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The intersection of identity construction & learning approach : the experience of college students with psychological disorders

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THE INTERSECTION OF IDENTITY CONSTRUCTION & LEARNING APPROACH: THE EXPERIENCE OF COLLEGE STUDENTS WITH PSYCHOLOGICAL DISORDERS

by

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DEDICATION

This dissertation is dedicated to all future and current college students with psychological disabilities engaged in the lifelong pursuit of learning and self-discovery.

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THE INTERSECTION OF IDENTITY CONSTRUCTION & LEARNING APPROACH: THE EXPERIENCE OF COLLEGE STUDENTS WITH PSYCHOLOGICAL DISORDERS

Abstract

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College for many adults represents a time for increasing independence, autonomy, and self-exploration. Yet the college experience may also be a time when students discover the presence of a psychological disorder, or navigate how to grapple with an existing disorder in the new and unfamiliar environment of college. An increasing number of students with such disorders are enrolling and participating in higher education yet current literature is often insufficient to adequately guide and inform postsecondary institution personnel regarding this complex student population (Beamish, 2005). Therefore, this phenomenological study aimed to discover the lived experience of a small sample of students with psychological disorders at one public university in the Western United States. Participants' reports of identity processes and classroom learning experiences were investigated through the combined lens of Identity Theory and the

Seven Vectors of Student Development. Study findings suggest (1) there is a pervasive yet varying effect of stigma on participants' identity and impression management behaviors, (2) crises resolution pertaining to seeking help and forming relationships associates with identity development, (3) student-role prominence may influence help-seeking behavior offering possible implications for student college persistence, (4) reconceptualizing psychological disorders may contribute to more positive self-concepts, (5) "sympathetic others" play a part in fostering a positive classroom emotional climate and relationship trust and building, and finally, (6) stigma (and concomitant inclinations to prove oneself) prompt participant classroom participation yet outward signs of professor and classmate discrimination stifle participant classroom participation.

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CHAPTER I: INTRODUCTION

College for many adults represents a time of increasing independence, autonomy, and self-exploration. Yet the college experience may also be a time when students discover the presence of a psychological disorder, or navigate how to grapple with an existing disorder in the new and unfamiliar environment of college. An increasing number of students with such disorders are enrolling and participating in higher education (Amada, 1992; Beamish, 2005; Megivern, Pellerito, & Mowbray, 2003). The severity, in addition to the prevalence, of mental illness on college campuses has increased over the last several decades (Beamish, 2005; Benton, Robertson, Tseng, Newton, & Benton, 2003; Kitzrow, 2003). For example, according to the National Survey of Counseling Center Directors at 274 Institutions, 17% of counseling center clients took psychotropic medication, as opposed to 9% in 1994 (Gallagher, Gill, & Sysko, 2000). Furthermore, the 2006 United States Census' American Community Survey reports 13.9% of 18-34 year-olds enrolled in college and graduate school report the presence of a disability; 13.4% of these students report having a mental disability.

The increase in the number of college students with psychological disorders is attributed to (1) legislative changes committed to treating psychiatric patients in their local communities, (2) increasing effectiveness of psychotropic medications in stabilizing psychiatric patients in non-institutionalized environments, and (3) the perception of postsecondary institutions as offering a welcoming and structured environment (Amada, 1992). Regrettably, faculty, staff, and administrators are often ill-equipped and under-prepared to interact and engage with these students (Beamish, 2005). Furthermore, current literature is often insufficient to adequately guide and inform postsecondary institution personnel regarding this growing and complex student population (Beamish, 2005).

College students with psychological disorders may face impediments to successful negotiation of the classroom setting and relationships with their peers and professors as evidenced by reported classroom disruption, absence attributed to hospitalization, and internal feelings of inadequacy and wariness (Amada, 1992; Gregg & Ferri, 1998; Kiztrow, 2003; Megivern, Pellerito, and Mowbray, 2003). An increase in the number of disruptive incidents among students at colleges and universities parallels an increase in the incidence of reported psychological disorders (Kitzrow, 2003).

> There is little doubt...that a significant number of the disruptive incidents reported by college employees involves students with such serious psychological disabilities as manic depression [now referred to as Bipolar Disorder] and schizophrenia, as well as some of the serious character disorders, particularly the antisocial personality disorder and the borderline personality disorder (acting out). (Amada, 1992, p. 203)

In addition, extant literature indicates that college students with psychological and cognitive disorders report being wary of how they would react or respond in any given academic or social situation leaving many students feeling a lack of trust in their capacities, a lack of engagement with others, and a need for control and routines (Gregg & Ferri, 1998; Olney & Brockelman, 2003; Olney & Kim, 2001).

College student development theory holds that students learn more by becoming involved in their learning and by interacting with their peers in the classroom (Pascarella

& Terenzini, 1991). Consequently, college students with psychological disorders may be at risk due to their suspected tendency to engage in what can be described as more passive, rather than active, forms of learning. Adoption of passive forms of learning among students with psychological disorders may be driven by stigma attached to mental illness, their own "outing" behaviors of mental illness, such as shakiness due to medication and pressured, rapid speech among others, and comparison of themselves in relation to their classmates. Two passive approaches to college student learning include: (1) Surface learning, or a focus on rote learning and completion of assigned tasks and (2) Strategic learning, or an approach that aims to fulfill an instructor's expectations with an emphasis on the attainment of high grades (Mann, 2001). Both distinct learning approaches are an expression of "an alienation from the subject and process of study itself" (Mann, p. 7). Alienation is said to emerge when students, especially those marginalized, perceive themselves as outsiders, lacking a sense of ownership, a perspective aptly known as "Student as Outsider." Here, students embody a passive role and become those being acted upon in the educational environment, absorbing the will of those in positions of power (Mann).

Conversely, Baxter Magolda (2002) contends that in active learning the self is the central learning vehicle. Baxter Magolda unveils a constructivist model of active learning featuring three key facets: (1) Knowledge is complex and socially constructed; (2) Self is central to knowledge construction; and (3) Expertise is shared in the mutual construction of knowledge among peers. These instructional principles or guides facilitate a community of learners where power and control are evenly distributed and students play an active role in deriving meaning from complex material presented.

Furthermore, Baxter Magolda (2003), having written extensively on the role of identity and learning, argues that "participation in the 'dialogue toward truth' hinges on assuming that one has something to contribute" (p. 232). Bean and Metzner's (as cited in Metz, 2004) "personal sense of usefulness" echoes Baxter Magolda's sentiment. Further, Baxter Magolda (2003) comments that "cultivating a 'capacity to respond' requires self-reflection on one's identity and relations with others" (p. 232). This would suggest that students with low or conflicted self-awareness, wariness about how they will act or respond in a given academic situation, attention to external rather internal controls, inability to see themselves as a critical contributor to knowledge construction, or whose identities bring with it social costs and penalties may opt to engage in more passive forms of learning. Existing literature indicates that college students with psychological disorders exhibit many of these characteristics. Therefore, it follows that this population may be inclined to pursue more passive, over active, approaches to learning within the postsecondary setting.

Identity formation involves, in part, freedom in peer relationships, a key component of classroom involvement (Chickering, 1969). Empirical research findings suggest an association between college students' level of classroom involvement and intellectual growth (Volkwein, King, & Terenzini, 1986). This said, classroom involvement may be impeded by problems associated with identity formation and relationship building. Chickering and Reisser's (1993) seven vectors of college student development situates identity establishment as the fifth vector; the identity vector depends partly on the previous vectors including developing competence, managing emotions, movement through autonomy toward interdependence, and developing mature interpersonal relationships. Chickering and Reisser posit that growth in each area contributes to identity construction. The seven vectors propose general directions for student development through its emphasis on "building blocks" in contrast to a strictly linear, sequential model (Chickering & Reisser). Thus, there are variations in the extent to which students develop along a particular vector suggesting some movement back and forth between and among vectors. Identity formation represents one such developmental task facing students in higher education. Yet, several psychological illnesses, such as Bipolar Disorder, emerge during adolescence or early adulthood, potentially disrupting these developmental milestones (Gerson, 2002).

Erikson (1980) asserts that identity development is a central developmental task during the span of college years for students. Robinson (2003) concludes that "[t]he degree to which undergraduates are seriously entertaining identity issues may have implications for their rate of matriculation through college as well as their serious consideration to drop out or persist" (p. 4). Students with psychological disorders may face an identity disequilibrium ushered in by internal perceptions and appraisals of external reactions regarding their psychological disorder. Competitive pressures regarding one's identities as conceived in Identity Theory (Stryker & Burke, 2000) to be explained in Chapter 2 could trigger "premature settling on one style of life, a single frame of reference, as the focal point for self-organization and self-esteem, as the core of one's being" thereby threatening college student development (Chickering, p. 91). According to literature, students with cognitive and psychological disorders face fluctuating mental and emotional states (Olney & Kim, 2001), uncertainty about their reactions in different settings and situations (Olney & Kim, 2001), expectations of rejection and decreased confidence (Link et al., 1997), concern over proving oneself (Quinn et al., 2004) and engagement in secrecy and withdrawal (Link et al., 1997). Such factors may impede students' journey toward identity development and, thus, threaten and delay active learning and intellectual growth and the attainment of a chief task and goal of higher education. Furthermore, students' internally verified self-meanings may conflict with their role expectation and identity standards. If the identity confirmation "process is unsuccessful, the salience of the identity [for example, the identity as a college student and learner] is likely to diminish and may contribute to premature college leave taking (Stryker & Burke, 2000, p. 289). Additionally, identity competition and conflicts may emerge that "complicate the reciprocal relationships between commitments, identity salience, identity standards, and self-relevant perceptions" (Stryker & Burke). For example, students' overwhelming drive to succeed and appear competent may adversely impact the character and number of students' social networks and self-appraisal leading to disguising identities beneath "masks" (Greg & Ferri, 1998).

Problem Statement

Students with psychological disorders may fail to engage actively in the classroom due to stigma or stereotype threat, mistrust in one's capacities, possible "outing" behaviors, identity disequilibrium and conflict, and absence from school tied to hospitalization, dismissal, or interfering symptoms arising from the diagnosis. Failure to engage actively in the learning process suggests possible troubling consequences for students with psychological disorders, given college student development theories that link identity formation and peer interaction with classroom involvement and intellectual growth. Specifically, Astin (as cited in Pascarella & Terenzini, 1991) contends that "students learn by becoming involved'" (p. 223) and classroom involvement associated with college student cognitive growth in empirical research by Volkwein, King, & Terenzini (1986). Additionally, the presence of a psychological disorder and inherent challenges may threaten students' identity development.

Based on a review of the literature, there appears to be the following spectrum of behaviors related to learning that suggest a graduated risk to the developmental process for students with psychological disorders:

1) Realization of a psychological disorder resulting in recognition and acknowledgement of the stigma associated with mental illness (Alexander & Link, 2003),

2) Demonstration of possible "outing" behaviors such as visible shakiness from psychotropic medication, significant and rapid weight gain from psychotropic medication, and pressured and rapid speech, among others (Megivern, Pellerito, & Mowbray, 2003; and Weiner & Wiener, 1997),

3) Disruptive behavior including verbal assaults of college staff or students, physical threats or actions to others, willful desire of college property, abuse or misuse of drugs or other substances on college property, belligerent demand for excessive time from college personnel, and offensive personal hygiene (Amada, 1992),

4) Visit(s) or referral(s) to hospitals' psychiatric department due to persistent suicidal ideation or other self/other harm behavior (Megivern, Pellerito, & Mowbray, 2003; Perlmutter, Schwartz, & Reifler, 1985), and

5) Hospitalization due to presenting symptoms of one's diagnosed psychological disorder (Megivern, Pellerito, & Mowbray, 2003; Perlmutter, Schwartz, & Reifler, 1985).

This spectrum of behaviors will be explained more thoroughly in the review of literature that follows. Furthermore, research suggests there is an inverse relationship between one's severity of manifestations and the level and character of classroom involvement, approach to learning, and interaction with peers (Megivern, Pellerito, & Mowbray, 2003; Olney & Kim, 2001; and Weiner & Wiener, 1997). This study aims to investigate behaviors and decisions of a select, small sample of college students with psychological disorders regarding personal and classroom learning interactions within the college context. The study will investigate changing concepts of the students' explanations and interpretations of their identities and classroom learning and interactions. This research will describe the experience of these often marginalized students by investigating their perceived challenges as learners and knowers and their perceptions of what helped them as learners and knowers. Reflecting the nature of the research questions listed below, the study will adopt the phenomenological tradition of qualitative inquiry. Phenomenology is a human science approach to studying the essence of lived experience (van Manen, 1990). This inquiry will focus on in-depth information gathered from a narrow and small sample of cases purposefully selected. Both phenomenology and the selection methods will be described in the chapter on methodology.

Significance of the Study

The importance of the qualitative research findings rests in the growing numbers, and increasing severity of symptoms, of students with psychological disorders entering higher education and the parallel and related increase in the number of disruptive student behavior. Furthermore, this study aims to fill existing research gaps illuminated by recent studies which call for more coordinated campus efforts to benefit college students with psychological disorders "who are struggling to legitimatize their place on college campuses" (Megivern, Pellerito, & Mowbray, 2003, p. 229) and evidenced in recent college student identity work absent a focus on those with psychological disorders (Torres, Howard-Hamilton, and Cooper, 2003). In addition, literature findings indicate college student university reenrollment decisions following premature withdrawal are linked to students' perceptions of their experiences at the university (Woosley, Slabaugh, Sadler, & Mason, 2005). As college students with psychological disorders comprise the ranks of premature college leave-takers, discovering the factors that contribute to the perception of a welcoming and positive academic environment for these students takes on heightened importance (Kitzrow, 2003). Thus, study findings will reveal the reality of the lived experience of these students in its ability to inform the nature of professor feedback and classroom activities and increase sensitivity and awareness within Student Affairs activities and programming.

Epistemological disclosure

I was drawn to this research topic after reflecting upon the kinds of challenges facing college students with Axis I psychological disorders with whom I had the privilege of engaging in my professional work. So too memoirs authored by those with psychological disorders combined with deep interest in the day-to-day experiences of those living with psychological disorders with varying levels of disability acceptance prompted me to embark on this study. I sought to gain a deeper glimpse into individuals' ways of being, of conversing about, and of living with a psychological disorder and how this experience may impact identity formation and sense of self within the higher education setting. I perceived that the voice of those labeled with one or another psychological disorder diagnosis was absent the pages of the DSM-IV-TR. Therefore, I believed that a study concentrating on discerning and illuminating participants' voices represented one way to fill missing holes and bring readers into "experiential nearness" (van Manen, 2002, p.61).

Research Questions

Specifically, this study will seek to answer the following overarching research question and supporting questions:

1. How do participants' reports of identity processes and self-concept impact their perception of learning experiences?
    a) How do these students talk about their interaction with classmates and professors (and others in authority)?
    b) What kinds of professor and student affairs professional feedback and interaction do these students report helped/hindered their developing self-directed/authored approaches to learning?
    c) How does the presence of stigma impact participants' perceived level and character of classroom learning and participation?

Definition of Terms

The following section presents definitions of key terms used throughout the study. Understanding these terms will yield increased clarity and a shared understanding as some terms carry more than one meaning in today's vernacular or different academic disciplines.

Academic Involvement: Defined by Mithaug (2003) as asking questions in class, interacting with peers, and classroom involvement.

Identity: Erikson (as cited in Chickering, 1969) defines identity as "the accrued confidence that one's ability to maintain inner sameness and continuity is matched by the sameness and continuity of one's meaning for others" (p. 13). A second definition, held by Identity Theory, describes identity as "internalized meanings and expectations associated with a role" (Stryker & Burke, 2000, p.289). More extensive explanations are provided in Chapter II.

Psychological disorder: (used synonymously with mental illness, psychiatric disorder, psychological disability, and mental disorder throughout the paper) This study recognizes two ways of conceptualizing psychological disorders, namely, a medical definition and a socio-cultural, or socially constructed, definition. Psychological disorders, when viewed through a medical lens defined according the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994), embody:

> … a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and is associated with present distress (e.g. a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this symptom or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. (pp. xxi-xxii)

This definition is further defined as constituting Axis I diagnoses. The following Axis I disorders are represented among this study's sample: Attention-Deficit/Hyperactivity Disorder, Bipolar Disorder, Schizophrenia, Post Traumatic Stress Disorder, Depression, Generalized Anxiety Disorder, Dissociative Disorder, and Social Anxiety Disorder. Four participants reported the presence of more than one Axis I disorder.

An alternate definition for psychological disorders or disabilities can be traced to a social constructivist view which holds that these disorders must be understood as socially constructed labels. Rather than equating a psychological disorder with a problem or impairment to the individual with the disorder, the social constructivist approach advances the notion that psychological disorder is a "concept which exists in the minds of the 'judges' rather than in the minds of the 'judged'" (Bogdan & Taylor, 1976, p. 47).

Self-authorship: Kegan (1994) defines self-authoring as "becoming the definer of one's acceptability" (p. 301). In other words, Kegan (as cited in Baxter Magolda, 2002) describes self-authorship "as the capacity to author, or invent, one's own beliefs, values, sense of self, and relationships with others" (p. 3). Self-authored beliefs are thus internally rather than externally constructed.

Self-concept: Conceptions of self, or self-concepts, are "cognitive appraisals, expressed in terms of expectations, descriptions, and prescriptions" (Hattie, 1992, p. 37). These appraisals thus operationalized are rooted in value statements and are continually subject to validation and invalidation (Hattie). Feedback from others has a most powerful affect on one's self-conceptions (Hattie).

Social Identity: Hogg, Abrams, Otten, and Hinkle (2004) define the social identity perspective as "an analysis of intergroup relations between large-scale social categories, which rests on a cognitive and self-conceptual definition of the social group and group membership" (p. 247).

Stigma: Goffman (as cited in Quinn, Kahng, and Crocker, 2004) defines social stigma as "some attribute that is deeply discrediting and reduces a person 'in our minds from a whole and usual person to a tainted, discounted one'" (p. 803).

This chapter focused on the increase in the population of students with psychological disorders attending college and a recognized need for more research and insight into the experiences of these often marginalized students. This chapter alerts us to student development barriers faced among this population given identity disequilibrium and conflict, susceptibility to suspected passive forms of learning and classroom interactions, and hospitalization. These issues will be examined in depth in the next chapter. A review of the literature will provide a framework for this study and present relevant empirical and theoretical findings to inform the present investigation. The following chapter describes current literature and acquaints us with what has been determined and discovered in the areas of psychological disabilities in higher education, identity research, self-concepts, academic involvement, and stigma.

CHAPTER II: REVIEW OF THE LITERATURE

This chapter, the review of relevant literature, is divided into the following sections: psychological disorders within the higher education setting, identity construction, self-concept, and academic involvement and learning approach. The academic involvement and learning approach section has been further divided into two subsections entitled role of stigma: learning and interacting with others, and stigma and stereotype threat. Each topic corresponds with the study's aim of uncovering the essence of identity construction and learning approaches among college students with psychological disorders. The literature review intends to provide a thorough look into research findings and theories to arrive at persistent literature themes as well as existing gaps. Furthermore, the literature will serve to guide the study's data analysis.

A review of the relevant literature and empirical findings suggest there may be an effect of stigma and an association between marginalized status and academic performance and interaction (Alexander & Link, 2003). Specifically, mental health symptoms, the possibility of discrimination regarding ones' psychological disorder, hospitalization, side effects of medication, and lack of trust in one's capacities comprise challenges college students with psychological disorders face (Megivern, Pellerito, & Mowbray, 2003; Olney & Kim, 2001; Perlmutter, Schwartz, & Reifler, 1985). Little research has been done to examine the identity formation of these students in particular, a population Weiner and Wiener (1997) describe as having a unique set of concerns, despite Chickering's (1969) claim that identity formation is an important task of higher education. Furthermore, identity and college student development theories illuminate obstacles to identity construction and confirmation among college students with psychological disorders given suspected identity competition, conflict, reluctance to experiment with various roles, and feelings of anxiety and pressure (Chickering & Reisser, 1993; Stryker & Burke, 2000). Such threats to identity formation and verification may impede students' ability to engage actively with others in the classroom and embrace self-directed approaches to learning, as is suggested by literature findings described in the following section.

Psychological Disorders within the Higher Education Setting

According to research investigating the experiences of 16 college students with cognitive and psychological disorders, uncertainty and inconsistency appear to plague the student participants regardless of diagnostic disability label (Olney & Kim, 2001). Students experience fluctuating mental and emotional states which may render them wary of how they might react or respond in any given academic or social situation leaving many feeling a lack of trust in their capacities, a lack of engagement, and a need for control and routines (Olney & Kim, 2001). Furthermore, students in the Olney and Kim study expressed concerns with short-term memory and organization.

A separate investigation by Megivern, Pellerito, and Mowbray (2003) examined types of college stressors reported specifically by 35 postsecondary participants with psychiatric disorders. Stressors identified in the study include mental health symptoms (which impacted students' ability to concentrate, memorize, and maintain motivation), hospitalizations, worries about college and house-hold expenses, and conflict and isolation (linked with experiences in which stigma and discrimination were perceived). Furthermore, many participants reported a lack of knowledge about campus support services and a lack of certainty about how to manage limitations and symptoms of their condition and side effects of medication. Megivern, Pellerito, and Mowbray's findings suggest a lack of coordination between campus and community entities and call for a coordinated effort to benefit students "who are struggling to legitimatize their place on college campuses" (p. 229). In addition, their findings indicate that there are no persistence differences among the sample population when variables such as race, gender, parental educational level, and mental health service use are taken into account.

