acts of self-administered care has been largely ignored in the context of mental health. In student populations, the limited attention paid to self-care fails to address the full extent of their resilience. Their feelings of control, desires to act upon the world, and the structural boundaries within which they still achieve this are central features of agency and self-care. An interesting avenue for future discovery will also include a thorough ethnographic study on clinical perspectives of self-care in the treatment of mental illness and how patient and physician
perspectives might be reconciled. Medical anthropology in combination with a critical
disabilities studies perspective is an area well-suited to addressing the subjective experiences of
self-care in students struggling with their mental health.

Future research might also investigate these topics by addressing some of the limitations
of my study. Due to privacy and timeline issues, this project did not have a participant-
observation element. Methodologically, in-person observation of student interactions
surrounding mental health (at campus therapy sessions, campus wellness events, etc.) would add
valuable richness to the data by allowing for the examination of how students discuss their
wellness in a non-research environment. This research was conducted over the summer so
campus events were scarce. Additionally, since Master’s research typically takes place over a
two to three month timeline, it was difficult to actualize my position as an observer in a clinical
setting like campus therapy sessions. However, these options should be considered for future
projects on student self-care.

Again, it is also important to note that my project did not include the voices of students
who did not want to disclose their identities as individuals with mental health struggles. My call
for participants attracted students who were comfortable enough to voluntarily provide their
accounts of mental health and illness. With more time and resources, it might be possible to build
the rapport and trust necessary to include the perspectives of students who may have slipped
through the cracks of my study.

Going forward, more prolific examinations of care in post-secondary institutions is
needed. Given our knowledge that experiences of psychiatric conditions are deeply shaped by
culture and context, broader voices from diverse communities must be included. What are the
experiences of students with mental health struggles in other areas of Canada and globally? How
and why do student experiences of mental illness in schools vary cross-culturally and what can we learn from each others’ practices? Participant observation in culturally and geographically diverse scholastic settings will provide more nuanced insight into student wellness from a global mental health perspective. Students with more ‘severe’ mental illnesses including schizophrenia and bipolar disorder should also be included in discussions about self-care. In what ways do they experience and engage with self-administered care and what can it do for them?

**Unmaking the Structure through Acts of Care**

Acts of self-care are diverse collections of practices that post-secondary students turn to in the quest for mental wellbeing. Caring for one’s self is a creative, intuitive process of adjustment that gives students feelings of control in the face of medical and educational institutions that make conflicting demands of them. Beyond its ability to promote positive emotional change, self-care is an agentic act that allows students with mental illness to resist normalizing assumptions about them. Still, self-care cannot be touted a universal cure-all for the campus mental health crisis. Deeply entrenched structural barriers prevent students from attaining wellness via self-care. The students who donated their time for this project explained that the university does not recognize the fundamental role that self-care plays in student wellness. Instead, they chiefly associate caregiving with clinical and professional services. I urge that we begin to recognize the importance of self-care on our campuses and promote students’ ability to stimulate their own resilience. Just as phenomena like stigma and systemic inequality are socially constructed, so can they be socially deconstructed. The enterprise of self-care, which gives students positive feelings of control, psychological wellness, and authority over shaping their identities, is one such way to begin deconstructing the barriers that create roadblocks to
wellness. In focusing on self-care as an important practice in need of recognition, we work toward making sure that students are cared for and can care for themselves on our campuses.
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APPENDICES