Weiner and Wiener (1997) explored the decision-making processes of eight students with psychiatric disorders regarding college retention and withdrawal at an urban Canadian university. The psychiatric disorders among the sample is as follows: schizophrenia and related disorders, major depression, general anxiety disorder, unipolar depression, obsessive compulsive disorder, and dissociative disorder. Citing Tinto's work on college student attrition and retention, the authors posit that not all retention and withdrawal experiences are the same. Rather, they assert that students with psychiatric disorders have a unique set of concerns and therefore represent a population that should be examined separately. Their findings indicate that students distinguished their illness into two stages, an early symptomatic stage and a later acute relapse stage. In addition, their results suggest there is an increased risk for premature withdrawal from college once students enter the acute relapse stage, begin missing classes and falling behind with class work, despite receiving academic accommodations. It is during this stage that symptoms of the illness seem to "just take over" (Weiner & Wiener, 1997, p. 2).

According to Kessler, Foster, Saunders, and Stang (as cited in Kitzrow, 2003), psychiatric disorders prompt premature college departure among 5% of college students. Concrete reasons for withdrawal from a college or university included hospitalization due to psychiatric symptoms, preoccupation with tics, inability to concentrate in and out of the classroom, feeling that people were watching and judging their behavior in class, and a "general feeling of awkwardness and self-consciousness" (p. 3).

Yet, there is also evidence that a portion of students withdrawing from a university or college setting return. While prolonged hospitalization or interfering psychological symptoms may contribute to premature attrition there exists an increasing "stop-out" phenomenon affecting college and university enrollment. Stop-outs include "those students who withdraw from a college or university but subsequently reenroll" (Woosley, Slabaugh, Sadler, & Mason, 2005, p.188). Research findings at one public university in the Midwestern United States conclude that stop-outs comprised a large proportion of student withdrawals. Findings further suggest that a student's prior experience at the university, rather than academic success or grade point average, was a greater predictor of a student's behavior, namely reenrollment intentions and reenrollment in the university. Thus, positive university experiences contributed to students' decisions to return, aligning with Tinto's (as cited in Woosley, Slabaugh, Sadler, & Mason) model of student attrition consisting of "linkages between positive experiences, integration, intentions, and commitment" (p.197). Findings suggest that what occurs in the classroom in terms of student-student and student-professor interaction dynamics and student-as-learner validation should not escape attention. While positive university experiences are associated with university reenrollment for students in general, literature would suggest such experiences for students reporting feelings of awkwardness, self-consciousness, and wariness, as is the case for students with psychological disorders in one study, takes on an even greater role in reenrollment decisions (Weiner & Weiner, 1997).

Separate research investigating the experiences of college students charts the emergence of methaphoric themes (metathemes) in the data. Dwyer's (2000) phenomenological research consisted of multiple interviews with eight female college students diagnosed with Attention Deficit/Hyperactivity Disorder (AD/HD). The participants described their feelings as being "robbed of time" and having "thoughts like a rubber ball" (p.123). The women in the study expressed a sense of never having sufficient time to accomplish various responsibilities including tasks and studying. The study participants described comparing themselves to others, including their classmates. These women compared the amount of time it takes their classmates to perform a particular task to the amount of time they perceived it should take them, reporting frustration when more time was required than estimated. Struggling and attempting to meet deadlines manifested as a ceaseless task resulting in negative interpretations of self as lazy and not exerting enough effort. The study participants' approaches to accomplishing tasks were individual and thus diverse. A second theme which emerged from the study included having thoughts that "bounce like a rubber ball" (p.140). Participants commented that racing thoughts made them aware of everything going on around them but they struggled to follow one thought fully. Such zooming thoughts caused adverse consequences. "The women's non-linear thought pattern described by the bouncing rubber ball analogy has a profound effect on their academic performance"

(Dwyer, p. 140). The educational system is described by Dwyer as not permitting and certainly not embracing deviations from the perceived norm. Participants reported that receiving the concrete diagnosis of AD/HD equated with a removal of guilt, self-loathing, and a dismantling of self-interpretations of laziness. In the place of guilt emerged an enriched self-awareness and acceptance of their difference. According to Kegan's theory of self-authorship (1994), which describes an internally-driven ability to be the definer of one's acceptability and sense of self, these women were entering such a developmental state through the recognition and internalization of their AD/HD diagnosis into their identity and self-construction. A second step the women took to overcome obstacles included recognition of how they uniquely could achieve academically. Skills used by study participants to overcome obstacles included the adoption of learning strategies, accommodations, and medication. The women in the study entered a sort of paradox when it came to structure: They realized its importance yet acknowledged a simultaneous abhorrence of it.

Three additional issues connected to the experience of students with psychological disorders in the literature include disruptive behavior, hospitalization, and stigma. The prevalence of the incidence of postsecondary student disruptions parallels a steep growth in the amount of students with serious psychological disorders enrolled in colleges and universities (Amada, 1992). A substantial number of disruptive incidents reported on college campuses involves students with serious psychological disorders (Amada). College student disruption, as defined by Amada, is "behavior that persistently interferes with academic and administrative activities on campus… and actively hampers the ability of other students to learn and of instructors to teach" (pp.

204-205). Examples of disruptive behavior include: verbal assaults on college staff, physical threats or actions against others, willful destruction of college property, abuse or misuse of drugs or other substances on college property, belligerent demands for excessive time from college personnel, and, albeit a more passive example, offensive personal hygiene (Amada). Yet, while it is this study's intention to recognize and highlight disruptive behavior as one theme present in literature regarding college students with psychological disorders, this theme did not surface as a factor facing the participants in this study (according to participant interviews, observations, writings, and college records) and therefore will not garner additional exploration and examination.

Emergency hospitalization represents a second challenge faced by some college students who are attempting to manage symptoms associated with their psychological illness. Interested in the composition and facets of these college students who present themselves to the psychiatric emergency department (PED), researchers investigated 933 PED college student admits over an eight-year period (Perlmutter, Schwartz, & Reifler, 1985). Perlmutter, Schwartz, and Reifler's findings conclude that the "relatively high frequency of depressive characteristics and dysthymic disorder that has been reported in the literature on college students is congruent with the frequency of depressive neurosis found in this study (18%)" (p. 156). In addition, they found one-fourth of all PED visits were attributed to students experiencing psychotic disturbance. Their research indicated that more than 70% of college student psychiatric hospitalization visits did not result in hospital admission. Consequently, Perlmutter, Schwartz, and Reifler conclude there are a number of students who have been discharged and will return to college campuses who have been considering issues of suicide or whose behavior has been described as bizarre or outside of the norm. How do students facing such inner turmoil and disturbance negotiate the classroom setting and interact with their peers, professors, and other college personnel? Yet, Megivern, Pellerito, and Mowbray's (2003) research findings suggest these students' intrinsic value of learning exceeds that for the college student population without mental illness. For example, when contrasted with national survey findings reporting students' academic objectives, more of the participants with psychological disorders stressed the importance of a desire to learn as an educational objective. How do students with psychological disorders then engage in learning and contribute to its construction?

Stigma embodies a third obstacle college students with psychological disorders face. Mental illness has been deemed "one of the most stigmatized conditions in our society," according to several studies (Albrecht et al., 1982; Corrigan & Penn, 1999; Tringo, 1970) cited in Alexander & Link (2003, p. 271). Underlying the stigma associated for individuals with mental illness is a belief or assumption that they pose a threat to others and are unpredictable (Link & Cullen, 1986; Link et al.,1999; & Nunnally, 1961; as cited in Alexander & Link). Stigma interferes with individuals' psychosocial endeavors whether through past direct recollections of discrimination or the possibility of such discrimination occurring (Alexander & Link). Smart and Wegner (1999) and Wahl (1999) (as cited in Alexander & Link) conclude: "Even in the absence of direct discrimination, people with mental illnesses may anticipate stigmatizing responses at work, in relationships and become preoccupied with concealing their status" (p. 272). Such status-concealing behaviors may take the form of withdrawing or reducing their social and work-related functioning (Link et al., 1987, 2001, Perlick et al., 2001 (as cited in Alexander & Link).

Link and Phelan (2001) note the presence of stigma surfaces when the following four components intersect:

> 1. People distinguish and label human differences. The taken-for-granted nature of these categorizations is one of the reasons that designations like these carry such weight.
> 2. Labeled differenced are linked to stereotypes. The label links the person to an undesirable set of characteristics that emerge from a stereotype.
> 3. Social labels connote a separation of 'us' from 'them.'
> 4. The labeled person experienced status loss and discrimination. When people are labeled, set apart, and linked to undesirable characteristics, a rationale is constructed for devaluing, rejecting, and excluding them. (pp. 367-371)

According to Estroff (as cited in Link & Phelan, 2001), individuals with mental illness are perceived as *being* their disorder or diagnosis. Additionally, stigma's impact or weight has some variability. For example, relationships containing a power hierarchy emit more stigma for the individual with stigma should he/she be in an inferior position (Link & Phelan). A professor-student dynamic represents one such example where stigma may pose a heightened threat for the student.

The stigmatized person, as defined by Arthur Kleinman (as cited in Stanley, 2004), is "an alien other, upon whose persona are projected the attributes the group regards as opposite to the ones it values… [the] illness experience is always culturally shaped" (p. 347). Those who are stigmatized often physically hide themselves from themselves and from others (Stanley). Not only are people with mental illness estranged from "themselves," but, says Stanley, others have difficulty finding the "self" they once knew before the onset of the illness. Certain disabilities or disorders carry more stigma than others. Olney and Brockelman (2003) found that college students with hidden and physical disabilities perceive a disability hierarchy influenced by the level of social stigma and acceptance; acquired physical disabilities top the hierarchy and psychological disabilities, those perceived as least socially acceptable, constitute the bottom rung. These perceptions impacted students' decisions to disclose their disability as well as the character of social and academic integration. One student participant reflecting this sentiment announced "for some reason I have diagnoses that I prefer over other ones" (Olney & Brockelman, p. 41).

The literature suggests that the effects of stigma may persist and endure over time. Link, Struening, Rahav, Phelan, and Nuttrock (1997) examined the experiences of 84 dual-diagnosed (mentally ill and substance abuse) males in treatment and the affect of stigma. The researchers tracked the study participants to discern if the perception of stigma was still present and associated with depressive symptoms one year after the participants began treatment. Three components of the stigmatization process were outlined, including: (1) "culturally induced expectations of rejection," arising from the belief the others will devalue and discriminate them based upon their label or diagnosis which impacts social interaction, dismantles confidence, and alters social and occupational functioning; (2) "experiences of rejection," including exclusion and negative remarks; and (3) "efforts at coping with stigma," including secrecy and withdrawal (p. 179). The study revealed that "there are no declines in the perception of stigma, in stigma coping orientations, or in the recall of rejection experiences over the one-year period while the men were in treatment" (p. 184). In other words, the effect of stigma, specifically perceived devaluation/discrimination and respondent reports of discrimination experiences, associated with mental illness and substance abuse, persist even after the effects of treatment had been realized and symptoms had decreased.

Goffman (1963) draws a distinction between two types of stigma categories: discredited or discreditable. Those whose stigma is outwardly known or visible fall into the discredited group while persons whose stigma is not known or possess the ability to largely conceal their negative stigma from others fit the discreditable category. Goffman concludes that for those who are discreditable versus discredited, as is often the case for college students with psychological disorders:

> The issue is not that of managing tension generated social contacts, but rather that of managing information about his failing…It is not that he must face prejudice against himself, but rather that he must face unwitting acceptance of himself by individuals who are prejudiced against persons of the kind he can be revealed to be. (p. 42)

Thus, it follows that the discreditable engage in practices to manage the unapparent discrediting aspect(s) of themselves and their identities. The following section aims to illuminate literature concerning identity processes and preservation of unspoiled identities among individuals with psychological disorders.

Identity Construction

Identity "is a complex field, and social psychologists, sociologists, political scientists, cultural critics and philosophers all use the word variously and in different contexts" (Shakespeare, 1996, p. 94). Two complementary conceptions of identity will be used in this study, namely identity as conceptualized in Chickering and Reissers' (1993) *Seven Vectors of Development* and that defined by Identity Theory. Chickering & Reissers' *Seven Vectors of Development* conceives identity attainment as a developmental, fluid stage process, while Identity Theory (Stryker & Burke, 2000) focuses on the role of external social structures and internal processes of self-verification in constructing one's identities. Both theories will serve as a combined framework for exploring the lived experience of college students with psychological disorders and will be explained more thoroughly in this section.

Chickering and Reisser's (1993) seven major developmental vectors comprise "maps to help [higher education practitioners] determine where students are and which way they are headed" (p. 34). Initially described as a progressive sequence of developmental stages achieved during adolescence and young adulthood in college (Chickering, 1969), the more recent research by Chickering and Reisser has contributed to a reconceptualization of the seven vectors. Rather than conceiving the seven stages and development as a strictly linear, stage-like model and process, Chickering and Reisser find affinity with aspects of Kegan's (as cited in Chickering & Reisser) claim that development:

> involves becoming temporarily embedded in one pattern until its inherent imbalance impels us to break away from it and move toward the other polarity. Each shift involves a change in how we construct meaning. To develop a new way to interpret our experience, we must first be able to observe the old one with greater detachment and to see a new boundary between what is me (subject) and not me (object). (p. 25)

Such a portrayal of students' developmental process is best illuminated as a "helix of evolutionary truces" suggesting movement from one pole or building block to another, according to Kegan (as cited in Chickering & Reisser, p. 24). Chickering and Reisser suggest that movement along the vectors can occur at varying rates, as demonstrated and expanded upon as follows: "Each step from 'lower' to 'higher' brings more awareness, skill, confidence, complexity, stability, and integration but does not rule out an accidental or intentional return to ground already traversed" (p. 34). Additionally, Chickering and Reisser's revised vectors has been adjusted to be applicable to adults and no longer limited to the period of adolescence and young adulthood.

Chickering (1969) contends that one of the chief tasks of higher education is not socialization but rather identity formation, influenced in part, by one's relationships with others. In a recent work entitled, "Identity in Higher Education," Torres, Howard-Hamilton, and Cooper (2003) conclude the "college years are critical for the development of identity," yet an examination of college students with psychological disorders' identity formation processes is entirely absent in their investigation (p. 3). Namely, Chickering and Reisser's theory recognizes Knefelkamp, Widick, and Parker's assessment (as cited in Chickering & Reisser) that development of one's identity rests on "(1) experiences that help people clarify their interests, skills, and attitudes; and (2) experiences that aid individuals in making commitments" (p. 206). Chickering and Reisser further conceive college student identity development "primarily as resolving crises" (p. 181). A crisis, according to Marcia (as cited in Chickering & Reisser) constitutes a challenge or a turning point featuring the opportunity to regress or progress in one's development; a crisis thus conceptualized must contain choices, or competing alternatives, and commitments. Marcia (as cited in Chickering & Reisser) concludes the way in which one resolves the crisis determines the direction of one's development.

Knefelkamp, Widick, and Parker (as cited in Chickering & Reisser) claim identity formation is facilitated by environments which permit "(1) experimentation with varied roles; (2) the experience of choice; (3) meaningful achievement; (4) freedom from excessive anxiety; (5) time for reflection and introspection" (p. 207). Chickering and

Reisser expand the list of factors to include "(6) interaction with diverse individuals and ideas; (7) receiving feedback and making objective self-assessments; and (8) involvement in activities that foster self-esteem and understanding of one's social and cultural heritage" as being instrumental in helping to foster students' identity construction (p. 207).

Establishing one's identity comprises Chickering and Reisser's (1993) fifth vector of development, following the first four vectors, namely, development of competence, managing emotions, moving through autonomy toward independence, and developing mature interpersonal relationships; growth in these four areas assists in the development of identity. While Erikson's (1980) assertion that "it is only after a reasonable sense of identity has been established that real intimacy with the other sex (or, for that matter, with any other person or even with oneself) is possible" (p. 101) is acknowledged, Chickering and Reisser also recognize other researchers' claims (see Straub, 1987) of the complexity between autonomy, intimacy, and interdependence and the impact on aspects of identity. While Chickering (1969), ascribing to Erikson's notion, initially concluded that individuals not certain of their identity are apt to avoid or resist forming relationships with others, Chickering and Reisser (1993) more recently acknowledge the "importance of students' experiences with relationships in the formation of their core sense of self" (p. 39). Such a conclusion prompted the authors to situate the relationship vector before the identity vector. White (as cited in Chickering), contends identity refers to:

> … [t]he self or the person one feels oneself to be… Gradually the sense of identity becomes a fuller and richer establishment, compounded of bodily sensations, feelings, images of one's body, the sound of one's name, the continuity of one's memories, and an increasing number of social judgments delivered through the words and behaviors of other. (p. 13)

In other words, identity formation emerges from external forces, self-testing, and experience in various roles and experiences (Chickering, 1969). Acknowledging the contextual nature of identity construction, Pascarella and Terenzini (1991) posit:

> The self is not defined in isolation but at least partially by one's interactions with others. Perceptions of self and beliefs about others' perceptions of oneself shape not only individuals' internal, psychological structures but also their responses to and interactions with their external social world. (p. 223)

The way in which one perceives him/herself and the accompanying identities thus impacts interactions with their environment and those who inhabit their environment. According to Chickering (1969):

> Ease in relationships with adults not only allows academic learning to proceed more fruitfully and efficiently; it fosters emotional independence from parents and more flexible relationships with authority. Further, through closer association with respected persons working at things that might become the focus of one's own future endeavors, the development of identity and purpose are assisted. (p. 104)

Both Chickering and Reisser's (1993) *Seven Vectors of Development* and Identity Theory (Stryker & Burke, 2000) conceive identity as influenced and shaped by outside or external forces, entail a subjective sense of self, and refer to the importance of roles. Identity Theory, however, envisions individuals having as many identities as social relationships, roles, and memberships, defining identities as "internalized meanings and expectations associated with a role" (Stryker & Burke, 2000, p.289). A second, more expanded, definition of identities under Identity Theory conceives of them as "cognitive schemas – internally stored information and meanings serving as frameworks for interpreting experience. As such, [identities] are cognitive bases for defining situations, and they increase sensitivity and receptivity to certain cues for behavior" (Stryker &

Burke, 2000, p. 286). In other words, individuals interpret experiences through the lens of their own identities and self-meanings. The goal of Identity Theory is to "understand and explain how social structures [in this case of this study, the higher education classroom and academics] affect self and how self affects social behaviors" (Stryker & Burke, p. 285). Viewed through this framework, the salience of one's identity may be jeopardized if one's internalized self-verified meanings conflict with role expectations and identity standards. Self-verification is defined as the process of aligning context-specific self-relevant meanings and the identity standard (Stryker & Burke). Specifically, Stryker and Burke assert "if the identity confirmation process is successful, the salience of the identity will be reinforced; if the process is unsuccessful, the salience of the identity is likely to diminish, perhaps considerably" (p. 289). For example, college students with psychological disorders may claim or ascribe to the following identities, among others: student, daughter/son, mental health patient, person with Bipolar Disorder, and classmate. If a college student does not feel him/herself to be fitting with the "college student" identity standard, he or she may lessen attachment to this identity and possibly withdraw, feel alienated, participate less in the academic arena, and the like. Emotions and emotion-charged behavior signal to others the interior state of the individual and perhaps the existence of a conflict in identity confirmation and validation.

Similarly, there exists the possibility for a clash and conflict between multiple roles and identities, such as those listed above (Stryker & Burke, 2000). Stryker and Burke contend that when such a clash occurs "they introduce identity competition or conflicts that complicate the reciprocal relationships between commitments, identity salience, identity standards, and self-relevant perceptions" (p. 290). Burke (as cited in

Stryker & Burke, 2000) suggests that stress can subsequently emerge thus preventing or hindering the "behavioral repair of a gap between standards and perceived self-meanings" (p.290). It can be argued that college students with psychological disorders may simultaneously negotiate and balance multiple roles which have the potential to conflict and clash. One's prominent identity may be that of college student and learner yet be challenged by the identity standard which does not allow or easily make room for the mental disorder identity. Therefore, such students may engage in fluctuating choices and behaviors motivated by the varying prominent identity: medication or no medication, participate in class or do not participate in class, lead a class group or do not lead a class group, and disclose mental health status or do not disclose mental health status. All of these decisions carry implications for the identities of "college student" and "person with Bipolar Disorder" and thus impact one's self-efficacy, level of active learning, and development.

Lee and Craft (2002) conducted a study aimed at discovering participants' identity processes and stigma management practices. Specifically, the authors examined 20 individuals participating in a genital herpes self-help group. Study findings reveal that participants' "negative, emotional reactions are rooted in social disapproval and, like other stigmatized persons, they use secrecy, withdrawal, and preventive telling as strategies to manage their stigma" (p. 267). Specifically, according to Lee and Craft, behaviors, differing from others, prompted participants to modify their behaviors and respond to others' perceptions of their stigma through secrecy, withdrawal, preventive telling. Social relationships, Lee and Craft (2002) found, rely on one's confirming other's expected behaviors of them. Therefore, the authors suggest, the number and importance of a social relationship tied to an identity determine its ranking in one's identity hierarchy. Additionally, Lee and Craft assert identities which are socially supported dictate one's behavior more than those identities which are not as socially supported or valued.

Self-verification, or one's need to align their own identity standards and others' views of themselves with their own self-view, embodies a motivational dimension of identity processes (Burke & Stets, 1999). Kleck and Strenta (as cited in Lee & Craft, 2002) claim "physically stigmatized individuals often read rejection or discomfort into objectively normal interactions with others because they conjure up thought about others' likely negative images of them" (p. 272). Further, Lee and Craft's study yielded evidence supporting stigma's fluctuating character. In other words, stigma was found to impact identities differently; stigma applied to, and jeopardized, some identities over other identities. Additionally, fear of losing relationships prompted passing and withdrawal behaviors according to the study's authors. Lee and Craft (2002) found participants reported that they tell others about their stigma, termed "preventive tell", because: "1) others are predisposed to accept them, 2) telling is demanded by the relationship's character, 3) the secret is getting in the way of the valued relationship" (p. 282). Participants sought pre-disease verification of their selves when telling others of their stigma. Frustration resulted, according to Lee and Craft, if participants did not get the verification they hoped. The study also uncovered evidence of participant self-perception shifts. For example, participants' self-concepts remained intact by transforming the meaning of the stigma. Participants came to see themselves as victims with a challenge (i.e., herpes) over which to rise above. According to Lee and Craft (2002), participants' lives are shaped by genital herpes to that degree that:

> 1. The stigma is relevant to identity definitions
> 2. There are many, prominent, relevant identities
> 3. Opportunities for relationship preservation and self-verification are closed off. (p. 292)

Lastly, study authors found participants were more motivated to tell others about their stigma when sexuality was relevant and intersected with more of their identities.

Research suggests that the identity construction process for 16 students with hidden and physical disabilities is contextual, flexible, and iterative (Gregg & Ferri, 1998; Olney & Kim, 2001). Writing about living with a hidden disability, Samuels (2003) asserts that "…we must still make decisions about coming out on a daily basis…" (p. 237). Findings from one investigation of 25 university students with psychiatric and cognitive disabilities concludes that these students engage in an ongoing, repeated process of meaning making and construction of identity, self, and their roles when interacting with family members, friends, professors, and peers (Olney & Brockelman, 2003). Students' identities were related to their reactions or responses to their situations and experiences and the meanings associated with their disability labels (Olney & Kim, 2001). Furthermore, students' complex identities often created an untenable incongruity that others attempted to oversimplify. Students grapple with their professors' and peers' inability or reluctance to judge them as simultaneously (1) able and competent and (2) in need of accommodations, or simply as smart in some areas and weak in others (Olney & Brockelman). Or, when viewed through Identity Theory, professors perceived a clash of students' identities and an inability to acknowledge and accept both identities, that of "competent learner/student" and that of "person with a disability." Overwhelmingly, students with disabilities opted not to "cure" their disability if this was possible, arguing instead that their disability highlighted their abilities and strengths, made them a better person, and defined part of their identity (Olney & Brockelman).

Gregg and Ferri's (1998) review of disability narratives and connection to the larger body of research led them to conclude that there are certain factors which impact identity construction and environmental interface among college students with hidden disabilities. Their paper, which concentrates on illuminating the lived experience of college students with learning disabilities, suggests that reactions to prolonged stress can lead to either an insensitivity or hypersensitivity to one's environment. Second, through a review of literature, the authors found self-appraisal incongruity between actual and perceived assessments of "social competence" contributed to students' social isolation, alienation and the embracing of avoidant behaviors. Third, they posit students' overwhelming drive to succeed and appear competent often adversely impacted their social networks (e.g. alienation) and self-appraisal, leading to the disguising of identities beneath "masks." In other words, "the drivenness to be elsewhere leads to feelings of belonging nowhere" (Gregg & Ferri, p. 518). Finally, the authors indicate the existence of an "imposter syndrome" whereby students bury self shame by attempting to conceal their weak, or less competent skill areas, via masks or false selves or avoid tasks and environments altogether in which their weaknesses would be revealed. This avoidance of certain tasks suggests a barrier to fulfilling one of Chickering's (1969) conditions of identity establishment, specifically, varied direct experience and roles. Gregg and Ferri (1998) speculate that the loss of one's identity results from this construction of false selves and suggest that the loss of students' actual selves, their "me," is responsible for hindering successful social and academic integration.

Literature suggests identity equilibrium for college students with hidden disabilities is one of adjustment and self-authorship. Naugle (as cited in Olney & Kim, 2001) defines adjustment as "a reordering of priorities and a reintegration of the self with a renewed sense of self worth" (p. 565). Adjustment is a reconciliation of conflicting self-perceptions and the birth of a new identity or inner equilibrium (Olney & Kim). For example, adjustment, according to Olney and Kim's study of 16 students with disabilities (including disabilities which affect mental or cognitive functioning, namely, brain injury and tourette syndrome, psychological disorder [thought or mood disorder], and learning disability [dyslexia or perceptional disorder]) at one prestigious university, involved the formation of a positive self-concept or self-definition, management of perceptions of others, and a deep comprehension of how the disability impacts one in all aspects of one's life. The next section aims to define and uncover literature surrounding self-concepts, or conceptions of self.

Self-concept

In Identity Theory "it is assumed that the self-concept of a person consists of a *hierarchically organized set of multiple identities*" (Hormuth, 1990, p. 77, emphasis in original). An individual's commitment to a particular identity influences its position in the hierarchy (Hormuth, emphasis is original). Hormuth contends this stratification is defined through "*identity salience*, operationalized as the probability of the performance of the role associated with the identity in a given situation" (p.77, emphasis is original). Baron (as cited in Gultekin & Baron, 2007) posits that development of one's self-concept is shaped by other people's evaluations. Early theories of self-knowledge describe how one's knowledge or conceptions of self are affected through interactions with others [Mead and symbolic interactionism] (Goldstein & Cialdini, 2007). Additionally, self-definitions are influenced by individuals observing how others' perceive and respond to them [coined "the looking glass self" by Cooley] (Goldstein and Cialdini). Lastly, Pajares (1996b) argues that self-concept judgments rely on social and self-comparisons.

Interactions or exchanges with others may involve indirect and direct communication and include facial or tactile expressions, but are often auditory (Hattie, 1992). Individuals ascribe various attributes to themselves based upon these interactions across various settings. Thus, individuals experience a confirmation or disconfirmation of these attributes or components of their self-concept. Integration of their attributes occurs through "self-verification, self-consistency, self-complexity, and self-enhancement," Hattie contends. Self-conceptions have also been described as analogous to appraisals. Conceptions of self are "cognitive appraisals, expressed in terms of expectations, descriptions, and prescriptions" (Hattie, 1992, p. 37). Hattie concludes that these appraisals, rooted in value statements, are continually subject to validation and invalidation. Feedback from others has a most powerful affect on one's self-conceptions. Prescriptions, one component of cognitive appraisals, embody standards of correctness; standards of correctness may come from various sources, including from teachers, parents, and peers. Furthermore, Hattie remarks, the salience of the different sources varies. By way of illustration of the process of differentiation, Snygg and Coombs in 1959 (as cited in Hattie) cite the example of a woman applying for graduate work in psychology who denies having a disability:

> Noting that she was badly crippled [graduate school staff] asked her if she had considered the degree to which the handicap might make things difficult for her. 'I don't have a handicap!' she replied. Clearly she so defined her 'self' as to ignore her crippled legs. The self-concept we hold selects our prescriptions and brings them in line with the way we see ourselves. (p. 41)

Past self-conceptions and future self-hopes also factor into one's current conceptions of self (Hattie, 1992). Weinrich (as cited in Hattie) contends self-concept is the "totality of one's self-construal, in which how one construes oneself in the present expresses continuity between how one construes oneself as one was in the past and how one construes oneself as one aspires to be in the future" (p. 40).

Academic Involvement & Learning Approach

Pascarella and Terenzini (1991) contend that research indicates that "a student's academic involvement holds the greatest potential for fostering growth in intellectual skills" (p.149). Students, they suggest, are "member[s] of a larger social system in which interpersonal interactions with the major agents of socialization (faculty and student peers) may provide an important influence on student intellectual growth in their own right" (p. 149). According to Chickering (1969), "a student's most important teacher is another student… Thus relationships with close friends and peer groups, or subcultures, are primary forces influencing student development in college" (p. 253). Bean and Eaton (2001) suggest that students do not automatically experience social and academic integration in their relations with various parts of the postsecondary setting. Rather, students develop self-assessments following each social and academic encounter which, in turn, impacts future motivation and subsequent behavior and employment of adaptive strategies. Bean and Eaton's model, incorporating Fishbein and Ajzen's (1975) research, holds that attitudes contribute to intentions that lead to behaviors. Students' feelings of college fit and loyalty impact intention to persist which leads to actual persistence (Bean & Eaton, 2001).

Volkwein, King, and Terenzini (1986) examined one postsecondary institution, assessing 231 transfer students' background characteristics and campus experiences including classroom involvement and relations with peers. Their findings indicate that a measure of classroom involvement had a statistically significant association with the scale of intellectual skill development (learning to apply fundamental principles, critically evaluating ideas, being creative, thinking analytically, and gaining factual knowledge), or, specifically, students' perceptions of their own cognitive growth. Gaff, Wilson, and colleagues (as cited in Pascarella & Terenzini, 1991) engaged in an eight-institution study which yielded results suggesting a significant association between degree of involvement with cognitive growth. Their findings show that "regardless of academic or vocational interests, students who were most involved in the pursuit of intellectual activities reported the most progress in learning abstractions, comprehending ideas, and applying principles" (p. 147). Pascarella and Terenzini (1991) further conclude:

> General results of this body of evidence suggest that net of the effects of confounding variables, students who reported the greatest cognitive development were also more likely to (1) perceive faculty as being concerned with teaching and student development, (2) report developing a close, influential relationship with at least one faculty member, and (3) find their interactions with peers to have had an important influence on their development. (p. 150)

Auster and MacRone (1994) investigated the impact of faculty members' behaviors among a random sample of 132 students enrolled at one private liberal arts college. To carry out the study, 22 students in a research methods course each interviewed six students face-to-face using a scripted questionnaire; the questionnaire aimed to discover students' comments regarding the courses in which they perceived they contributed the most and, conversely, the least. Regarding these courses, interviewers asked respondents about the frequency

> … with which the faculty member engaged in such behaviors as calling on the student when he or she volunteered; calling on the student by name; nodding, smiling, and generally communicating interest in what the student said; encouraging the student to elaborate on his or her answers; and giving the student reasonable time to answer a question before going on to another student. (Auster & MacRone, p. 292)

Auster and MacRone found respondents participated most in classes in which professors often call on student volunteers, call students by name, exhibit signs of approval/interest, give sufficient time to answer, ask analytic questions, and encourage elaboration. The authors conclude professors' repeated engagement in these practices will help students see their expected role in this "negotiated social setting" (p. 297).

A similar study into classroom interaction by Fassinger (1995) examined 1,059 students in courses selected from a random sample of professors at a small, private liberal arts college in the Midwestern United States. The survey instrument administered to students included six questions designed to measure the dependent variable, class participation, along with additional questions featuring likert-scale response options. Questions asked students, for example, to rate their perceived frequency of contributing to class in comparison to peers, degree of contributing without hesitation, and amount of volunteering in class. The study sought information about the effect of three independent variables, namely, class traits, student traits, and professor traits, on students' classroom participation and interaction. The class traits' scale featured questions regarding students' perceptions about their and their peers' knowledge of, and comfort with, interaction norms and emotional climate. The student traits' scale examined how students perceive themselves in regard to three traits including confidence, preparation, and comprehension. Lastly, the professor traits' scale measured students' perceptions of their professors' supportiveness, approachability, and discussion facilitation and promotion. Fassinger's research into student classroom participation found class variables (namely, class size, student-to-student interactions, participation positively affects one's grade, and emotional climate) and student variables (confidence, interest in subject, and gender) emerged as more prominent factors influencing college student participation than professor traits/variables. The author concluded, however, that the findings demonstrate that professors exert influence on college classroom participation through their course design. For example, Fassinger contends "when professors create class activities that foster positive emotional climates, they are likely to help cultivate interaction" (p. 93).

There is limited scholarly research about classroom involvement and learning construction, or conversely, classroom and peer disengagement, of college students with psychological disorders. However, parallels have been made between the experiences of college students with hidden disabilities and those of ethnic minorities. For example, one article by Olney and Kim (2001) compared students with hidden disabilities with those of racial/ethnic minorities and concluded that both groups are perceived as having differing abilities than the majority culture; both can be impeded from fully engaging in educational and vocational achievement due to societal perceptions, stereotypes, and biases; and for both, one's identity brings with it social costs. Findings from a separate investigation of 799 freshman college students at one residential, public research university in the Midwest conclude that while academic integration proved to be an important factor for academic achievement among all college students, it was more important than entering ability for determining first year academic achievement among ethnic minority students (Elmers, 1997). The authors designed a self-report survey aimed at measuring how freshman experiences contribute to their college success (Elmers). The hypothesized casual model, the authors employed, included the following constructs: entering ability, external encouragement, perceived discrimination, affinity of vales, faculty-student interaction, academic achievement, academic integration, social integration, perceived quality, perceived gains, institutional commitment, goal commitment, and, lastly, intent to persist (Elmers). It can be argued that research investigating the experiences of postsecondary students with psychological illnesses can be enriched by turning to literature about ethnic minorities and academic integration and disengagement to better illuminate possible themes facing those with psychological disorders. Additionally, experiences of those with hidden disorders will be explored in a subsequent section examining stigma.

Gibson investigates and critiques John Ogbu's work, entitled *Black American Students in an Affluent Suburb*, comparing this work with the Ogbu's research regarding students of Mexican descent. Gibson, in undertaking such an investigation, aims to discover the underlying reasons for the factors contributing to minority youth academic disengagement (Gibson, 2005). Gibson's analysis of Ogbu's works reveals the following influential factors: feelings of isolation and not fitting in; mistrust of teachers; negative peer influences that berate and discourage a focus on academic pursuits; and missing connections, or minimal parental involvement, lack of effective study skills, and little or no knowledge of the educational system. Gibson suggests that students of Mexican descent who enrolled in advanced courses opted to be silent and not participate in class to avoid being labeled as rude or stereotyped by peers in the class. Moreover, Gibson's interpretation and analysis of Ogbu's research leads her to contend that students of Mexican descent often selected the easier classes to surround themselves with friends and escape insults or attacks on their identity or abilities encountered in advanced courses. Second, Gibson claims teachers often lacked self-awareness about how their actions or inactions in managing classroom dynamics impacted Mexican students' performance and persistence.

A separate study (Grant & Breese, 1997) argued that African American college students' reactions to situations will vary, based upon students' differing interpretations of marginality. Specifically, this study examined 23 students from a state university in a city in the Midwestern United States and involved participant interviews, namely, a set series of questions. In their study, Grant and Breese set out to distinguish participants' responses to marginality as falling into one of six distinct reactions found in existing literature, namely:

- Affected, or heightened race sensitivity and awareness often leading to delinquent acts;
- Emulative, or denial of one's race and culture often leading to attempts at "passing" for the dominant culture;
- Defiant, or discomfort with one's present place in the society which often manifests in positive change efforts or, conversely, acts of aggression and angry withdrawal;
- Emissarial, or mediating or shuffling simultaneously between two disparate cultural worlds whereby one seeks to educate each about the other;
- Withdrawn, or absolute denial of the marginal reality often leading to outright flight to the country of origin or decision to reject all that does not belong to one's original culture; and

- Balanced, or perception not of two cultures, or parts, but of one united, and integrated whole often leading to comfortable exchanges with those from the minority and majority cultures.

Their research findings suggest that individual interpretations of marginality status and experiences influence behavior within the postsecondary education setting (Grant & Breese).

Role of Stigma: Learning & Interacting with Others

There is some evidence linking stigma to adverse academic performance. For example, Quinn, Kahng, and Crocker (2004) investigated the impact of disclosing a concealed stigmatized identity, mental illness, on one's behavior. In particular, their two studies sought to uncover whether or not academic performance, manifest in performance on a standardized test, is compromised when one's social identity becomes "discredited" within the postsecondary educational arena. The researchers point to previous studies which indicate that mental health stigma, beyond the actual symptoms of the psychiatric disorder, affects individuals in their social interactions, self-esteem, social networks, and employment opportunities. Quinn, Kahng, and Crocker found that, among the 63 University of Michigan students in the study, 32 with a mental illness treatment history and 31 without, individuals' performance on a standardized test was worse when they were asked about their mental health history than when they were not asked. Quinn, Kahng, and Crocker's second study examined 48 University of Michigan students, 24 with a treatment history for depression and 24 with no depression history. Study findings suggest that disclosing a mental illness history resulted in worse performance on the standardized exam for those possessing a history of clinical depression yet yielded no effect for those without a history of depression. Quinn, Kahng, and Crocker conclude that "revealing a mental illness identity is broadly devaluing and likely leads to concern over proving oneself competent and worthwhile in an evaluative situation such as a standardized test" (p. 812). It is reasonable to conclude that concerns with proving oneself may extend into other academic environments and tasks in addition to standardized tests.

Stigma & Stereotype Threat

Stigma or negative stereotypes attached to a social identity may impact the behaviors, actions, and performance of the person identified with the stereotyped social identity. Tajfel (as cited in Hogg, Abrams, Otten, & Hinkle, 2004) defines social identity as "the individuals knowledge that he belongs to certain social groups together with some emotional and value significance to him of this group membership" (p. 248). According to Steele, Spencer, and Aronson (2002):

> When a negative stereotype about a group that one is part of becomes personally relevant, visually as an interpretation of one's behavior or an experience one is having, stereotype threat is the resulting sense that one can then be judged or treated in terms of the stereotype or that one might do something that would inadvertently confirm it. (p. 389)

Stereotype threats are situational and limited to the domains in which the negative stereotypes are perceived (Steele, Spencer, & Aronson). For example, a stereotype exists that holds that women perform poorly in math (Tiedemann, 2002). This negative stereotype threat is confined to math and math-associated domains only and therefore would only apply to women and their perceived ability in this specific domain. Steele, Spencer, and Aronson explain that how a stereotype is interpreted or perceived directly impacts the situations, people, and activities to which the stereotype applies. They further suggest there is a corresponding relationship between the amount of weight one gives to a particular domain (such as school) and the degree of concern about being negatively stereotyped in that given domain. Steele, Spencer, and Aronson further argue that the degree of the negative stereotype also rests in one's perceived ability to cope and/or respond to the threat and counter its adverse effects. They contend that "the mere threat of discrimination and devaluation implied by the perceived relevance of a negative group stereotype – the like threat of a snake loose in the house – can have effects of its own" (p. 389). In other words, simply being aware of one's marginality or stigma-cloaked identity interferes with one's trust, comfort, and self-efficacy to interact freely in a setting in which the stereotype threat has relevance. The stereotype dilemma is shaped and influenced by a number of factors, including:

> The nature of the stereotype involved, the importance of the behaviors to which it applies, the number of people in the environment who know the stereotype, the group's collective capacity to resist the stereotypes, the extent to which the stereotype can be avoided or disproved, and so on. (Steele, Spencer, & Aronson, 2002, p. 406)

In other words, the stereotype threat experience varies and is not static, changing depending upon the person, environment, and transactions between members of the environment. Wegner and fellow researchers (as cited in Steele, Spencer, & Aronson), contend that the act of attempting to suppress a thought ironically serves to keep the thought alive in one's mind. Such a phenomenon occurs to allow the person to observe and be cognizant of the presence of the thought. Such thought obsession resembles aspects of "mindfulness" described in a subsequent section of this chapter. Wegner and associates contend that this attempt at thought suppression presents additional challenges and interferences for the person (Steele, Spencer, & Aronson). Specifically, Steele, Spencer, and Aronson suggest that "the fitful effort to suppress stereotype concerns while one is trying to focus on a test might well be one process through which stereotype threat interferes with test performance" and, by extension, learning and class involvement and interaction (p. 405). Wegner's research raises a possible remedy: "when a person substitutes another thought for the to-be-avoided thought… it reduces the frustration of trying to find a substitute thought and makes suppression more effective" (as cited in Steele, Spencer, and Aronson, p. 406). Studies by Steele, Spencer, and Aronson, "provide evidence that stereotype suppression may be a mediator of stereotype threat effects on test performance" (p. 406).

Steele, Spencer, and Aronson (2002) illuminate several other acute and chronic reactions and responses to dealing with stereotype threat in addition to thought substitution and suppression. Acute reactions to stereotype threat the authors contend, include domain avoidance which, if adopted, can pose a barrier to intergroup relations. Domain avoidance is the act of avoiding the area in which the stereotype is realized and apparent (Steele, Spencer, & Aronson). Steele, Spencer, and Aronson further assert self-handicapping behavior involving the act of sabotaging one's performance in an area and pre-excusing poor performance signifies a second reaction. An example of self-handicapping behavior includes a student who waits until the night before an intense comprehensive exam to study, thereby providing him/her with the opportunity to blame a poor test score on not having enough time to study (something external) rather than on faulty time management techniques (something internal). Implications of self-handicapping, Steele, Spencer, and Aronson purport, include the confirmation of the negative stereotypes. A third acute reaction to stereotype threat is counterstereotyping behavior, an effort to disprove the stereotype by engaging in behavior that counters the negative stereotype with the intent of being perceived as falling outside the stereotyped group (Steele, Spencer, and Aronson). One limitation of this reaction, the authors argue, is that it is situation bound and imposes immense pressure on the person. For example, an African American college student, attending an elite university in which she is a minority, feeling pressured to dismantle stereotypes about her race may overextend herself studying to the point of physical and mental exhaustion. Disengagement, or disengaging one's view of him or herself and of their skills from performance on a test, embodies a forth and final acute reaction to stereotype threat. Here, one separates one's self view from one's academic and class performance (Steele, Spencer, &Aronson, 2002). Schmader and Major (2001) cite literature pointing to individuals of color reporting the same levels of self-esteem as European Americans, and that grades were not associated, or only weakly associated, with the reported levels of self-esteem for the former. The processes of psychological disengagement, or coping strategies, are suggested to be at play, including (a) devaluing the domain, or minimizing the importance of an outcome so that it no longer factors into one's self-evaluation or self-concept; and (b) discounting, or internally discrediting the evaluation one receives (Schmader & Major). Chronic adaptations to stereotype threat include disidentification or distinguishing between one's self and domain-applicable evaluations from one's performance in the domain.

There may be a connection between stereotype threat and classroom learning and involvement. According to Steele, Spencer, and Aronson (2002), "underachievement problems are caused, in some part, by threat – by persistent patterns of social identity and stereotype threat that, as something tied to a person's social identity in school and workplace settings, can become a chronic feature of his or her experience in those settings" (p. 424). Remedying the detrimental effects of stereotype threat includes relational, contextual, and individual strategies. Relational strategies include developing friendships with those outside one's devalued group, seeking mentors who impose high standards and affirm the ability of their identity-threatened mentees, and success-affirming role models and mentors (Steele, Spencer, & Aronson). Contextual strategies include the creation of settings which present evidence of fairness, objectivity, and respect, referred to as procedural justice (Steele, Spencer, & Aronson). Literature suggests that such environments fostered trust in identity-threatened individuals even when the outcome (e.g. academic grade) was not to their liking (Steele, Spencer, & Aronson). Finally, individual strategies include self-effacing humor that acknowledges, but dismantles the allegation inherent in the stereotype, distancing oneself from the negatively stereotyped identity, exerting effort to dispel the relevant negative stereotypes, and learning to take responsibility for not trying hard while simultaneously accepting failure without self-ridicule (Steele, Spencer, & Aronson).