APPENDIX A: Breakdown of Participants

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alycia</td>
<td>Female</td>
</tr>
<tr>
<td>Carter</td>
<td>Female</td>
</tr>
<tr>
<td>Cornelius</td>
<td>Male</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>Female</td>
</tr>
<tr>
<td>Em</td>
<td>Female</td>
</tr>
<tr>
<td>Grace</td>
<td>Female</td>
</tr>
<tr>
<td>Hudson</td>
<td>Male</td>
</tr>
<tr>
<td>Jamie</td>
<td>Female</td>
</tr>
<tr>
<td>Katie</td>
<td>Female</td>
</tr>
<tr>
<td>Liu</td>
<td>Female</td>
</tr>
<tr>
<td>Maddison</td>
<td>Female</td>
</tr>
<tr>
<td>Mannard</td>
<td>Male</td>
</tr>
<tr>
<td>Marcus</td>
<td>Male</td>
</tr>
<tr>
<td>Marcy</td>
<td>Female</td>
</tr>
<tr>
<td>May</td>
<td>Female</td>
</tr>
<tr>
<td>Monica</td>
<td>Female</td>
</tr>
<tr>
<td>Omar</td>
<td>Male</td>
</tr>
<tr>
<td>Petra</td>
<td>Female</td>
</tr>
<tr>
<td>Sadie</td>
<td>Female</td>
</tr>
<tr>
<td>Sarah</td>
<td>Female</td>
</tr>
<tr>
<td>Tiranah</td>
<td>Female</td>
</tr>
</tbody>
</table>

This descriptive chart is purposefully vague to protect the identities of the participants of my study. Many of my participants are vocal everyday advocates in the sphere of mental health, which already compromises their identity. The inclusion of program or level of study in this chart would be further compromising. The inclusion of the sex of participants as an identifier was outlined in the informed consent form.
# APPENDIX B: Key Interview Questions

<table>
<thead>
<tr>
<th>General questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>- How long have you been a student at the University of Guelph?</td>
</tr>
<tr>
<td>- Why did you choose to study at the University of Guelph?</td>
</tr>
<tr>
<td>- Where are you in your studies (undergraduate, graduate) and what is your program of study?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experiences as a student with a mental health issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>- How would you describe your mental health status?</td>
</tr>
<tr>
<td>- How has being a student affected your mental health?</td>
</tr>
<tr>
<td>- Tell me about elements of university life that positively/negatively affect your mental health</td>
</tr>
<tr>
<td>- What understandings of mental health do you think the university promotes?</td>
</tr>
<tr>
<td>- Describe a time when being a student with a mental health issue affected your ability to perform as a student.</td>
</tr>
<tr>
<td>- What kind of support does the university provide for you?</td>
</tr>
<tr>
<td>- Where do you go and what do you do when the university cannot fulfill your wellness needs?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self-care practices and wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What are some activities or hobbies that give you positive feelings?</td>
</tr>
<tr>
<td>- How do you feel when you are practicing these?</td>
</tr>
<tr>
<td>- In what ways have you taken care of yourself in the past to improve your mental health?</td>
</tr>
<tr>
<td>- Which self-care techniques have been effective/ineffective? Why?</td>
</tr>
<tr>
<td>- How do you take care of yourself as a university student?</td>
</tr>
<tr>
<td>- Tell me about an empowering experience with self-care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How self-care practices affect students’ identities and sense of agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What elements of your life do you feel like you have control over?</td>
</tr>
<tr>
<td>- What kinds of things make you feel disempowered or powerless?</td>
</tr>
<tr>
<td>- What are some barriers to your control?</td>
</tr>
<tr>
<td>- Can you describe a time when using self-care led to a feeling of personal control?</td>
</tr>
</tbody>
</table>
**APPENDIX C: Codebook Sample**

<table>
<thead>
<tr>
<th>Coding Theme</th>
<th>Code Examples</th>
</tr>
</thead>
</table>
| Definition of self-care                                | - What a person wants and not needs to be doing  
- Involves a maintenance of mental health  
- Involves an improvement of mental health               |
| Types of specific, effective self-care practices       | - Sporting activities  
- Artistic activities  
- Hygiene maintenance                                     |
| Types of specific, ineffective self-care practices     | - Journaling  
- Binge drinking  
- Watching scary movies                                   |
| Self-care as a social practice                         | - How friendship connections help  
- How familial connections help  
- What a lack of social connectivity can do                |
| Self-care as a physical practice                       | - How a person feels during/after exercise  
- Practices that are physical apart from exercise  
- Feelings of control associated with physical SC         |
| Benefits of self-care                                  | - Reduced negative affect  
- Able to manage daily tasks  
- Ability to relax in times of stress                     |
| How self-care makes a person feel                      | - Self-care gives participant a feeling of control  
- Self-care gives participant happy feelings  
- Feelings of ability rather than disability               |
| Factors that prevent the practice of self-care         | - Time constraints  
- Academic responsibilities  
- Belief that other activities are more important          |
| Disclosure of mental health status to other person     | - Belief that the person will/won’t stigmatize them  
- The person is their peer or their superior  
- The person has/doesn’t have MH issues themselves        |
| Mind-Body Connectedness                                | - Bodily practices can affect the mind  
- Cognitive practices can affect the body  
- Comorbidity between physical and mental health issues    |
| Perception of mental illness as a disability           | - Negative feelings about mental illness being categorized as a psychiatric disability  
- Positive feelings about mental illness being categorized as a psychiatric disability  
- Belief that the term disability implies a lack of ability, and is therefore not applicable to them |
| Negative opinions about professional care              | - Can be belittling  
- Does not give patients agency in handling their own care  
- Achieved no positive outcomes though professional care |
| Positive opinions about professional care              | - Can provide feelings of support/understanding  
- Able to prescribe medications that are beneficial  
- Achieved positive outcomes through professional care     |
## APPENDIX D: Self-Care Practices Used by Students