As described in a prior section, ethnic minority students and those with psychological disorders are perceived as having differing abilities than the majority culture (Olney & Kim, 2001) or possess what Goffman (1963) labeled a master status. A master status embodies a significant unusual or infrequent variation as being central to an individual's character or identity. A master status can be "culturally stigmatized or culturally valued; they may be conspicuous or concealable. But regardless of the valuation or visibility, according to Frable, Blackstone, and Scherbaum (1990), each master status places people firmly outside of the norm" (p. 140). A master status can include, for example, obesity, homosexuality, being from an underrepresented ethnic group, or carrying the label of a psychiatric disorder; they are most noticeable, that is most obvious, in social interactions. One study investigated 44 female dyads, namely 44 women with a self-identified master status who were paired with 44 women who did not identify as belonging to any of the listed critical groups. These dyads "engaged in spontaneous, unstructured social exchanges" (p. 140). Chanowitz and Langer (as cited in Frable, Blackstone, & Scherbaum, 1990) hypothesized that individuals with a master status are likely to be keenly mindful of the various aspects and dynamics of their environment; that is, mindful behavior embodies "a close attention to and an active cognitive processing of all the different elements in an environment" (p. 141). In other words, some individuals with a master status may be engaged continuously in observing others and the environment when in social interactions, consumed with imagining the various directions the conversation and interaction will take. Furthermore, the study hypothesized that such individuals will follow the lead of the other person and take their perspective and expressed views (Frable, Blackstone, & Scherbaum, 1990). Such literature implies that individuals with a master status, such as a psychological disorder, may take a passive, rather than an active, role when interacting with others.

Findings of Frable, Blackstone, and Scherbaum (1990) suggest that "invisible deviants *(sic)* were more likely than their normal *(sic)* partners to adopt the other person's perspective" (p. 144). Measures on the partner attraction assessment revealed "normal *(sic)* partners of stigmatized deviants rated their partner the lowest" (p. 146). The study indicates that "invisible deviants *(sic)* must manage any and all information that might relate to the existence of their condition. Close attention to the conversation, then, is essential" (p. 146). Mindful behavior, on the part of "invisible deviants," causes fatigue that arises from constantly being on and alert during social interactions. Furthermore, the social interactions between the dyads were judged to be strained. Lastly, Frable, Blackstone, and Scherbaum's findings suggest that "marginal status people....all negotiate, manipulate, and change their unpredictable social environments by being mindful" (p. 148). Examined through this lens, college students with psychological illness may engage in mindful behavior in an attempt to manage perceptions and interactions. Such mindful behavior on the part of the college student with psychological illness may lead to fatigue, a suppression of the desire to share something in class that may be interpreted as contrary to the norm, and alienation, defined as an approach to preserve students' sense of self (Mann, 2001). It follows that persons with a marginal status exercising mindful behavior may face barriers to the development of self-authored/directed ways of learning and knowing. Excessive attention directed outward, observing others and efforts to suppress their own outing behaviors, could impede students' capacity for self-testing and role-playing.

Additional theories, namely Duval and Silvia's (2002) "self-to-standard" and Burke's (Burke & Stets, 1999) "self-verification" models, offer further speculative insight into the interaction dynamics of university students with psychological disorders. Duval and Silvia's "self-to-standard" system compares the self to standards, or norms, held by society as "correct" (Duval & Silvia). Their system declares that if one perceives that s/he shares these standards, a positive effect occurs. Conversely, if one perceives that his/her attributes diverge from the perceived norm, negative effect occurs (Duval & Silvia). Burke's "self-verification" system within Identity Theory holds that "people act so as to bring perceived self-relevant meanings in a situation (based in part on feedback from others and in part on direct perception of the environment) into congruency with the meanings contained in their identity standards" (Burke & Stets, 1999, p. 349). When viewed through the lens of self-verification, individuals attempt to confirm their self-views by turning to others' reactions (Burke & Stets, 1999). In other words, self-verification is synonymous with self-confirmation (Burke & Stets). Hattie (1992) echoing Burke's claim, asserts "the preservation and enhancement of this self is a basic human need" (p. 41).

Trust, accompanied by commitment, entails critical components of Burke's self-verification model. Holmes and Rempel (as cited in Burke & Stets, 1999) explain:

> When another person verifies one's self-view, the process of trust is activated. The self begins to see the other as predictable and dependable, and responds by developing trust in, and dependence on, the other. If the other responds benevolently (is trustworthy), then commitment to the relationship is fostered. (p. 348).

Thus, self-verification has implications for one's self-feelings and for feelings toward others. When trust is built, one's motivation to forge relationships with these interaction partners is sparked and triggers commitment to the relationship (Burke & Stets, 1999). Conversely, negative self-feelings emerge when other's self-responses are incongruent with how one feels s/he should be behaving, achieving, or being. Higgens (as cited in Burke & Stets) contends "with respect to different standards involved...when *actual* perceptions are different from ideal standards, depression results. When perceptions are different from *"ought"* standards, however, distress is felt" (p. 349, emphasis is original). For example, the college student role includes both ideal and "ought" standards. Failure to self-verify could result in both distress and depressive feelings for students who perceive such disparities.

A review of the relevant literature has revealed both persistent themes and exposed gaps and areas not yet explored. Empirical findings suggest there may be an effect of stigma and an association between marginalized status and academic performance and interaction. Research describes the external and internal influences of identity formation and effect on behavior and interpretations of one's self and others. Identity and college student development theories illuminate obstacles to identity construction and confirmation among college students with psychological disorders given suspected identity competition, conflict, reluctance to experiment with various roles, and feelings of anxiety and pressure. Such threats to identity formation and verification may impede students' ability to engage actively with others in the classroom and embrace self-directed approaches to learning, as is suggested by these literature findings. The chapter that follows will outline the study's methodology and has been divided into the following sections: nature of the study, data collection procedures, phenomenology, purpose of phenomenology, data in a phenomenological study, data analysis, and assumptions. The aim of the subsequent chapter is to clearly chart the study's qualitative research intentions and path.

CHAPTER III: METHODOLOGY

The purpose of this research study is to gain deeper insight into identity construction and classroom learning among a small and specified group of college students with psychological disorders. Therefore, the study sought to gain an understanding of these students' behaviors and decisions about personal and classroom learning interactions within the college context, recognizing the varying and fluctuating severities of psychological disorder manifestations. The study investigated changing concepts of these students' explanations and interpretations of their identities and classroom learning (including perceptions of their interactions with peers and level of classroom learning and involvement). This research examined the experience of these students by investigating their perceived challenges as learners and knowers and their views as to what helped them as learners and knowers. Specifically, this study aimed to answer the following overarching research question and supporting questions:

1. How do participants' reports of identity processes and self-concept impact their perception of learning experiences?

    a) How do these students talk about their interaction with classmates and professors (and others in authority)?

    b) What kinds of professor and student affairs professional feedback and interaction do these students report helped/hindered their developing self-directed/authored approaches to learning?

    c) How does the presence of stigma impact participants' level and character of classroom learning and participation?

Data collection procedures

The study aimed to discover the essence of the experience of being a college student with a diagnosed psychological disorder, with particular attention to students' perceived learning and identity. The study's unit of analysis is the individual student and therefore concentrated on the experience of individual students within the setting of one public university in the Western United States. The university, with an ethnically diverse and sizeable student population, bears a reputation as a commuter campus.

This study adopted the phenomenological tradition of inquiry; phenomenology is described in the next section. The inquiry focused on in-depth information gathered from a purposeful sample (Patton, 2002). Specifically, the researcher employed an intensity sampling selection strategy to arrive at what Patton declares is a "sample of sufficient intensity to elucidate the phenomenon of interest" (p. 234). Participants purposely selected included students registered with a disability services unit at one public university in the Western United States. Therefore, all study participants had documentation (including a DSM-IV diagnosis, date of diagnosis, medication prescribed, functional limitations of the disorder, and treatment plan) on file with the university's disability services unit verifying the presence of a psychological disorder as diagnosed by a licensed mental health professional. It should be noted that four of the seven participants selected claimed to have, and documents support, the presence of more than one psychological disorder.

Decisions about sample size reflect the nature and aim of the study, the richness and quality of information sought, and the methodology, namely phenomenology, selected. Morse (as cited in Sandelowski, 1995) suggests that "phenomenologies directed toward discerning the essence of experiences include about six participants" (p.182). Further, according to Sandelowski, "[s]ample size in qualitative research may refer to numbers of persons, but also to numbers of interviews and observations conducted or numbers of events sampled" (p. 180). The researcher solicited participation by sending e-mailed and mailed invitations to students with psychological disorders registered with the University's disability services center and providing notice of a ten dollar Visa gift card should they opt to participate. Participants volunteered to participate in the study either by contacting the researcher directly via e-mail or consenting via a phone call the researcher placed to follow-up on the mailed invitations. Eight students with Axis I psychological disorders with whom the researcher had never met or worked with volunteered initially to participate in the study and were selected; seven of these eight participants remained for the duration of the study. The eighth participant was unable to be reached following the initial interview and was therefore not included in the study. The participants selected were limited to: (1) those with disorders reported on Axis I (clinical disorders) on the multi-axial system to increase psychiatric diagnosis sample homogeneity and (2) students with whom the researcher had never met.

For the purposes of this study, the purposefully selected sample permitted extensive, in-depth interviews and provided each participant with the opportunity to review parts of his/her verbatim-transcribed statements for factual verification, a process called member checking. Giving participants an opportunity to review their statements yielded an increased level of trustworthiness and validity in the data findings. According to Gall, Gall, & Borg (1999):

> Researchers can check their reconstruction of individual's … perspective by member checking, which is the process of having individuals review statements in the researchers' report for accuracy and completeness….Member checking might reveal factual errors that are easily corrected…. (p. 306)

An underlying assumption of qualitative research in general and phenomenological research in particular is that truth resides with the individual (Moustakas, 1990).

Phenomenology

Phenomenology is a human science approach to studying the essence of lived experience; phenomenology is a *"theory of the unique,"* according to van Manen (1990, p. 7, emphasis is original). Phenomenology traces its roots to philosophy and Husserl. As an educator and parent, van Manen argues phenomenology is well-suited for pedagogy to facilitate practitioners' ability to make "interpretative sense of the phenomena of the lifeworld in order to see the pedagogic significance of situations and relations of living with children [or young adults, or college students]" (p. 2). Van Manen described lifeworld as a term deriving from Husserl's work and refers to the world of lived experience in a pragmatic way. Phenomenological inquiry, van Manen asserts, is "discovery oriented," intent of discerning the meaning of a certain phenomenon (in this case the experience of being a college student with psychological disorder) and how it is experienced (in this case how it is experienced in the classroom and related learning contexts) (p. 29).

Purpose of Phenomenology

The purpose of phenomenological human science research, van Manen (1990) posits, is to "borrow other people's experiences and their reflections on their experiences in order to be better able to come to an understanding of the deeper meaning or significance of an aspect of human experience, in the context of the whole of human experience" (p. 62). This study aimed to uncover the essence of the lived experience of college students with diagnosed psychological disorders within the setting of one public university in the Western United States. The phenomenological tradition of inquiry in particular gives voice to individuals with an externally imposed identity, as is the case with the participants in this study, and situates the reconstruction of identity as part of their overall lived experiences. The college classroom and wider learning environment was purposely selected for this study because of the classroom and university's role as a place in which teaching and learning occur and unique human interactions and dynamics unfold. Furthermore, "[i]n comparison with many other social settings, classrooms are perhaps the most crowded human communication environments. Here, young people are involved in discussing, debating, arguing, talking, and chatting as well as nonverbal interactions" (van Manen, 1990, p. 89). Thus, it follows that delving into students' experiences and sense-making of living with the knowledge of a psychological disorder in a crowded and social environment may yield meaningful data. Such data will provide descriptive inquiry and in so doing may contribute to the growing knowledge base, and inform larger studies.

Data in a Phenomenological Study

Van Manen explains that human experiences comprise the data in phenomenological research and offers several phenomenological methods for gathering data, or reflections on the lived experiences: written descriptions, interviews, close observation, diaries and journals, art, and phenomenological literature. This study gathered data from interviews, observations, college records, and writings from seven college students with a diagnosed psychological disorder/disorders including Attention Deficit/Hyperactivity Disorder (ADHD), Bipolar Disorder, Depression, Social Anxiety Disorder, Schizophrenia, Generalized Anxiety Disorder, Dissociative Disorder, and Post-Traumatic Stress Disorder (PTSD). The interviews were recorded and subsequently transcribed to facilitate textual analysis.

The relationship between collecting descriptions and generating interpretations is complex. Van Manen (1990) presents six suggestions for facilitating phenomenological descriptions from the study's participants to which this study carefully adhered when conducting interviews about participants' lived experience:

> 1. You need to describe the experience as you live(d) through it. Avoid as much as possible causal explanations, generalizations, or abstract interpretations…
> 2. Describe the experience from the inside, as it were; almost like a state of mind: the feelings, the mood, the emotions, etc.
> 3. Focus on a particular example or incident of the object or experience: describe specific events, an adventure, a happening, a particular experience.
> 4. Try to focus on an example of the experience which stands out for its vividness, or as it was the first time.
> 5. Attend to how the body feels, how things smell(ed), how they sound(ed), etc.
> 6. Avoid trying to beautify your account with fancy phrases or flowery terminology. (p. 64-65)

Type of Questions in Phenomenological Research

Van Manen (1990) encourages the use of participant descriptive anecdotes as a way of depicting lived experience and personal life stories. Anecdotes, van Manen (2002) reports, embody a "helpful method since they bring the phenomenon that we study into experiential nearness" (p. 61). Van Manen (1990) concludes that the importance of anecdotes can be traced to the "keen sense of the *point* or *cogency* that the anecdote carries within itself" (p.69, emphasis is original). Contrasting between sameness and difference represents another way of capturing the essence of lived experience. Van Manen (2002) elaborates:

> We need to examine how people differ by being attentive to what we share in common, by showing how we are different through sameness. In doing so phenomenology does not offer special theories that explain either being healthy or being disturbed. Rather phenomenology seeks to understand how insights into our ordinary or healthy existence can help us understand in what ways existence can be disturbed and become extraordinary. (p. 61)

Such a compare and contrast approach is grounded in van Manen's (2002) belief that "we will best understand uncommon experiences by looking to the outside, to the external things of the world in the midst of which the person lives" (p. 62). Further, van Manen prompts the researcher to ask participants "How does this person 'see' the things? What is important in this world? How does this person interact with his or her environment?", cautioning researchers to "suspend our judgment about what is real and what is illusory" (p. 62). Additional phenomenological questions applicable to this study include:

- How do you come to know that your thoughts (e.g. suicidal, obsessive/compulsive, or anxious) are different from those of others? (van Manen, 2002, p. 67).
- How does keeping these kinds of secrets affect people's perceptions of themselves? (van Manen, 2002, p. 68).

Data Analysis

The researcher conducted a series of formal, semi-structured interviews with each of the seven participants over a period of six months, stretching from May 2007 through October 2007. For the purposes of the study, a "semi-structured interview" is a combined interview approach. A "semi-structured" is defined as consisting of a standardized interview protocol and format combined with the opportunity (at the interviewer's discretion) to ask additional questions or related topics should they be warranted by the participants' previous/earlier response. These follow-up, probing questions designed to "explore certain questions in more depth," according to Patton (2002, p. 347) may take on a conversational-like quality. The interview protocol can be found in Appendix C. It is important to note that questions may have been asked out of the sequence in which they are displayed in the protocol to facilitate the natural flow of each interview. Interviews were audio recorded with the knowledge and verbal permission of the respondent and subsequently transcribed. The researcher and participants co-selected interview locations that were convenient for participants and facilitated their openness as well as upheld confidentiality. Examples of interview locations include public parks, a college outdoor seating area within close proximity to the participant's home, and a library meeting room, among others. Data included over 21 hours of audio-recorded interviews with participants that resulted in 748 pages of transcripts.

This study pairs phenomenology and its emphasis on capturing the essence of the lived experience with Patton's (2002) concrete steps to data analysis. The interviews were transcribed, analyzed, and coded for themes. After receiving taped interview transcriptions, the researcher read the transcriptions arranged and framed according to the research questions and examined additional observational notes. The researcher grouped the voluminous interview data into emergent themes, a process which resulted in fifty pages of grouped data. Following the grouping of the interview data, the researcher returned to the arranged data now arranged thematically and made notes in the margins commenting about the data's fit within the body of existing literature. Here, the researcher referred to the literature review conducted (see Chapter 2) along with additional literature discovered. This process was conducted several times to "verify meaningfulness and accuracy of the categories and placement of data in the categories" (Patton, 2002, p. 466); thus involved an iterative process. Moustakas (1990) illuminates this process in his following remarks:

> The heuristic researcher's 'constant appraisal of significance' and 'checking and judging' facilitate the process of achieving a valid depiction of the experience being investigated. They enable the researcher to achieve repeated verification that the explication of the phenomenon and the creative synthesis of essences and meanings actually portray the phenomenon investigated (p. 33).

Thus, this study engaged in thematic analysis, an approach designed to achieve its aim of uncovering the essence of the data. Themes, according to van Manen (1990), can best be conceptualized as experiential structures of experience" (p. 79). Phenomenological thematic analysis, van Manen reports, involves that act of unearthing "something telling, something meaningful, something thematic in the various experiential accounts – we work at mining meaning from them" (p. 86). Van Manen offers a four-part definition of a theme:

1. *Theme is the experience of focus, of meaning, of point.* [Ask, what is the meaning or point of an anecdote or oral/written description?]
2. *Theme formulation is at best a simplification.*
3. *Themes are not objects one encounters at certain points or moments in a text.*
4. *Theme is the form of capturing the phenomenon one tries to understand.* (p. 87, emphasis is original)

In other words, thematic analysis describes a process of illuminating or revealing themes that exist in interview transcripts and descriptions, of uncovering the meaning (van Manen, 1990). Thus, thematic analysis leads the researcher to ponder, "What does this (oral or written) expression reveal?" (van Manen).

Patton (2002) lists several key ways to interpret qualitative data for meaning. Adopting Patton's approach the researcher delved into the set of interviews and collection of notes and asked:

- What does this data mean or reveal?
- What does this data tell me abut the nature of the phenomenon of interest? (Here, the researcher will pattern herself after Patton by working back and forth between data (evidence) and her own perspective and experience and themes from literature; thus employing an iterative process to data analysis)
- Interpret the essence of what the interviewees reported.

Furthermore, in phenomenology, the author must set aside all prejudgments and experiences, a Greek word called Epoche, and "rel[y] on intuition, imagination, and universal structures to obtain a picture of the experience" (Creswell, 1998, pp. 51-52). The active role of the researcher will contribute to the integrity and unfolding of the phenomenological paradigm. Van Manen (1990) points to the use of bracketing as a means of understanding one's own preconceived notions of the phenomenon to be studied. Husserl (as cited in van Manen) used "bracketing to describe how one must take hold of the phenomenon and then place outside of it one's knowledge about the phenomenon" (p. 47). Bracketing yielded a realization that while literature is abundant with medical descriptions and empirical, experimental data about mental illness, there exists a lack of research of an illuminative and experiential nature about this population within the college and university context.

Assumptions

This brief section acknowledges and outlines assumptions the researcher holds regarding the nature of qualitative inquiry and invites the reader to observe when absorbing the study's findings.

- The participants responded to the open-ended interview questions honestly and with adequate thought and consideration.
- Due to the personal nature of the research topic and vulnerability the interview can induce, student participants may withhold applicable information or attempt to skew their responses due to shame, embarrassment, or the like.

This qualitative study aimed to discover the meaning of the experience of college students with psychological disorders. Adopting the tradition of phenomenology as a framework for pondering the essence of the student experiences yielded rich and deeply personal data which would not be possible through a quantitative lens. These data findings unfold in Chapter IV.

CHAPTER IV: FINDINGS

The following chapter uncovers the rich, phenomenological data emerging from participant interviews, writings, and classroom observations. The chapter opens with participant profiles and is followed by three sections, each addressing a specific research question or questions. The overarching research question, "How do participants' reports of identity processes and self-concept impact their understanding of learning experiences?" is examined in all three sections. The first section, Self-Concepts and Self-Meaning, discovers participants' reported identities, or internalized roles (Hormuth, 1990) and self-concepts, or cognitive self-appraisals (Hattie, 1992) in relation to their psychological disorders. The next section, Identity Processes and Impression Management, explores the second research question, "How do these students talk about their interaction with classmates and professors (and others in authority)?" through (1) an examination of participants' identity processes within the college arena and (2) participants' reported interactions and relationships with peers, family members, classmates, and professors. The third and final section entitled, Classroom Learning and Interaction, examines participants' reported approaches to learning and interacting in the classroom and addresses the final two research questions: How does the presence of stigma impact participants' level and character of classroom learning and participation? What kinds of professor and student affairs professional feedback and interaction do these students report helped/hindered their developing self-directed/authored approaches to learning?

Participant Profiles

This following section is intended to acquaint you with the seven research participants at one public university in the Western United States. The brief participant portraits below present a context to make meaning of the participants' stories and unveil select details and facets of their lives, including, their age, ethnicity, academic standing and major, employment, psychological disorder diagnosis/diagnoses and extracurricular affiliation and membership. The participants have been identified by pseudonyms.

Morgan is a 43-year-old Caucasian female graduate student working on her master's degree in special education. While working on her graduate degree, she works full-time in elementary education. Morgan currently resides with her mother, into whose home she moved following acceptance into the graduate program. Morgan describes herself as an athlete, enjoying biking and camping. Morgan and her mom are both active members of a national organization dedicated to mental illness. Morgan has been diagnosed with Bipolar Disorder, Obsessive Compulsive Disorder, Dissociative Disorder, and PTSD.

Emily is a 23-year-old female student of Vietnamese ethnicity pursuing a bachelor's degree in art (she recently switched from animation/illustration to creative arts). Emily's completed college units place her at about junior standing. Emily describes an uncertain future with indistinct job prospects yet strong feelings of obligation toward supporting her family. Emily is active in art, art clubs, and poetry.

Emily was raised in the Buddhist faith. Emily does not believe that any in her family have a mental illness. Emily has been diagnosed with Schizophrenia.

Billy is a 20-year-old African American sophomore pursuing a bachelor's degree in the social sciences, formerly a biological sciences major. Billy reports pursuing his own business and modeling. Billy considers his Middle College instructor, whom he had in his senior year of high school, as being instrumental in his decision to change his major. Billy lived with his father in Georgia for many years and moved in with his mother while in high school. Billy reports that both of his parents place a great deal of importance on the value of a higher education. Billy currently lives in an apartment off campus. Billy is a Buddhist, a member of Buddhist-based organization, and works at a retail establishment. Billy's biological dad and grandfather have ADHD. Billy has been diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD).

Susan, a 40-year-old, Caucasian woman, worked full-time while earning her bachelor's and master's degrees; she completed her master's in social work in May 2007 and now works full time in her field. Susan describes her future employment aspirations as a therapist working with those with mental illness and drug/alcohol addictions. Susan currently resides with her fiancé, whom she met in college. Susan is the youngest of three children, an older sister and brother; her father is deceased. Susan, a recovering drug addict, is a Narcotics Anonymous (NA) sponsor and spends time in NA activities including hiking. Susan has been diagnosed with Post Traumatic Stress Disorder, Depression, and ADHD.

Joey is a 26-year-old Caucasian student in junior standing pursuing a degree in occupational therapy. Joey entered college upon graduation from high school but dropped out. After working full-time for several years with mixed success, Joey returned to college. Joey lives in an apartment off campus with roommates. Joey works while attending school, most recently as a lifeguard. He is a mentor in a community organization and practices martial arts in which he has been involved since childhood. Joey describes a childhood where he strove to remain "under the radar." Joey has been diagnosed with ADHD.

Anna, a 26-year-old Caucasian student pursuing a bachelor's degree in child development, resides with her parents and older sister. Anna works part-time as a nanny caring for two young children. Anna envisions a future as a teacher, director of a Montessori school, and a mom. Anna describes having close relationships with her family and her social network to include her boyfriend and a best friend. Anna describes that her mom also disclosed having feelings of anxiety. Anna has been diagnosed with Social Anxiety Disorder and Generalized Anxiety Disorder.

Jason a 19-year-old Caucasian male who recently withdrew from college during the second semester of his freshman year. While in college, Jason was a member of a fraternity which he talks about as a highlight of his college experience. Jason currently works full-time as a promoter and resides with his parents. Jason describes having a close relationship with his older sister. Jason envisions returning to the college from which he withdrew in one year yet expresses some doubt about making it. Jason has been diagnosed with Bipolar Disorder and ADHD.

Self-concepts and Self-meanings

The profiles illustrated above provide simply a glimpse into various facets of participants' lives leaving a chasm only filled by delving deeper into participants' stories and perceptions of themselves and their experiences. This next section offers an illustration and explanation of self-concepts. Self-concept is conceptualized in this study according as:

> [A]n organization (structure) of various identities and attributes, and their evaluations, developed out of the individual's reflexive, social, and symbolic activities. As such, the self-concept is an experiential, mostly cognitive phenomenon accessible to scientific inquiry. (Hormuth, 1990, p. 70)

Baran (as cited in Gultekin and Baran, 2007) concludes that other people's evaluations influence the development of positive or negative self-concepts. An examination of the evolution of one's self-concept involves three factors including the "interactions a person has, the continuity and change in these interactions, and the relationships with the roles of the interaction partner" (Hormuth, p. 74). The self is conceived as a "process" and its "product" the self-concept, situated in the individual social situation and larger social environment (Hormuth, p. 72). Gecas (as cited in Hormuth) describes the social situation as "the context in which identities are established and maintained through the process of social negotiation" (p. 72).

Conceptions of Psychological Disorders, Stigma, and Impact on Self-Concepts

Participants' reports of self-concepts and identity processes nested in relevant literature embody the focus of this section. Specifically, this section aims to examine participants' perceived conceptions of psychological disorders and stigma, self-meanings and concepts at the time of diagnosis and in college, role hierarchy, and finally, the intersection of medication with self-concepts.

The experience of being introduced to, and labeled with, a psychological disorder and the diagnoses' impact on participants' self-concept will first be investigated. According to Goffman (1963), individuals with a stigma undergo a socialization process, or a moral career in three stages. A moral career is defined as the "natural history of a category of persons with a stigma" (Goffman, p. 32). The phases, namely absorption, realization, and later life stigma, mark either a progression or a difference in the method through which stigma is attained.

The first phase of the moral career involves the person with a stigma absorbing and sharing the beliefs, identity concepts, and norms of the larger society (Goffman, 1963, p. 32). Link, Struening, Neese-Todd, Asmussenm, and Phelan (2001) assert that people develop conceptions of psychological disorders early in life and these conceptions are formed from family lore, media, and experience. In other words, individuals in this phase form impressions of psychological disorders in general, not relative to themselves, but in a more abstract way. Link, et al. conclude "if a person believes that others will devalue and reject people who have mental illnesses, that person must now fear that this possibility of rejection applies personally" (p. 1621). These impressions take on personal relevance when the person learns that he/she falls into this stigmatized category. As a result, when examined through the lens of Goffman's theory, participants' initial, pre-diagnosis conceptions about psychological disorders have relevance and shape their later, post-diagnosis self-conceptions.

The second phase of the moral career entails the realization, on the part of the person with a stigma, that he/she has a stigma *and* the implications of having it (Goffman, 1963, p. 32). Goffman concludes that individuals' journey through their moral career "provides a foundation for later development" (p. 32). Viewed through Goffman's socialization paradigm, this study is concerned with how participants' experiences of being diagnosed with a psychological disorder impact their identity development and their development as a student in college.

Individuals learn that they possess a stigma in various ways and points in their lifetime. For example, Goffman (1963) identifies a set of patterns which capture the multiple ways by which a person comes to be acquainted with a stigma. The first pattern includes those with an inborn stigma while the second pattern describes those who are held within the protective circle of a family or neighborhood, shielded from the disparaging comments and self-definitions held by the larger society until there is a break from this cocoon of protection. Three of this study's participants, namely Joey, Jason, and Billy, fall into the second pattern having received psychological disorder diagnoses as children ranging from first grade to middle school. All three participants learned of their stigma through the lens of their parents' reactions. Jason explained that "[initial diagnoses] was a really tough time for my parents. I didn't really know what was going on." Billy commented that the diagnosis experience was "kinda cool… Like the idea that I had to take medicine or something." But this reaction was influenced by the recognition that his dad, who was present during the diagnosis disclosure, "probably had different thoughts." In other words, Billy juxtaposes his initial reaction to the diagnosis and being prescribed medication as "cool" with this father's reaction, perceiving a conflict or a tension between the two differing reactions and viewpoints; hence, Billy forms a more complex outlook about having a psychological disorder.

Goffman (1963) asserts that these individuals' entry into environments that no longer afford protection, such as public school or dating, place them face to face with the stigma and its consequence for the first time (p. 34). College represents a particularly free and unprotected environment where individuals are often for the first time thrust into independence; where the presence of laws, such as Family Education Rights and Privacy Act of 1974 (FERPA) decrease parental oversight and announce to parents that their children must give them permission to gain access to information such as grades and academic progress; entry to college thus triggers a parent-child power and role shift. It follows then that these participants will presumably face their stigma and its impact in college in an entirely new way when compared to high school. Furthermore, college situates traditional-aged students in the precarious position of straddling, and thus inhabiting, the space between youth and adulthood.

The third phase of the moral career describes those who acquire a stigmatized identity later in their lives and for whom "the medical profession has the job of informing him/her of who he/she is going to have to be" (Goffman, 1963, pp. 34-35). The remaining study participants, namely Susan, Emily, Morgan, and Anna, fit the third pattern as they learned of their stigma in their late teens and twenties, in hospitals following a mental health crisis or a session with a mental health professional in an outpatient setting. Morgan explains it this way:

> The doctor, you know, I've just been out of the hospital and they have a list of five or six things that I have. And so I'm dealing with all of those. You know, are [the diagnoses] right or are they wrong? And how does this impact me to try to

> finish my undergrad work? Am I going to be able to do it? Do I really want to admit to having a psychiatric disability? Posttraumatic stress disorder, that I didn't understand at the time why they gave that diagnosis to me. It wasn't until later that I understood what was going on.... So you are struggling with all of these labels...

Goffman concludes that these individuals in particular "will have a special problem in re-identifying himself, and a special likelihood of developing disapproval of self" (p.34). In other words, according to Goffman, these participants are more vulnerable to possessing negative self-concepts than those who learned of their stigma as children within the confines of their parents' protection. Susan commented on her self-thoughts following diagnosis: "It was really hard to just process and kind of re-identifying who I was and kind of looking at that part of myself."

Goffman (1963) further concludes that the self-concepts of individuals who learn of their stigma in an institutional setting such as a jail or hospital, as was the case with Morgan and Emily, will be shaped and influenced by their observing and interacting with others undergoing similar experiences (pp. 36-37). Emily recounted an initial experience in a halfway house following a hospital stay:

> Like the first time I was there I was just really, pardon my language, I know I'm crazy but there was this really, really crazy lady, right. And she was like cussing people out and calling them this and that and she was like kind of cross-eyed. And she was talking to her little Mickey Mouse and she would talk to it. Sometimes when it talked back to her it would call her ugly she would cry.

Emily reflects on the conflicted feelings she faces while in the halfway houses, torn between sharing a connection with the other inhabitants on the one hand, and prejudice and fear, on the other hand:

> People that have worse symptoms than you do that could get scary... Like even though you have symptoms.. someone else who has the symptoms you get prejudiced, man because you know how bad it can be...There is a double side to

> it. Like a connection to that person but ....like you know that sometimes you can't trust a person because they have this illness you know because the certain things they say... It's just scary because you never know when they will be like that because I know I am like that sometimes so it is scary.

It is during these processes where individuals are "fighting [their] own battles of identification," attempting to reconcile their pre- and post- stigma selves and their publicly defined and privately held notions of self (Goffman, p. 40).

Self-meanings and Concepts: At Time of Diagnosis

The period during which the participants first received or absorbed knowledge of their diagnoses (as is the case with the participants who learned of their diagnoses as children) is best captured by the following metaphors or metathemes reported by participants who describe their experience as being "in a fog" and "in a black hole." Participants, such as Morgan recall the time of diagnosis as a black hole, as a time of confusion and blurriness and uncertainty over the labels being attached to her: "I was in a fog...What I can remember or what I can tell you was told to me." Morgan further explained: "Have you ever been sucked into a hole? It was horrible. But, I mean, just thinking about that now, I remember I was sucked into a hole. A black hole. There was no way out. So what was going on around me, it was very difficult to figure out." Jason commented that he had "no clue" about the diagnoses attached to him and their implications initially. Jason recalls a "black hole" in his memory, and "very dark times" around the time he learned of the bipolar disorder.

Early on, participants adopted the public definitions of mental illness or their psychological disorder in particular, wrestling with being "crazy," "bad," "helter skelter" man or, if children, perplexed by their parents' external reactions. As iterated earlier, three participants, Joey, Jason, and Billy, describe parents' reactions as "crying" and recalling that the diagnoses were "tough for my parents" while simultaneously admitting to not really knowing why their parents were upset or being in a blur or "black hole."

Overall, the diagnostic labels at this time took on the undesirable characteristics of the stereotype of mental illness and disability (Link & Phelan, 2001). Jason remarked being labeled mentally ill and sick, saying that it made him think that he "was some kind of helter skelter guy with paint and blood on the wall." Emily commented that for her, the diagnosis was the "end of the world" and described being very depressed with suicidal thoughts and crying a lot. "I felt really bad about myself. Like the end of the world. I should die. I –I shouldn't go on." Susan equated the diagnosis experience with "like jumping, like walking at the end of the earth and jumping off. It just felt really scary and that foreign to me." Initially, there was minimal discrepancy between participants' virtual and actual identity at this time. The one exception is Anna who describes something akin to relief upon receiving her diagnosis concomitant with the realization there is a medical reason for her behavior and mental state:

> I actually felt like not relieved but just in a sense felt a little bit better knowing that there was some reason for what I was feeling, how I was acting and things, so it felt okay. I could call it something. I'm not just weird.

Name-Calling

Being labeled or diagnosed with conditions such as psychological disorders shares similarities with name-calling, according to Hayne's phenomenological work delving into the experience of diagnosis (as cited in van Manen, 2002). For example, an individual may intuit or suspect that he/she has a particular condition (i.e., a mental illness) or a particular characteristic (i.e., overweight). However, the act of being called or named "crazy" or "fatso" acknowledges the stigma attached to the name and announces how others see us (Haynes as cited in van Manen). Thus, name-calling can contribute to the development of felt stigma. "Does diagnosis call something into being, in the same way as the other things are called into being – through naming?" asks Hayne (as cited in van Manen, p. 183). Participants' "disorders" were named or revealed to them by parents, therapists, or psychiatrists, individuals with perceived authority and expertise. Once clothed in a particular diagnosis, participants were "named" a second time by others and themselves. These names (see list below) embody socially constructed definitions of psychological disorders and represent others' reactions or sentiments about a generalized notion of psychological disorders or mental illness. Thus, participants simultaneously grapple with two name-categories: (1) the medical diagnosis or label (i.e., schizophrenia) and (2) the socially constructed interpretation (e.g. crazy). "Name calling may touch upon something deep within us. It penetrates our vulnerabilities and zeroes in on some tender spot on the tissue of our being" concludes Hayne (as cited in van Manen, p. 183). The following words represent either the names and phrases participants attached to themselves following the diagnosis or the names others bestowed on them upon learning of their diagnosis:

- Crazy
- Someone in the corner twitching and you know holding a knife
- Weird
- Mentally ill
- Helter skelter guy with paint and blood on the wall
- Schizophrenic
- Bad
- Freak
- Lazy
- Mad
- Flake

- Goofy

Diagnoses, and the words we and others attach to them, and thus to ourselves, carry power, a "judgmental power, a transformative power" asserts Hayne (as cited in van Manen, p. 185). These words have the ability to influence and shape behavior, self-concepts, and even future goals, as evidenced by the participants' stories. The naming of the diagnosis by a recognized "expert" makes it real to others and to the recipients of the diagnosis if acknowledged and internalized.

Self-meanings and Concepts: In College

Comparison Making as "Self" Constructing

Participants defined themselves in relation to others or in relation to their pre-diagnosis selves. In reflecting upon why some of his peers label him "weird," Billy explained:

> I think it's because when I have to contribute to a conversation a lot of times they'll be talking about one specific thing and in my head I'll take that one thing, like I'll run a couple minutes ahead. And then I'll contribute what I have to say. And then they will be like, what are you talking about? I have to explain because they'll be like, you're weird. I don't know. It's weird, but that it what they usually say. It's kind of frustrating because it's like, fuck, just listen to me.

Joey recalled prior educational experiences in which he compared himself to his classmates, perceiving himself to be left out, not able to grasp material as fast as his peers:

> And I wanted to learn it, I really did, but I didn't understand it and they were already on something else. It was like you missed your chance. Tough luck. Now you can't learn that. It's just terrible. I missed my chance. That's all you hear. You wanted to understand you really wanted to learn but no you ran out of time. You didn't do it as fast as everyone else.

Where Billy and Joey report feelings of being misunderstood or left behind, Susan describes the diagnoses as something which sets her apart from others and places her in an inferior status position. "[The diagnoses] is just one of the re-occurring things that I think about myself. It makes me feel that I am less than other people."

Emily's self-concept emerges from a comparison of her pre- and post-diagnosed self. Emily labels herself "bad" in reference to being a "bad student." Here, Emily compares her post-diagnosis course grades and performance with her pre-diagnosis grades in which she went from a top-performing student with aspirations of becoming a doctor to "bad" grades and murkier future career prospects. As Emily explains, her self-concept evolved from helper to patient and one who receives help, from top student to bad student:

> And in some ways [schizophrenia] kind of ruined my life. Because I used to be a really good student. I feel like I lost the things that I used to like about myself. I used to take things really, really seriously. In some ways it's kind of a good and bad thing. As a patient, I can't take things as seriously as I should. I can't like, fight as hard as I want to. Like I can't deal with stress as much as I want to. I used to like be in the center of things and fight really hard. I was the person you go to if you need help. .. I feel like I reversed the role, you know? As a patient, I go to them for help. I am the vulnerable one. And I don't like that. Because I feel like I just reversed roles.

Self-concepts are also formed by what participants view themselves as NOT being. Participants were asked to write responses to the question "Who Am I?" as well as "Whom Am I Not?" "to illuminate the not-me" and reveal "the negative and positive roles of identity" (McCall, 2003, p. 12). "Who Am I?" and "Who Am I Not" statements will also be referred to as Me and Not-Me statements, respectively. As Goffman noted (as cited in McCall, 2003) "a shorthand is involved here: the individual is actually denying not the role but the virtual self that is implied in the role for all accepting performers" (P.12). In other words, participants' "not me" statements will reveal a dissociation with virtual selves, or those attributes others cast upon them which conflict with participants' actual selves. Participants' responses to the Who Am I? and Who Am I Not? tests will be explored shortly. Further justification for examining self-disidentification statements rests with Burke's (1980) claim that "an identity (as the internal component of a role) is given meaning in relation to counteridentities" (p. 19). Emily noted that she is not like those with a mental illness who "are homeless and they end up like wandering the streets" and then shuttled to the hospital after an incident in which the police must get involved. Similarly, Morgan announced who she is not by describing people with her diagnosis who she does not resemble. "I know people that are out there constantly going in and out of jail because they won't stay on their meds." Thus, Emily is asserting that she is not a transient, and, like Morgan, not unstable.

The Who AM I and Who AM I Not statements

Participants' responses to the "Whom Am I Not?" and "Who AM I?" assessment revealed illuminative self-identifications and self-disidentifications.

> [T]o assert an identity (and thus to make a claim about Me) amounts to accepting other's altercasting (i.e accepting the received identities). To deny an identity (and thus make a claim about Not-Me) amounts to resisting other's altercasting (i.e. denying the received identities). (McCall, 2003, p. 22)

Morgan and Emily's Not-Me claims demonstrated that they no longer conceive of themselves the way they did following diagnosis; they assert that they are not bad, ugly, sick – words they attached to their illness or their initial feelings upon receiving the diagnos(e)s. Anna's Not-Me claim of "I am not crazy" suggests a disidentification with the stigma attached to those with psychological disorders. Billy's Me and Not-Me claims suggests a tension between accepting and denying received identities. When asked to provide words which describe himself now, Billy replied "laid back, out of the ordinary, and weird." Billy offers two examples in which other people describe him as weird, and yet in the Not-Me exercise he asserts a resistance and a disidenitification with this identity. Jason's Me statement includes claims of being "challenged" and comments made during the interviews suggest that he perceives his disorders as presenting challenges for him similar to everyday obstacles other's face as demonstrated by these comments:

> I have to take pills sometimes, and stuff like that. And going to the doctors. Those are the basically main reminders that I'm a little bit different. Besides that, I consider myself just like everybody else walking down the street. Everybody else has their own little problems. I don't really consider myself much different. I know I talk fast but that's different.

In other words, Jason perceives his disorders are not a part of him, as reflected in his claim: "I'm separate from the disability." Similarly, Morgan asserted "I am not my illness." Both statements show evidence of a reaction against virtual identities.

Table 1: Participants' Not-Me and Me Statements and Descriptors below contrasts participants' Not-Me statements with their Me statements, juxtaposing their negative and positive self-conceptions and roles. Several participants' Me and Not-Me claims include symptoms or characteristics of their psychological disorders, rather than the name of the disorder(s) itself or broader category (i.e., mental illness, psychological disorder, disability), as if taking ownership of certain aspects of their disorders but not the disorder or mental illness itself. Participants distance their "selves" from words associated with their disorder, working to exclude negative words and associations from their self-concepts. For example, as illustrated in the table, Morgan seeks to exclude sad,

manic, obsessive, compulsive; Anna asserts she is not anxious; Jason takes ownership of being flaky/lazy, not motivated, not hard working; Joey, not well-organized, always on the go, and anxious [difficulty with organization is often a characteristic of those with ADHD while 50% of those with ADHD experience anxiety (Dendy, 2000)]. Morgan asserts that persons with psychological disorders have to accept being “a person with a disability.. And it’s something that I had to realize or still have to,” suggesting that she is grappling with a level of continuing acceptance and the presence of some denial regarding her psychological disorders.

“[T]he Not-Me is not a set of negative identities; rather, it is a set of various self-disidentifications” (McCall, p. 14). Some participants’ Not-Me statements represent past self-identifications, perceptions, or states of being suggesting a change or movement away from former self-views. For example, Susan’s Not-Me claim announces who she is no longer (i.e., no longer an addict). Still other Not-Me and Me statements hint at movement and active searching. For example, “Not yet” preceded “balanced” in Joey’s Not-Me statement suggesting that he is making active efforts to enter a state of inner equilibrium or balance and that he perceives such a state is possible. Change or movement is also evidenced in Joey’s Me statement: “Always growing.” Similarly, Emily notes that she is “trying to find myself every day” suggesting a lack of self-constancy and a searching for self.