<table>
<thead>
<tr>
<th>Effective Self-care Practices Used by Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baking, playing with dog, volunteering, jumping jacks, cold showers, being around people who care about her, making new friends</td>
</tr>
<tr>
<td>Eating meals, getting dressed in the morning, brushing hair, leaving the house, swimming, going for a run, going to the coffee shop</td>
</tr>
<tr>
<td>Singing in choir, socializing with friends from choir, creative writing, confiding in significant other, watching movies, speaking with family on the phone</td>
</tr>
<tr>
<td>Going to AA meetings, watching Netflix, ordering in pizza to the home, going to yoga class, allowing self to cry, keeping a quote book</td>
</tr>
<tr>
<td>Horseback riding, sewing, going to cafes, going to night clubs, keeping an herb garden, drinking good coffee, laughing so hard you can’t stop</td>
</tr>
<tr>
<td>Boxing, playing the guitar, yoga, relaxing, visiting tranquil places</td>
</tr>
<tr>
<td>Reading, playing soccer, video chatting with cousins, chewing gum, exercising, cooking, keeping a calendar</td>
</tr>
<tr>
<td>Socializing with friends, getting food with friends, doing sport with friends, exercising, cooking, having fancy drinks with friends, going for walks, dating, cooking, meeting new people, showering, drinking tea</td>
</tr>
<tr>
<td>Taking time off from school, cheerleading, reading, cooking her favorite meals, reading fiction before bed, putting on makeup</td>
</tr>
<tr>
<td>Listening to music, taking a bath, looking at e-mails only once a day, intramural sports, having TV marathons with friends, spending time with family</td>
</tr>
<tr>
<td>Light candles, punch a pillow, call significant other on the phone, eating good food, taking breaks from school</td>
</tr>
<tr>
<td>Playing viola, listening to music, skipping class, being social, getting ice cream at an expensive ice cream shop, going on walks, showering</td>
</tr>
<tr>
<td>Dance class, going for a walk, schedule time by herself, schedule time with friends, volunteering, having a routine, walking or biking instead of taking the bus, deep breathing, reading a book</td>
</tr>
<tr>
<td>Listening to music, going on family vacation, temporarily disabling social media accounts, doing yoga, watching youtube videos, taking showers, shaving legs</td>
</tr>
<tr>
<td>Seeing personal trainer, going to cafes, having a glass of wine, taking days off from studying, calling family, spending time with old friends and making new friends, membership at campus clubs</td>
</tr>
<tr>
<td>Walking to and from campus, napping, board games with friends, doing a puzzle, taking a bath</td>
</tr>
<tr>
<td>Working out, socializing at the gym, cooking and eating healthy meals</td>
</tr>
<tr>
<td>Listening to podcasts, exercising, going on walks, checking out, ignoring friends for a bit, walking down the river</td>
</tr>
<tr>
<td>Exercising, seeing friends, eating healthy meals, getting a good night’s sleep, tea parties, drawing in coloring books with friends</td>
</tr>
<tr>
<td>Running, shopping, driving at night</td>
</tr>
</tbody>
</table>