Table 1. Participants' Not-Me and Me Statements and Descriptors

	Not-Me	**Me**
Susan	• Lazy • An addict • A drunk	• Person with a mental illness • Strength-based
Billy	• Weird • A liar	• Buddhist
Emily	• A bad person	• Survivor • Trying to find myself every day
Jason	• Motivated • Hard worker • Stupid	• Challenged • Smart • Flaky/Lazy • Talkative
Morgan	• Bad • Sick • Ugly • Weak • My illness	• Strong • Sad • Manic • Obsessive • Compulsive • Hard working
Anna	• Crazy	• Anxious
Joey	• (not yet) Balanced • Well-organized • Stupid • Without error	• An observer • Always on the go • Anxious • At war within • Alone • Always growing

Role Hierarchy

Participants were asked to list their roles, both prior to their diagnosis and now, following diagnosis. In addition, participants were asked to rank and prioritize these perceived roles according to the importance of the role in their lives. The following section will unfold participants' perceptions of their roles as college students.

Additionally, the section will examine how participants' "student role" factors into their other reported roles. In other words, the prominence of the "student" role will be explored. The importance of examining participants' various perceived roles and their ranking of these roles can be traced to Identity Theory, which according to Hormuth (1990) concerns itself with

> …the relationships between commitment to an identity and behaviour. It is assumed that the self-concept of a person consists of a *hierarchically organized set of multiple identities*. An identity is a specific content of the self-concept, and is usually conceptualized as an internalized role: role-identities. However, it has to be noted that roles are actively made rather than passively played. (p. 77, emphasis is original)

Consequently, one's commitment to a particular identity determines its ranking or position in the hierarchy (Hormuth).

Emily ranked the role of student as her most important role prior to her diagnosis. Emily's student role prominence slipped slightly following her diagnosis, being ranked third, behind the role of provider. Morgan ranked the role of student as her fourth most important role prior to her diagnosis. Morgan's "student" role prominence following her diagnosis remained the same except that now she included a new role, "survivalist," which she ranked as her most prominent and important role. Susan ranked the role of student as sixth prior to her diagnosis. Susan's student role took on elevated prominence following her diagnosis, being ranked her first priority role. Anna did not include the role of student in either her pre-diagnosis nor post-diagnosis roles. When asked about her role as student, Anna placed the role of student as lowest. Anna explains: "Well, I think it's important that I get a college degree. But looking at [student role] compared to other [roles], [student] is actually at the bottom." As Billy, Joey, and Jason received their diagnoses as children, their perceived roles prior to diagnosis are not as illuminative; however their post diagnosis, current role rankings will be examined. Jason ranked the role of student last, as his least important role, following the more prominent roles of pledge (fraternity) and coworker, among others. Billy ranked the role of student as his fifth most important role, following leader, motivational speaker, business owner, and boyfriend. Joey ranked the role of student (of life and in college) second, after the role of friend.

Comments made throughout interviews with participants lend support for their role rankings and the position they placed "student" within their role hierarchy. Emily, for whom the role of student was ranked high, notes: "College is all I have." Morgan, who also ranked her student role high, remarks: "My math helped me focus. It gave me something to focus on, something that I could be successful at." Furthermore, Morgan concludes: "[Being a student] keeps me alive. It really does. It makes my brain work.... The student aspect being in the classroom, I have to think, be on my toes. Keeps me alive. It's really important. [Going to school] made my brain start to work on something other than being sick." Susan, for whom the role of student is also prominent, asserts: "I think school was pivotal for me. Like I think it's really the best thing since slice[d] bread." Susan explains: "My whole reason for going to school was not about money or a job. Those are perqs. It was about accomplishing something I wanted to do and so just feed my head with information like enlightening myself. It was such an empowering process... and it made me know like if I wanted to I could." Susan also disclosed that she postponed getting married to complete her degree. Joey, who ranked "student" high in the role hierarchy, claimed "I gave up everything to be a student." Furthermore, Joey talked about the importance of learning overall for him, stating that even if his student role in college did not work out he would always be a student of life, learning each day. Billy, for whom student is ranked relatively low in the role hierarchy describes school as "a nagging person" and expresses conflicts about his motivation for attending college. Billy's uncertainty regarding college are best captured in his following remarks:

> Well, when I first started doing this side business thing, I was like, well, if that's the case, if I'm going to have all this money then I don't need to go to school... So I was going to say forget it. But, seeing that I want to do some of the things I want to do I would need to learn like society and stuff like that. I would need to – I feel like I would need to just go through school anyways. So, it's like, I would need to meet a lot of people...And then, I don't know. I mean, there has been a couple of times where I have not seen the reason of going to school.

Jason, who ranked the role of student as his least important role and ranked his role in the fraternity higher asserts:

> When I was rushing... I was pledging at the fraternity like you know they called me out on basically all the things that I screwed up on. Like you're doing this and you're doing this. If you are not going to change man, you're booted. And I was like, shit man, I really wanted to join that thing...Like it really meant a lot to me. That was the turning point I guess one night...

Jason's membership in the fraternity was important to him, thus his brothers' challenge to change his behavior carried weight, while the possibility of failing a class, a threat to his student role, which ranked last in the role hierarchy, did not. Anna ranked her student role at the bottom of the hierarchy, not because, as she says, her student role is not important to her, but rather that the other roles (i.e., sister, daughter, girlfriend,) were more important. Anna talks about being a student in terms of external, rather than internal, outcomes or transformations. For Anna, being a student will lead to a college degree which in turn will give her credibility and respect in her field. Anna does not speak about her student role as "all she has" or "life-giving" as do Joey, Morgan, Emily, and Susan whose student roles emerge as prominent in their role hierarchy. Thus, participants revealed varying commitment to the role of "student" as indicated by responses on the "Role Identification and Prioritization" assessment and interview protocol questions. Those participants for whom the role of student ranked high, namely, Joey, Susan, Morgan, and Emily, appear to gravitate toward, and invest in, higher education for affirmation and legitimation purposes, while the students who ranked the "student" role as less prominent, namely Billy, Anna, and Jason, appear to seek affirmation and legitimation through other means, including a business venture, membership in a fraternity, and family membership, respectively. According to Identity Theory (Stryker & Burke, 2000) disclosure of one's stigma (in this case carrying a label of a psychological disorder) poses less risk to participants' student role identities if the student role is not a prominent identity and if there are no or few meaningful relationships and other roles attached to the student role.

Medication

The topic of medication emerged frequently, and in unexpected periods, during the dialogues with participants. Medication, taken to treat psychological disorder symptoms, intersected with participants' self-concepts and thus, merits analysis. Medication also played a role in participants' social relations and interactions and therefore will be examined from this perspective focusing on academic and social interactions and relationships. As a theme, medication personified an unwelcome yet necessary organ, simultaneously instrumental yet troublesome, for the majority of participants, with distinct qualities evoking powerful sentiments and, at times, dramatic side effects. The persistence of medication as a reality for participants fell along the following dimensions: bodily-change producer and credibility/creativity sabotager. However, participants also perceived medication, once the correct medication was identified, as initiating a turning point in their functioning and thus their daily life activities; these perceptions will be examined in a subsection entitled, stabilizing agent.

Bodily-change producer

Participants reported several psychotropic side effects responsible for producing visible changes to their bodies. Such body transformations, however subtle, left participants physically different in some aspect or aspects than their pre-medication selves. As students' concepts of their physical selves and bodies comprise one of Chickering and Reisser's (1993) identity vectors, discussion of participants' conceptions of their outer selves will be examined here; the significance of participants' conceptions, within the framework of identity and student development theories, will be explained in Chapter V. Emily remarked: "You see [mental illness] physically within yourself. Like women with facial hair, which is gross....Because of the medications, you are actually seeing physical changes which is associated with the illness." In addition, participants faced verbal comparisons of their pre and post medication-selves. Changes in weight embodied one shared experience. Anna, who tried a few medications to treat anxiety disorder symptoms before opting out of psychotropic treatment while attending community college, explained: "When I first started, I dropped a lot of weight. I heard comments about, she's anorexic. Whatever. Things like that." Billy remarked that ADHD medication made him nauseous and lose weight while Emily recalled an incident with her aunt regarding her medication-triggered weight gain, stating that her aunt said: "You know sweetie if you lost a few pounds you would be really pretty." Emily said she felt bad about her aunt's comments and misunderstood, stating that the medication leaves her with less energy than she had before, and thus less ability to exercise. Yet, Emily went back and forth between blaming the disorder or herself for the weight gain, suggesting an element of guilt regarding the changes to her body. Emily also reported that her medication, taken to treat symptoms of schizophrenia, caused her breasts to produce milk, prompting her mom to falsely speculate and accuse her of being pregnant. Such physical changes, in the midst of a college environment in which images of the ideal body are plastered on posters and blaring from television and movie screens pervade, pose a threat to the formation of positive self-concepts among participants.

Credibility and Creativity Sabotager

Participants described additional self-changes which accompanied the consumption of psychotropic medications. One such change appeared in public presentation and delivery of verbal information. Billy explained: "Like sometimes I can be kind of monotone and slur my words when I'm on my medicine. But he [referring to a well-known personality whom he recruited to speak at his college] was like every time I called him he said that he could not understand what I was saying." Thus, Billy's credibility was in question and his slurring was perhaps falsely attributed to his being in an alcohol-induced state. Jason, taking medication for bipolar disorder but not ADHD as the ADHD medication would adversely impact his mood disorder, remarked: "I just talk fast because my thoughts just come out too fast kind of boom, boom, boom. I kind of slur my words sometimes." A second medication impact revealed itself in perceived personality shifts. Billy linked the medication with altering his personality, rendering him "bland and boring." Billy also remarked that he is not as creative on medication, stating that he cannot "think outside of the box" or simultaneously think and daydream. In other words, attributes of his personality that he perceives to be positive are lost. It follows then that there is a kind of grieving process that emerges following the physical changes ushered in by medication; a grieving of a former self, or aspect of self.

Stabilizing Agent

Medication also personified a stabilizing partner for Morgan, Emily, Jason, Joey, and Susan. Once the medication prescription was right, the participants experienced something equivalent to a turning point. Initially, Morgan reported that she was "so drugged up" she could not participate fully in her undergraduate courses. However, once she was diagnosed correctly eleven years later and prescribed the appropriate medication, Morgan explains: "Well, a big turning point for me was the medication… And it was for me again because I could not function until we got that under control." Jason cites that medication was critical in treating the bipolar disorder symptoms: "But things got better once we figured out what was wrong. We got me medicated and everything is cool now though but I still got problems with organizing ambitions, goals, tasks, motivation." Yet for Jason, medication also embodies "one reminder that something is different with me." Likewise, for Susan, "medication was pivotal" in reducing the symptoms of her depression and ADHD. However, medication was viewed negatively by her Narcotics Anonymous (NA) sponsor who disagreed with taking psychotropic medications. By accepting one part of herself Susan risked alienating a relationship very close to her and her recovery from narcotics. Susan states that in her circle, "[i]t is more socially acceptable to be a drug addict than it is to be mentally ill."

During initial interviews, Joey commented that he is not taking medication now, that he keeps forgetting to take it and describes this as a problem. "The problem is I rarely take my medication. I still forget." In terms of any perceived differences Joey observes in terms of when he is on/off medication "I don't really see a difference but I think that ....that others do." Yet during a later interview, Joey reported that he has been making an effort to take his prescribed medication and incorporate it into his routine. Joey remarks that the impact of medication has been "huge" for him in a positive way yet the battle to ensure he takes the medication regularly persists.

Identity Processes and Impression Management: Participant Interaction Behaviors

This next section aims to depict participants' perceived interaction with others and ways of managing their disorders and responds to following research question, "How do these students talk about their interaction with classmates and professors?" Furthermore, how does interaction with others impact participants' identity processes? The section is divided into the following subsections: Concealment Impulses and Behaviors, Relationships, Mindfulness and Passing, Disclosure Decisions and Motivations (Preventive Telling), Marginality Sharing, and Classroom Learning and Interaction Influences and Disincentives. The character of participants' relationships and interaction within college will explored within the body of each subsection.

Concealment Impetuses and Behaviors

Participants' stories reveal a focus on survival behaviors, or impression management, including constantly monitoring themselves and their surroundings, mirroring peers' body language, styles and stance, and "self-policing" and "laying low." One factor underlying participants' decision to conceal their disability-status, to "keep it as a secret, a very tight secret" (Morgan) to others is to avoid "sticking out like a sore thumb," a metaphor offered by a participant. Scared about what people would think about her unpredictable behavior and fear over losing her meaningful relationships in college where she was pursuing her bachelor's degree, Morgan chose secrecy regarding her psychological disorder. Morgan recalls:

> I was scared. I was scared because I didn't know what people would think. They knew something was wrong. They didn't know what and you know, honestly, when I was first diagnosed, I thought okay, that was it. It was easy enough. We'll get some medication; we'll take care of it. You know, the medication made it worse. And my family and friends could not figure it out because my behavior was so erratic. And they didn't... There came a time when they didn't know how to deal with me anymore because they couldn't understand what was going on. And honestly, I couldn't either. I couldn't figure it out. It felt bad. It really felt bad. I was afraid that I was going to lose my friends and family. With the physical education department I didn't really care, but the music department I did because that is where my relationships were.

Susan reported that she learned not to talk about her psychological disorder to protect herself, stating that she consciously tried not to "stick out like a sore thumb" in college. Jason also revealed efforts reflective of a desire to blend in and be like his peers. A highlight of Jason's freshman year included membership in a fraternity, a membership in which he cites was important to him. Jason describes social situations in which alcohol is involved as an occasion in which the bipolar disorder presents itself as a factor to consider. Jason explains it this way:

> It's like you don't want to be like I can't guys I'm driving home or like – like you can say that but or like then they go 'like find someone else to drive' or like you can't be like 'guys I've got a disability', I can't. It sounds like a fricken woose man. You're gonna get your butt kicked. It's like 'hey guys no man not tonight man I got...I got some medication I can't mix with.' You know you've got to be cool about it.

Regarding disability disclosure, Jason asserts that "I don't feel I need to tell people…It's just that they don't need to know." For Jason, his role in the fraternity was important and disclosure of his disability was seen as a potential threat to this valued role and identity.

Fear of being "pigeon-holed," a metaphor which emerged from the participants' stories, represents a second factor underlying participants' motivations to conceal their disorder(s) from others. In other words, a fear of being treated or perceived less favorably due to being labeled or linked to the stigma of mental illness and assumed to possess stereotypical characteristics or behaviors associated with psychological disorders discouraged disclosure. Billy asserts that when people find out about the disability, they tell him to take his meds or to stop being annoying. Consequently, Billy does not like to tell people. People tell Billy he is annoying but he does not realize when he is being annoying, as illuminated in his comments:

> It just seems that whenever I told people I was taking [medication for ADHD] there would come a point where I wasn't taking it and they would be like, go take your medicine. So, I didn't really like telling people just because they would use that against me as an insult.

Susan assumed professors and classmates in her human/social science field would be open-minded about mental illness but changed her mind after observing how a friend and classmate with bipolar disorder was treated after she disclosed her disability. "People treated her differently. Like you feel – discredited just, you feel you are looked down upon for even saying it." Such observations, which included noticing classmates' rolling their eyes when her friend spoke in class or the professor asking her to give others a chance to talk, have prompted Susan to adopt a "Don't talk, don't tell, don't trust people" motto in her workplace, in college and graduate school. Susan asserted that her friend, implying herself as well, did not want to "be different. She wanted to fit in like everyone else." This longing to be treated and perceived like the general college student population resonated repeatedly in participants' stories and is best illustrated in Jason's remarks: "Besides [medication] I consider myself just like everybody else walking down the street. Everybody else has their own little problems. I don't really consider myself much different." Jason explains the effect he hopes to receive upon revealing his psychological with others: "I don't look for any reaction. I look for non-reaction. I just look for them to treat me the same." Anna's disclosure decisions hinged on weighing the possibility that she would be perceived as less than an asset to her classmates: "Not that they will judge me, just that maybe they will. They might think. 'We shouldn't rely on her.'" Morgan's motivation to conceal her disability from others can be traced to her belief that if the disability was disclosed, some would treat her differently:

> But there is just some people in the class that wouldn't...you know, as a whole I think yes, but for some people [disability status] does change things. They think...it goes back to stigma. They think maybe you are not that smart. You know, you are here on a whim...So you got to take care of yourself.

Another perceived impetus for concealment includes fear of loss; a fear of losing social status and esteem, the opportunity for social mobility, or one's employment. Morgan asserted that she fears being fired from her job should her psychological disorder be revealed due to the pervasive stigma she feels exists. Morgan describes a close relationship with her boss yet she "can't share this [psychological disorder] part of her" with her boss. Morgan continues:

> As much as I would like to [disclose my disability to peers in my classes] because there is course work, there is presentations that I have given or other groups have worked on that they could use my expertise in the area, but I don't open myself up

> to that for fear that somehow it might get around to my employer…So you just don't know how people are going to react.

Susan and Emily echoed Morgan's sentiment about a fear of retribution following disclosure within the workplace. Emily voices a similar fear-induced motivation for concealing her psychological disorder:

> I worry a lot about the working world because they discriminate a lot. They can't help it but they do discriminate. Some do more than others. Like like you know like, you look at a program like they have certain programs to find jobs for people. And like they have like they have you don't get regular jobs. It's like you are labeled you are only good enough to have a job to fill up boxes or something.

A final reason for concealing a psychological disorder includes a fear or possibility of being misunderstood. Billy explains it this way:

> I don't see why I have to, you know, keep myself you know from letting it out, you know what I mean? But, it's simply because it's people in general like, if they don't know [about the particulars of the ADHD disorder] then they just kind of like it's not usually a positive thing if they don't know. Most of the time if they don't know they'll either laugh at it or make fun of me later or like, I don't know. It doesn't really make that big of a difference to me because, I mean, if I don't have to tell them that's fine, I don't really care. I'm still going to be who I'm going to be.

Susan's concealment impulses are triggered by her past disclosure experiences. For example, she reports that "people treat you differently" upon learning about the presence of a psychological disorder. Susan describes feeling ignored in the past because people's reactions to her revelation were too painful to confront. Jason recounts experiences in which peers tell him that they have a brother or friend with bipolar disorder after he discloses to them that he has bipolar disorder. Jason questions the accuracy of his peers' claims and says they are "full of shit," asserting that bipolar disorder is rare and many people do not know what it is and confuse it with other disorders such as depression.

Jason's reactions indicate a resistance to being mis-labeled, mis-perceived or placed into a box someone else has constructed.

Implications for concealing one's psychological disorders from others surfaced in participants' stories. Withholding knowledge of one's psychological disorder(s) from others impacted participants' academic performance and perceived solidarity with their peers [or, "freedom in peer relationships," as described by Chickering and Reisser (1993)]. Morgan recalls that she made a conscious decision to forgo the possibility for a grade of "A" in a graduate course upon realizing that in order for her to take the test and get an "A" she would have to disclose to the professor her need for additional test time and thus her disability. In this case, Morgan determined that the risk of disclosure was not worth it. Morgan explains: "I kept this as a secret, a very tight secret." Morgan wanted others to see the positive rather than the self-described "not so positive" aspects of herself and thus retain their view of her as a "perfectionist." A similar decision point occurred while she was pursuing a math credential. According to Morgan,

> There were times when I could have used that extra time on the testing but I didn't want anybody to know what I going through, because I was still pretty sick as I was doing this math credential. My medications were not solidified. They were still moving them around, so I was still having a hard time. So, you know, stigma has a lot to do with it and my behavior and how I'm handling myself.

Withdrawal

Participants reported that concealing their psychological disorder(s) from others also impacted their relationships, or way of relating to others. Withholding her psychological disorders from others caused Susan to withdraw from other people. Susan explains: "It certainly made me be more withdrawn from other people… I guess in a way you know I felt disconnected from other people because I couldn't be one hundred percent honest." The theme of "playing a part" surfaced in dialogues with Anna as well. Anna shares the consequence of telling family members and close neighbors about her disorder: "I knew that they knew, so I didn't have to play a part or anything. I didn't have to pretend I was okay if I wasn't." Anna's revelation that disability-disclosure leads to her ability to be more herself with others suggests that lack of telling may prompt withdrawal or result in more limited relationships evidenced by Anna's claim that she has not made a lasting friendship at her college. Emily recalled that some peers "just kind of stopped talking to me" upon learning of her psychological disorder. "Yeah like they ignore me after a while." Morgan, recalling the time shortly after she was initially diagnosed, remarked: "And being by myself was hard. But yet I sought that out." During a separate interview, Morgan concluded that during this time period she was "very withdrawn on campus, in the classroom, and with my roommates." Morgan continues: "You know I stayed so far away, you know, I withdrawed so I wouldn't have that relationship issue… Kept my distance" and with professors "I just took a few steps back." As an explanation for withdrawing, Morgan asserted that her priority was keeping safe and that she would "goof up on" her relationships during the time following her initial diagnosis in her third year of college. Billy recalled a recent occurrence at work in which his coworkers facetiously challenged that he could not withhold himself from talking for a period of time. Billy recalled that he responded by walking away from them and determining it is better to just be alone.

Relationships

The presence of psychological disorders influenced the quantity of participants' relationships with peers while attending college and the meaning of these relationships.

Such findings take on added importance when framed through Chickering and Resisser's (1993) assertion that "relationships [in college] provide powerful learning experiences about physical expression of feelings, others' evaluations, levels of self-esteem, and other aspects of identity" (p. 24). Morgan describes herself as a "loner" and one who is very cautious when entering into friendship with others: "It's just that that I really am careful of who I choose to have a relationship with and that is because of the mental illness." Morgan reported that she went from 1999 to 2004 without finding a true friend. It was in church that she met a close friend who she describes was "very supportive" and knew about her illness. Anna reports that she has not found a lasting friendship yet in college. Billy reports a close relationship with a girlfriend, also a student at his college, but reports not having made other close friendships, or people he can really talk with about things. Billy talks about the meaning of finding a friend who shared his disability diagnosis in high school: "It was really cool because we'd always be able to relate to each other. I think if I had not hung out with [student's name] all the time then I probably, I don't know. Because I've tried to hang out with other people at the school. I never really got along with them as I did with [student's name]." Susan reported that she did not make many friends following her initial diagnosis; however, she reports finding several peers in her master's degree courses with psychological disorders with whom she could confide and enter into mutually supportive relationships.

The experience of living with a psychological disorder influenced one participant's redefinition of what constitutes true friendship in college and reinforced the meaning and value of these relationships. Emily's recognition that friendship should involve reciprocity and that she is worth standing up for suggests a level of growth and maturity, as Emily illuminates in these comments

> I realize friends matter. Like, one thing that is positive about like college, not just college but like about my illness is that you realize that camaraderie is important. Like your friends you realize like what friends matter and what friends don't. You realize up to a certain point you got to kind of let people go. And in college I found people who were willing to be my friends. Who were willing to be there for me because that meant a lot. Because I realize I don't have to deal with that if they are not going to be there for me I don't want to be conditional and I don't want to be like having a grudge, but to a certain point I feel if they are not willing to fight for me I shouldn't be there to fight for them either. Because it should be a two-way street...You realize who to listen to you realize like their true face comes out.

Mindfulness & Passing

Participants talk about being actively mindful of themselves, their behavior, and how they are perceived by others. Emily, Morgan, and Susan talk about being on guard and alert to behavior and signs that hint at the emergence of their symptoms, those things that set them apart from others. Emily explains this state of mindfulness:

> The Buddhist said when someone asked him, like what is the difference between like what you guys do? What do Buddhists do? And the Buddhist says, "We talked. We eat. We sit and we do this and that." And then the guy would ask, "So what is the difference between that and a regular person?" The Buddhist says, "We know when we talk. We know when we eat. We know when we sit. We know when we meditate. We know when we do things." And I started to recognize that certain things because I obsess about it so much and it really bothers me. I try to stay away from it because you don't want to be obsessing. I want to be free.

Morgan reveals a similar state of mindfulness and self-monitoring practices:

> I'm very in tune with what my body does now. Before I wasn't. So, I'm very in tune. I know what I'm looking for. So, I'm very afraid of it but, it's... I can't stop it. So, that's what bugs me the most. For example, just last evening my brother and his kids came over to drop some stuff off for my mom. And you know I was very animated and knew what was going on. It was very frustrating for me that I couldn't stop and then I would just stop and sit there, okay don't say anything. Okay, just don't say anything. Then I would pop up and say something again.

> That to me is a sign that something is not right. Or I will withdraw. You know I will do this within a day's time... So it's out of control. Something is out of control. I don't like that. Even though I can see it happening.

Joey recounts his decision to self-monitor his actions in high school and continuation in college: "I kind of realized in order to be better at what I wanted to do I have to observe my environment more often. Sort of like being more observant I became less interactive as well. Well, immediately interactive." Joey recalls that over years from listening to people tell him to "shut up" he has become a lot quieter, monitoring when to say something or do something. Jason recounts a similar experience from his childhood: " I observed other kids' behaviors and realized that it's not acceptable to throw desks, or blurt out thoughts in class." Jason asserts that he has learned that he needs to be observant of himself and mindful, to ask himself why he is getting depressed or angry. Such mindfulness triggers participants to modify, or attempt to modify, behaviors that stray or diverge from the perceived norm. Participants' actions and self-monitoring reflected Goffman's (1963) concept of social passing, or

> [D]isidentifiers, a sign that tends...to break up an otherwise coherent picture but in this case in a positive direction desired by the actor, not so much establishing a new claim as throwing severe doubt on the validity of the virtual one. (p. 44)

Joey describes how he monitors his behaviors and ADHD symptoms: "I have to remind myself, kind of police myself." He explained that the need to police himself emerges in settings in which he is bored; he further comments that he engages in self-monitoring, telling himself: "Like, no, now is not the time to get up and do something." He reports that often others are surprised to learn that he has ADHD; Joey concludes that people's surprised reactions are "a good thing" and an indication that he "has learned to cope," or conceal the symptoms. Jason talked about his practice of mimicking others' behavior to conceal his disorder: "When I'm around different people, I act different." Jason explains that he acts differently in different settings (i.e .night club) and around different people (i.e. parents):

> Some of our friends have a certain way of acting...When I'm around them I mirror them in some way when it's like body language or the way they talk or something about them. Like when I'm around certain people I'll duplicate them almost in an eerie accuracy like you know when you see somebody far away like you know they are standing there.

For example, Jason duplicates the way his peers say things or the way they laugh. Susan describes a symptom of her psychological disorder, which is talking a lot. "I need to talk all the time which is really difficult." To conceal her disability she modified her behavior, namely reducing her amount of talking in class, deciding to "lay low" after seeing how her classmates and professors perceived her friend with a psychological disorder, ridiculing her for dominating the class discussion. Dialogues with Morgan revealed examples of covering behaviors prompted by the consequences of memory lapses: "So, I try to remember as much as possible so that when somebody brings it up I can really say, oh yeah, I remember that. Instead of, of yeah, I remember and not remember that at all." Morgan goes on to say that if she is with her mom and does not recall a particular situation "I'll tell her I don't remember, but if it is with somebody else, I play along."

Billy engages in a ritual designed to influence his peers' impression of himself at the outset, to depict a particular self-image before others have a chance of drawing their own conclusion about him. Billy explains:

> I mean sometimes when we first start the semester and I don't really know anyone I just kind of, you know, do my little bit so that.... Like, I'll try to build myself up

> in the beginning so that's it not so hard. Who is this kid talking in the back not having anything to say? I try to make sure my voice is heard each time.

Disclosure Decisions and Motivations (Preventive Telling)

There were several forces prompting participants to disclose their psychological disorder(s) to professors and peers in college. Telling [or, as Lee and Craft (2002), suggest, "preventive telling" defined as "thwarting disapproval by educating and informing others before one's secret is exposed" (p. 220)], about one's disorder to prevent the attachment of false labels and attributions (that threaten their student identity) comprised one motivating factor for participants. Susan revealed her disability status to her professors to avoid being perceived as "lazy." Anna will disclose at times that "she has lots of anxieties" to group project members so her peers will know why she is not there and "won't think I'm a flake or something because problems usually occur in a group project." Emily confronted a professor upon learning that he labeled another professor with Bipolar Disorder a "kook" and remarked that the college "shouldn't hire people like that." Emily chose to disclose to the professor to disassociate herself with stereotypes and present a more accurate portrait of herself, despite the inherent risk:

> But I thought like if I told him [about my disorder] that then like he would look down on me. He would be prejudiced and he would also make comments like schizophrenics are like this, schizophrenics are like that and then when I told him I was schizophrenic, I was like well I'm not like that and I'm schizophrenic. He's like, well, do you take medication? Like what is that supposed to mean, you know?

Emily perceived the professor's reaction as one of disbelief in her credibility and disidentification with negative stereotypes.

A second factor influencing participants' disclosure decisions includes a simultaneous need to be understood and honest. Just as participants attributed a fear of being misunderstood as an incentive to conceal their disability from others, so too the possibility for increased understanding acted as a motivating agent for participants to disclose their disorder or disorders to others. Participants' stories revealed a theme of being misunderstood. Emily recounts how her mom mistakenly blames all of her behaviors or actions on her psychological disorder. Telling, divulging a piece of themselves, permits participants an opportunity to emit a more complete and accurate self-portrait amidst a sea of stereotypes. Such telling can also be empowering as participants become the ones doing the telling; they are in control even when at times they are not in control of their disorders' symptoms. For example, Emily, referring to the disorder's symptoms, says: "You can't control it. It just happens." Joey reveals his disorder in class discussions in which psychological disorders or ADHD are taught to share his expertise as a person living with ADHD. Consequently, in this very act of disclosing, he shapes his peers' and professors' perceptions of ADHD, and thus, of he who is doing the telling. By giving a fuller picture of ADHD, presented by someone who has direct experience, he is speaking to the power of his own experience. Yet the knowledge that others receiving this news may have negative or incomplete conceptions of the psychological disorders induces fear. Fear and trepidation also surface when participants realize that telling involves a risk, and a possibility that the way they were perceived prior to disclosing will be forever altered. The possibility for lost esteem or pre-diagnosis self perceptions prompts Emily to test people prior to sharing knowledge of her psychological disorder with others. Emily tests people by asking them general questions about mental illness to see their reactions before self-disclosing. Emily explains: “Some people I’m more open with. I mean, pretty open about it. I will say, I have schizophrenia. But I don’t know how people are going to think of me.”

Anna, Morgan, and Billy report feeling relief after disclosing the presence of their psychological disorders to others (peers, professor, and girlfriend respectively); such relief suggests their decision to disclose was not made lightly and that the opinion of themselves according to other person(s) was important and carried consequences. Yet, the anticipated or hoped-for outcome (i.e., increased understanding and ability to be more fully honest) outweighed the possible risk and fear (i.e., rejection and diminished esteem) as demonstrated by Billy’s comments:

> Like one time I was in class. I didn’t yet tell my teacher that I had ADD. There was this other kid that was kind of like being goofy. [The teacher] was like, What is the fuck wrong with you? You have ADD? I was kind of sitting there like, it just made me sad then.

Marginality Sharing

Dialogues with participants revealed disability disclosure unleashed a sharing of marginality, illuminated by Emily’s anecdotal recollections:

> When I share[d] with them that I have the illness they shared with me that they are gay. It’s not an illness for them but it’s like a struggle because they still have to deal with the person in that way. So they were relating to me in that way. So they were relating to me in that way that they still feel prejudice and it’s like a struggle for them. It’s like we both shared this really big secret and we both have to keep it hush, hush.

Emily goes on to say “But, somehow it always leaks. I wouldn’t say on my part but on their part.” After much contemplation and faced with seemingly no other choices but to approach a professor for help, Morgan confided in a professor about her disorder and need for assistance. Morgan recalls that she felt relief upon hearing the professor confide that she has a friend going through similar mental health issues. Similarly, Anna shared that when she told a professor about her disability, he disclosed that his wife has a similar disorder and offered assistance.

Classroom Learning and Interaction Influences and Disincentives

The third and final section of this chapter examines participants' reported approaches to learning and interacting in the classroom and addresses the final two research questions: What kinds of professor and student affairs professional feedback and interaction do these students report helped/hindered their developing self-directed/authored approaches to learning? How does the presence of stigma impact participants' level and character of classroom learning and participation?

Several themes surfaced in participants' recollections of what facilitated their learning and interaction, on the one hand, and motivation to attend college, and by extension, their decision to engage in self-helping behaviors, on the other. The following emerged as themes when analyzing participants' stories of their college classroom learning experiences: professor flexibility, hands-on learning, student-directed questions, and professor humanness coupled with positive recognition of the students and affirmation of their efforts. Joey and Emily described the importance of flexibility. According to Joey, "professors that are flexible and recognize when students are having a tough time and want to help and don't need to know why" are instrumental to his ability to combat obstacles that threaten his continuation in college. Joey recalled another professor who was key in helping him through a rough time this past semester, concluding that the professor was

> …real flexible, understanding. Made me feel a lot more comfortable. Kind of makes me want to try for him. I mean, if he is going to cut me so much slack, I want to bring to the table something worth giving slack for...

Interfering symptoms related to Emily's psychological disorder often appear when she is alone and prevent her from attending class; she explains: "Sometimes I can't go to class because I'm just like so out of it." Given these periods of unpredictable incapacitation, flexible assignment deadlines and exam dates would be helpful, Emily notes. Emily recalls:

> Like a couple of semesters ago in 2005 or 2006, like I was going through like it was the end of the semester because I had, like, a lot of stress again and so I had to drop out of most of my classes and most of my classes they require that I had, you know, my projects done because I couldn't finish it, like, in the right time because the final was due on that day I couldn't do anything about it so I had to drop the classes. So if there is, like, another time [to turn in the project] like later on, that would be good.

Emily's comments illustrate a dilemma faced by students with psychological disorders: disclose your disability (and risk alienation) in order to receive accommodations and assistance or conceal the disability and struggle through without the necessary support systems, such as extended time for testing. When symptoms emerge in class, Emily reported there is little that can be done. She said that in such cases she would be sent to a hospital or halfway house for varying lengths of time depending on the severity of the symptoms.

In addition, participants' stories reveal a preference for hands-on learning over classes in which the lecture format dominated. Jason recalls: "You know sometimes the professor sometimes they sit up there and have us be quiet and take notes and that's....extremely boring. I can't stand it…" Morgan describes the impact of a lecture-intensive class on her learning experiences:

> I had one instructor this last semester that lectures straight out of the book and she didn't care if we came to class. So, that was… I didn't learn anything in that course accept for what I read. So it was a waste. It really was a waste.

Overall, Morgan reports that when professors merely lecture "she doesn't learn as much because her mind goes." Billy asserts that he learns best in classes with dialogue, stating that he is less apt to daydream when he is participating. Billy offered an illuminating comment which helps illustrate his dilemma: "…[I]n class, I would be constantly thinking about ADD especially when it came down to concentrating. Okay, I need to concentrate. All the while the teacher is talking I can't really concentrate because I'm thinking about concentrating." Participants' accounts indicate a desire to be a part of knowledge construction and meaning making, to be perceived as active makers of meaning rather than passive receivers of knowledge. So too, participants entered into fuller understanding of who they are, that is, their identity standards matched their internal self-meanings and views, in the process of talking out ideas in class and asking questions for clarification and/or reassurance. Participation in class aligns participants' virtual and actual selves, thus assisting in their identity development.

Furthermore, participants' learning was enhanced by professors who asked them questions and genuinely seemed interested in hearing their opinions and responses. Anna, who has Social Anxiety Disorder, which at times inhibits her in social arenas or environments, asserts that she will share her opinion in classes in which the professor is not merely lecturing but really asking for students' opinions. Asking students questions, according to participants, signified that the professor was admitting that s/he did not have all of the answers, and, as a result, that the students had something to contribute to the learning and teaching process. Susan's learning is facilitated by professors' writing on the board, slowing down, outlining, and asking students the questions, rather than doing all of the speaking. The professor is saying to students, in situations in which lecturing dominates, "I have all the answers. I am the one," Susan claims. Similarly, Billy notes: "I like going to class…. where you actually get to think and then talk about why you said what you said and this and that." According to Joey, hearing his opinions in class "gives me a kind of sounding board where I can sound my opinion and in turn, use the class discussing opinions and in turn get a reflection of how others see that opinion." Morgan remarks that she learns more when she asks questions while Joey reveals:

> I don't feel withheld to confront about something, because if I don't confront my misunderstandings or my possible misunderstandings, then I'm not going to see what I'm thinking is right, so I need to ask the questions in order for the expert to break it down in better terms, or maybe take a look at what he is saying.

Joey continues, "I have to engage. I learn, think better interacting with others. If I can tell you what I think you're telling me then I can process whether I'm getting it or not." Joey reports that he is "highly interactive in class;" learning for Joey is compared with "playing a game" and "getting in there." Joey observes his professors to see what level of engagement they feel is appropriate and adjusts his behavior accordingly. He recalled that he has been reprimanded in class for talking and goofing off causing him to remain quiet the rest of the class session. Jason provides insight into the impact of interactive classes on his learning: "It made me feel more involved like I was more motivated to do well. Like if I don't - if it's in the bag or if I if I don't really feel like I'm contributing – not only do I not feel like I'm even like it matters if I'm there or not, I don't even want to go [to class]." Billy reports having closer relationships with people in his classes than outside of class because they see more than one side of him; they see his serious, not just goofy, side.. However, Anna tells us "I talk to people in class and things like that, but I have not found a lasting friendship [in college]." Morgan participates in class more as a graduate student than as an undergraduate, saying that she forces herself to participate in class at least twice per class session and to see her professors outside of class to "make sure I absolutely knew what I was doing." Susan talked less in class after watching how her friend was treated, opting to "lay low."

Classroom Observations

Table 2 depicts three participants' observed behaviors and actions in the classroom in a single class session. Attempts made to observe the remaining two participants still taking classes were unsuccessful due to professor decline (reportedly due to a lack of seating) and a participant's withdrawal from the semester (to be discussed further in a subsequent section). The researcher arrived to each class early and sat in the back of the classroom to decrease attention and permit a clearer, less obstructed view of the participant in the class. Prior to the start of the class session, the researcher did not acknowledge or interact with the participant. During the participant observations, the researcher tracked participants' rate of participation (i.e., number of times the participant raised his/her hand to ask a question or offer an answer), chosen seating location (none of the class sessions observed featured assigned seating), arrival time to class, and nonverbal communication (i.e., level of eye contact with the professor). In addition, the researcher listened and noted any disability-related comments the participants made in the class session.

Table 2. Classroom Observations

Participant Name	Freq. of Hand Raising	Seating Location	Arrival Time to Class	Nonverbal Communication	Significant Comments in Class
Joey Class: 1st day of class, overview of syllabus/assignments)	5 times	Front row, to the far left, away from the door, back to the windows lining the wall.	Early, at least ten minutes before the class start time. Seated at desk with materials on the desktop.		During Joey's class, the professor asked students to introduce themselves by sharing their name, experience with disability, major, and course expectation, Joey disclosed that he has a "learning disability", not "ADHD." When discussing portrayals of disability in the media, Joey shared that the sitcom "Rescue Me" depicts a fireman with ADHD.
Billy (Class instruction: Lecture mode (didactic) powerpoint slides)	2 times	Came in the back door of the classroom. Sat toward the right hand side, back-	Late, by 14 minutes. Arrived with skateboard in hand. (Informed	Periodically rocked left leg side to side; jostled in his seat; stretched; placed left leg on the wheels of his skateboard;	

		middle.	me that he missed the previous class session).	looked at his cell phone; moved right hand/arm holding pen back and forth; bounced knee.	
Anna (Class instruction: Lecture mode (didactic) powerpoint slides	Raised hand when class was being polled; did not answer any of the four open-ended questions posed by professor or ask questions.	Sat toward the middle of the classroom, on the far left, closest to the door.	Arrived 10 minutes early to the class.	Overall posture - Looked down at her notes during the class; Raised her glance and smiled when professor shared examples from her own life that related to the lecture material.	

Overall, classroom observations produced illuminating yet limited findings. For example, Joey engaged in disability disclosure after the professor invited the class to share their "experience with disability" but opted to reveal that his disability is a learning disability rather than ADHD; this disclosure may suggest that Joey equates ADHD with a learning disability or feels a learning disability is more socially acceptable than ADHD. Later in the class session, Joey shared the name of a popular sitcom which depicts a fireman with ADHD. Joey and Billy both participated two or more times by raising their hands and offering a question or comment in the class session. This level of participation in a lecture-style format reflects their reported preferred learning and participatory style. While participating in the professors' hand-polling (see above), Anna did not ask questions or offer comments in the lecture-style class session.

Finally, participants' stories spoke of observing the professor for signs of "humanness" and personal recognition. Participants immediately recognized professors' tones, gestures, approachability, and ways of relating to the class as a whole and to them individually. How participants perceived these "signs" influenced the character of their classroom learning and interacting, decision to perform to their potential, or their decision to remain in the class. Morgan asserts that she will remain silent in class if the "instructors are very distant. And they are very intelligent people, sometimes too intelligent that gives them a distance between me and them and the students." Anna talked about the importance of professors being friendly, saying about one professor, "I like teachers that not necessarily are your friends, but just make you feel like they are not, you know, really strict and not mean but kind of in a sense have that aspect about them. Like there is this one teacher. She is actually my advisor and I'm scared of her. So I have not taken a class with her." Jason talked about professors "who can laugh at themselves" and "put themselves out there" as facilitating his learning and motivation. Billy's stories revealed the importance of professors who can "think outside the box."

Being positively recognized, as opposed to negatively recognized, in class by the professor surfaced as another prominent theme. Jason explains: "The teachers who don't notice me individually like the first couple of weeks, then I usually don't even to try to like yeah to feel engaged you know?" Being unacknowledged or not addressed makes it easier for Jason to slip away unnoticed, Jason notes. Instead, Jason seeks professors who engage him personally and appreciates professors who call on students. Anna recalled a math class in which the professor had taught her sister and thus recognized her, saying that it felt better and more comfortable knowing that the professor knew her. Morgan's story told of the importance of professors who are "not distant" and "who knows I'm there." Accordingly, participant interviews and anecdotes revealed being positively recognized, acknowledged, and directly folded into the teaching process as critical to their learning and motivation.

Participants also paid attention to professors' comments regarding psychological disorders in general and then applied these general views to how they anticipated the professor would perceive them specifically. Emily described one professor who referred to artists with mental illness as "being like strange… and delusional and really crazy. And living this wild and eccentric life, crashing cars, and having affairs and having a double life." Emily reacted to this characterization, by stating "And I'm not like that at all." Participants recalled professors' responses to them following disclosure of their disability. According to Susan, her professor/advisor shared that her son has the same psychological disorder diagnosis and discounted her experience by questioning the disorder's legitimacy, stating that it is not a real disorder. The professor's comments and denial of the reality of her experience and her disorder affected Susan deeply. Susan reported that she cried, was hurt, really upset, and on the verge of quitting school as a result.

Self-helping behaviors and Disability as excuse

Decisions to engage in self-helping behaviors involved some vulnerability for participants as seeking help often equated with disability disclosure or acknowledgement of problems to themselves and/or others. Impetus to seek help surfaced when psychological disorder symptoms or overwhelming anxiety sabotaged participants' ability to complete assignments, attend class, or process material. Jason reports that it is difficult asking for help as he does not want to use his disability as an excuse: "I don't want to use [my ADHD and bipolar disorder] as an excuse but I think it's probably something. It's partly responsible for me not not so much the bipolar but at least the ADHD. Probably has a problem with me trying to be able to focus as efficiently as I can on my work…" Emily reveals: "Like every time something happens, I just use [schizophrenia or the medication] as my excuse like I can't do this." Emily also reports that her mom tends to blame all of her behaviors on the disorder. Billy does not tell others about the ADHD out of fear that it will be perceived as an "excuse." Susan feels knowledge of the disability gives people an "excuse" to pigeon hole her and concludes that it is difficult for her to ask for help.

Summary

Phenomenological inquiry into the experiences of college students with psychological disorders yielded understanding of participants' perceived self-concepts, identity processes, and approaches to learning and its meaning to them. Dialogues with participants regarding their self-concepts revealed that they turn to others for crucial self-concept input. Participants described themselves using words others have ascribed to them. In addition, participants' stories revealed testing and observing others to estimate and predict their reactions to their psychological disorder, and thus themselves. Participants reported not liking their disorders but establishing an increased acceptance of it over time.

Those who learned of their mental disorder early in their lives conceived of it differently than those who learned of it later in their early adulthood, congruent with Goffman's (1963) theory of the moral career of a stigma. The period during which participants received or absorbed knowledge of the diagnoses can be summed up in the metaphors articulated by several participants who describe being "in a black hole" and "in a fog." Participants initially adopted the public definitions of the psychological disorder, including crazy, bad, and helter skelter man. Immediately following and shortly after the diagnosis, there was not much of a discrepancy between participants' virtual and actual identity. However, participants report changing self-concepts and self-definitions. Specifically, participants see themselves as survivors; as possessing something others do not have, that is, the knowledge of their experience and experts in their field of their disorder. They also see themselves as *not* being those who are off medication, in and out of jail but realize they could be and thus, feel a sense of luckiness; and lastly, they perceive themselves as challenged and different rather than weird, a freak or crazy as others see, or saw, them.

Participants' narratives illustrate that, for them, disability identity is an evolving and unstable one that is contextual and situational. At times, participants' psychological disorder is an identity to "overcome" that is "in conflict with positive identities," such as student or professional or fraternity member. The convergence of fluctuating and unpredictable symptoms and stigma describes the experience of being a student in college with a psychological disorder. Emily tells us:

> It's just like a matter of staying awake, you know? Or it's a matter of being able to concentrate or a matter of not talking to yourself. Or a matter of like getting work done. Or a matter of being able to socialize with someone enough to gain their trust enough and be able to work with them.

Participants' stories present a portrait of an inconsistent self, one whose psychological disorder is not present all of the time, and is sometimes forgotten. Participants report not being "disabled all the time" and difficulty discerning what should be attributed to the psychological disorder and what should be attributed to one's personality or core elements of one's self. Such ambiguity leads to feelings of anxiety, uncertainty, guilt, and mistrust in one's capabilities, as illustrated by Joey: "And you are given this label. How do I deal with it? Not as easy as being white or being depressed.'"

Participants focused on survival behaviors, or impression management, both consciously and unconsciously. They engaged in monitoring themselves and their surroundings, being attuned to cues that either would out them, set them apart as different from others, or yield an unwelcome reaction. For example, participants' spoke of mirroring peers' body language, styles, and stance and "self-policing" and "laying low."

Additionally, participants rate the prominence of their student identity differently and thus commit to the role of student in varying degrees. Those for whom the student identity is prominent were willing to take a risk to keep this role intact even if it involved jeopardizing this identity through telling others about the tainted identity, that of the psychological disorder. Those for whom the student identity was less prominent, took less risks and sought help less, perceiving the disorder as more of an excuse and school as a "nagging person." According to Craft and Lee (2002), Identity theory is used "because it links social relationships and internal motivation to behaviors" (p. 268). When perceived through this lens, study findings reveal participants held (1) conflicting motivations to get academic help from others and maintain pre-disclosure self-concepts, and (2) conflicting motivations to develop close social relationships and be true to all parts of self and to maintain pre-disclosure self-concepts, and thus credibility.

Classroom learning for participants was deemed best when teaching is engaging, personal, and dynamic. Participants' disengaged and symptoms unfurled when a more didactic instructional mode was delivered, where participants were expected to absorb information and not be active contributors to knowledge construction. Participants reported increased learning when asking questions and engaging in hands-on activities. Stigma, overall, did not dissuade participants from engaging and contributing in class. On the contrary, stigma often motivated participants to prove themselves and make their presence and expertise known. Yet, when participants witnessed professors chastising another student with either a suspected or known disorder they would tend to disengage and adopt a posture of silence, despite acknowledging that they learn better by engaging.

Chapter V which follows will examine how the findings outlined in this chapter fit within the current body of literature and explain how the descriptive findings and inquiry confirm, diverge, and extend existing studies. Additionally, the chapter explores the trustworthiness and verification of the data and data analysis, presents limitations, proposes areas for future study, and lastly, reflects upon implications for professional practice within higher education.

CHAPTER V: DISCUSSION AND CONCLUSIONS

This chapter will provide a broad overview of the methodology, highlight key aspects of chapters one through four, relate the study's findings to the research questions and literature, present gaps and recommendations for areas of future study, unveil the study's limitations, and discuss implications for professional practice. As it relates to literature, this chapter will not only demonstrate how the findings were confirmed and fit the literature, but will also explain how the study's findings diverge from and extend the current body of literature related to identity development, adults with psychological disorders and stigma, and higher education classroom learning and involvement.

This research in the area of identity construction and learning processes among students with psychological disorders in higher education is important for a number of reasons. First, there is a growing numbers and increasing severity of symptoms of students with psychological disorders entering higher education. Second, recent studies indicate an existing research gap illuminated by a need for more coordinated campus efforts to benefit college students with psychological disorders "who are struggling to legitimatize their place on college campuses" (Megivern, Pellerito, & Mowbray, 2003, p. 229). Third, literature suggests college student university reenrollment decisions following premature withdrawal are linked to students' perceptions of their experiences at the university (Woosley, Slabaugh, Sadler, & Mason, 2005). As many college students with psychological disorders comprise the ranks of premature college leave-takers, discovering the factors that contribute to the perception of a welcoming and positive academic environment for these students takes on heightened importance. Fourth, Chickering and Reisser (1993) and Erikson (1980) contend students' identity formation is a central task during the college years. A large body of research on the effect of stigma on persons with psychological disorders (Goffman, 1963; Link & Phelan, 2001; Link, Struening, Rahav, Phelan, & Nuttrock, 1997) suggests identity processes are influenced by the perception of negative stereotypes and stigma surrounding mental illness.

Increased understanding of identity processes and self-concepts of college students with psychological disorders, therefore, is critical to any discussion of ways to support this population's identity development, learning, and perceived intellectual growth. Thus, this study's findings will yield particular importance regarding the reality of the lived experience of these students in its ability to further knowledge relating to self-concepts, identity processes, and classroom learning and interaction dynamics. Such findings seek to inform the nature of identity development, professor feedback, and classroom teaching and learning while simultaneously increasing sensitivity and awareness of students with psychological disabilities. Specifically, this study sought answers to the following research questions:

1. How do participants' reports of identity processes and self-concept impact their perception of learning experiences?

    a) How do these students talk about their interaction with classmates and professors (and others in authority)?
    b) What kinds of professor and student affairs professional feedback and interaction do these students report helped/hindered their developing self-directed/authored approaches to learning?
    c) How does the presence of stigma impact participants' level and character of classroom learning and participation?

An investigation of the topic area commenced with a thorough review of the literature. The literature review aided the development of the study's research questions and initial interview protocol. The interview protocol draft was piloted to one student whose characteristics reflected the study's participant sample criterion. The pilot interview and additional literature review prompted changes to the interview protocol; additional questions were added including questions designed to build rapport with participants and questions aimed at delving deeper into participants' subjective experiences and perceptions. Furthermore, interview protocol changes addressed assumptions inherent in some of the initial interview questions. Lee and Craft's (2002) interview guide was adapted and incorporated into the final protocol, following permission from one of the guide's authors. Seven of eight participants recruited for the study remained for the study's duration; the eighth participant was not able to be reached following the first interview and thus was subsequently removed from the study. Qualitative data derived from a series of one on one interviews, classroom observation, document review, written assessment, and participants' personal writings.

The recorded interviews for this phenomenological study were transcribed and analyzed for themes. Van Manen (1997) posits theme analysis in phenomenologicalguided studies is "the process of recovering the theme or themes that are embodied or dramatized in the evolving meanings and imagery of the work" (p. 78). For example, the following questions were asked of the data: How do the participants make sense, forge meaning, of their experiences as a college student living with a psychological disorder? How does this experience impact their forming identities? Their learning experiences? Their relationships with others? What notion provides insight or captures the significance of the particular situation for the participants (van Manen, 1997).

Phenomenological inquiry involves "unearth[ing] something 'telling,' something 'meaningful,' something 'thematic' in the various experiential accounts… [It involves] mining meaning from them" (van Manen, 1997). Discerning the essence of participants' various anecdotes and shared experiences embodies van Manen's notion of seeking meaning (1997, p. 86). A theme, according to van Manen, "touches the core of the notion we are trying to understand" (p. 88), he contends a:

> …phenomenological theme is much less a singular statement (concept or category such as 'decision,' 'vow' or 'commitment') than a fuller description of the structure of a lived experience. As such, a so-called 'thematic phrase' does not do justice to the fullness of the life of a phenomenon. (p. 92)

I adopted van Manen's selective, highlighting approach to uncovering themes in the transcribed interview data, and asked "*What statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?*" (emphasis in original, p. 93). Toward this end, I culled the data for illuminative anecdotes along with key and recurring phrases, analogies, and descriptions. Anecdotes or short narratives, van Manen (1997) concludes, "can be understood as a methodological device in human science to make comprehensible some notion that easily eludes us" (p. 116).

This study is grounded in previous research, and draws from literature regarding stigma (Goffman, 1963), stigma and mental illness (Link & Phelan, 2001; Link, Struening, Rahav, Phelan, & Nuttrock, 1997), identity theory (McCall, 2003; Stryker & Burke, 2000; Stryker & Serpe, 1994), college student identity development (Chickering, 1969; Chickering & Reisser, 1993; Torres, Howard-Hamilton, & Cooper, 2003), faculty impact on college student participation (Auster & MacRone, 1994; Fassinger, 1995; Tinto, 1997), and disability identity (Olney & Brockelman, 2003; Olney & Kim, 2001; Shakespeare, 1996).

The following section offers two phenomenological approaches for making meaning of the findings presented in the preceding chapter. The first, entitled, an existential approach, presents a distillation of the core experiential aspects of being a college student living with a psychological disorder. The second subsection presents a comparison between literature findings and the study's themes, analyzing the study's findings' fit within the existing body of literature. In other words, the second, much lengthier, section offers a discussion regarding the ways in which the study's findings' confirm, diverge, and add to the current body of literature.

An Existential Approach

An existential approach to examining the lifeworld, or the world of lived experience, of the student with a psychological disorder in college will first be presented. The purpose of engaging in an existential approach is to isolate the essence of the experience of being a student with a psychological disorder in college. In other words, an examination of this study's data through an existential lens distills the core of the participants' experience. Such an approach assumes there are different experiential qualities from the lifeworld, between the college student with a psychological disorder and without a psychological disorder (van Manen, 1997). Four lifeworld categories, or essentials, include: temporality (lived time), spatiality (lived space), corporeality (lived body), and lived human relation (lived relationship to others; communality) (van Manen, p. 102). Reflecting on the experience of being a student with a psychological disorder in college, these four "existentials allow us to perceive an immediate richness of meaning," according to van Manen (p. 105). Such an analysis prompts the following question: In what ways are the themes of being a student with a psychological disorder different from being a student without a psychological disorder? Van Manen contends "[i]n determining the universal or essential quality of a theme our concern is to discover aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is" (p. 105).

The first lifeworld category, temporality, or lived time, is conceived as subjective time (van Manen, 1997). For example, how do/have students with psychological disorders experience[d] time differently from students without psychological disorders in college? Van Manen claims "[t]he temporal dimensions of past, present, and future constitute the horizons of a person's temporal landscape" (p. 104). Discovery of a psychological disorder(s) occurred in participants' past, shaping present and future hopes and possibilities. The time of diagnosis, an event marking participants' pasts, embodies one temporal theme which emerged from participants' experiential accounts. The construct of uncertainty encapsulated the time of diagnosis for participants. Specifically, participants grappled with the uncertainty of the diagnosis prescribed (i.e., Is this diagnos[e]s accurate? What does this diagnosis or label mean?), uncertainty of their identity perceived through the lens of stigma and entrenched societal definitions of mental illness (i.e., Do I fit the stereotypes? Are the stereotypes accurate?), and finally, uncertainty for the unfolding present and future (i.e., How does this label, this diagnosis, impact my pre-diagnosis dreams and aspirations for the future? What does my future hold for me now?). Participants characterized the period during which they received psychological disorder diagnoses as being in a "black hole" and "in a fog." In essence, participants reported the time, and thus the events and experiences that filled the time surrounding the initial diagnosis, as hazy, unclear, and confusing. Such findings carry increased significance for those students who are labeled with psychological disorders for the first time approaching and in college, as suggested by this study's findings. These students, then, are not only navigating the newness of the college landscape but are faced with the task of "re-identifying" themselves (Goffman, 1963).

The second lifeworld category, spatiality, or lived space prompts the following question of the data: How do students with psychological disorders experience space and place differently from students without psychological disorders? Dialogues with participants reveal "fear of loss" as the theme capturing how participants experienced place while "vigilant mindfulness" illuminated participants' experience of space. "Fear of loss" characterizes participants' experience of place. Potential loss of one's place, namely one's employment, social position or status, or current student reputation and standing following others' discovery of his/her disability describes participants experience of place; place is thus construed as having a tenuous quality. Therefore, participants negotiate their world making distinctions between those who can be trusted and those who cannot be trusted with news of their psychological disorder. The realization that participants' current place or position could somehow be jeopardized prompts participants to adopt a posture of caution in certain settings.

The experience of space was defined by the adoption of survival behaviors, or impression management, including vigilant self- and environment- monitoring, mirroring peers' body language, styles and stance, and "self-policing" and "laying low." A desire to avoid "sticking out like a sore thumb" or to appear credible and competent among peers and professors motivated such behaviors. Emily captures participants' perceptions and experiences of lived space when she describes an anecdote about Buddhism and vigilant mindfulness in one's space. Emily recounts that she is closely aware of herself when engaged in all activities and is greeted with "obsessing" over things she observes and laments a level of freedom lost in the process. Morgan recounts that she is in tune with what her body does when sharing space with others. Participants describe being alive to their surroundings and attuned to what one is doing in one's space; a lack of freedom or spontaneity is voiced as one regretful implication for such mindfulness. Thus, "living in one's space" is characterized by participants as being on patrol for possible emergence of symptoms or behaviors not deemed appropriate for a particular environment or conducive for learning or a task at hand.

Corporeality, or lived body, embodies the third lifeworld category. Van Manen claims "[i]n our physical or bodily presence we both reveal something about ourselves and we always conceal something at the same time – not necessarily consciously or deliberately, but rather in spite of ourselves" (p. 103). The corporeality category asks the following questions of the data: What is it like to be the body? How do symptoms, medication side effects, and stigma manifest themselves within the body of a student with a psychological disorder? Themes related to the lived body, or corporeality, category include "psychotropic medication" and "disorder manifestations, or symptoms." As a theme, psychotropic medication personified an unwelcome yet necessary organ, simultaneously instrumental yet troublesome, for the majority of participants, with distinct qualities evoking powerful sentiments and, at times, dramatic side effects. The intersection of medication with the corporeal forms the following sub-themes: bodily-change producer and creativity sabotager. Participants reported several medication side effects responsible for producing visible and physical changes to their bodies. For example, participants experienced weight gains and losses, reduced energy, speech impacts (monotone voice and slurring of words), and less perceived ability to "think outside of the box." Such physical changes sparked comments, scrutiny, and mistaken states from others. In essence, participants' changed bodies invited comments and comparisons from others, thereby transforming a personal experience into an unwanted public experience for participants. For example, participants' body changes prompted others to mistake medication-induced bloating for pregnancy and medication-induced appetite suppression for anorexia. Thus participants not only battled their own internal struggles but external critiques and false assumptions as well. In addition, participants reported some medication inconsistency, namely, withdrawal, erratic use, or medication changes, necessitating time for bodily adjustment and stabilization along with medication misuse (i.e., alcohol consumption in conjunction with psychotropic medication).

The second theme tied to the lived body category constitutes "disorder manifestations" or symptoms. Here, participants revealed a variety of symptoms (i.e., talking to self, talking fast, anxious state around groups), of their psychological disorder(s) which emerge unpredictably and for which they were increasingly mindful. Regarding the relationship between the disorder and one's body, Morgan explains: "I'm very in tune with what my body does now. Before I wasn't. So, I'm very in tune. I know what I'm looking for. So, I'm very afraid of it but, it's.... I can't stop it." Underlying the presence of the symptoms is the construct of control and participants' realization that there are disorder-related manifestations to which they can control and those which exist outside of their control. Participants' stories also suggest the experience of living with a psychological disorder has contributed to attainment of an increasing intimacy and knowledge of their physical selves with all its mysteries and surprises.

Sociality, or lived relationship to others and communality, comprises the fourth and final lifeworld category. Sociality or relationality, embodies " the lived relation we maintain with others in the interpersonal space that we share with them" (van Manen, 1997, p. 104). The sociality category concerns itself with the following questions: How do students with psychological disorders relate to other students and professors within the domain and related domain of the college experience? Themes related to the relationality category include withdrawal, testing, lack of close friendships in college, and connection to others with a shared marginalized identity. In varying degrees, participants embraced withdrawal as a way to manage the uncertainty and stigma associated with the psychological disorder in college; withdrawal appears as a persistent tactic yet is most pronounced in the days and weeks following the initial diagnosis/diagnoses. In addition, participants employed testing as a means of determining who should be a valued, trusted confidante and to anticipate others' perceptions of psychological disorders in general to surmise their treatment and impression of them personally. Namely, evaluating and mining others' expressions, words, and body language were employed to determine the individuals participant can trust with his or her secret or for help. Participants' stories suggest they are, overall, cautious when entering into relationships. So too, participants report the lack of close friendships in college. Finally, findings indicate participants appreciated connections to others with the same or other psychological disorder(s) and those with other marginalized identities.

Adopting an existential approach to discovering the core of the lived experience of a college student with a psychological disorder provides a deeper closeness to the rich subjective data and its meaning. In addition, such an approach permits a glimpse into what makes participants' experiences unique and different from students without psychological disorders. Through a journey into how participants experience the realms of time, place and space, relations with others, and body, prominent themes emerge and distill the essence of participants' experience.

Fit Within Literature

This section examines the study's findings in relation to current literature. The six conclusions, outlined and described below were developed through an iterative process as I moved back and forth between the data and literature. The conclusions situate the findings discussed in Chapter IV within existing literature, illuminating ways in which the findings confirm, conflict, and extend existing theories and studies.

Conclusion One: Recognition of stigma and medical definition of mental illness prompts the adoption of impression management behaviors among students with psychological disorders

The belief that others will see participants' virtual identity, constructed from stereotypes and stigma attached to psychological disorders, rather than participants' actual identity, prompts the adoption of secrecy, withdrawal, and passing behaviors among participants. This study's findings confirm Chickering and Reisser's (1993) conclusion: "One problem for the evolving self is that those in the immediate neighborhood may not be affirming, especially if we are remodeling in a way that does not look right to critical egos nearby. If mutuality does not exist, there may be reciprocal negation" (p. 198). In other words, the possibility of others' rejection, discrimination, and devaluation of students with psychological disorders, encourages participants' conscious and unconscious exercise of information management strategies. This engagement in impression management behaviors reflects Burke's self-verification theory which holds that individuals act to bring themselves into alignment with other's (peers, professors) views of them or the identity standards, in this case the standard of a student in higher education (Burke & Stets, 1999). This study's findings indicate participants are motivated to meet others' expectations and standards; impression management techniques offer one way or attempt to do so.

This study's participants presented anecdotes and examples indicating use of information and identity management, including secrecy, passing, and covering, to manage signs of their disability and identity within the college environment. Evidence of participants' passing and covering behaviors include: (1) becoming less immediately interactive in class following negative feedback from others and mindfulness of environmental norms for behavior, (2) self-policing, or telling self to refrain from engaging in certain behaviors perceived as falling outside he norm, (3) mimicking peers' behaviors, including body language, style, and stance in social venues (4) laying low, or talking less in class after observing the harsh treatment (i.e., admonished for excessive talking) directed at a fellow student with a similar marginalized and known identity, (5) playing along, or pretending to remember parts of unrecalled (due to medication side effects, etc.) conversations and events when talking with others outside of the tight family circle, (6) image crafting, or purposely adopting a ritual at the beginning of the semester to "build the self up" and avoid being perceived as someone with nothing to say, (7) attributing a decision to abstain from drinking alcohol to a non-disability related reason to peers, and (8) avoiding accessing academic accommodations to continue passing for a "perfectionist" and non-stigmatized student (i.e. student without a psychological disorder) among peers and professors.

There is a rich body of literature linking identity work among stigmatized individuals to "facework" or impression management (Goffman, 1963; Gregg & Ferri, 1998; Lee & Craft, 2002; Link, Struening, Rahav, Phelan, & Nuttrock, 1997; Tracy as cited in McCall, 2003; Stanley, 2004; Shakepeare, 1996; Steele, Spencer, & Aronson, 2002). However, there is minimal research into how college students with psychological disorders process their identity; this study confirms and adds to this small body of literature. Commonalities surface between this study and Megivern, Pellerito, and Mowbray's (2003) work. Specifically, participants in both studies turned to identity management practices such as isolation during times when stigma and discrimination were perceived within their college environments.

Conclusion Two: Repeated crises resolution associated with disability contributes to students' identity development

When perceived through the lens of the Vectors of Student Development (Chickering & Reisser, 1993) which conceives college student identity development "primarily as resolving crises" (p. 181), study findings suggest that identity development for participants involves resolution of crises (Erikson, 1980) unique to students with a stigmatized identity, namely a psychological disorder. A crisis, according to Marcia (as cited in Chickering & Reisser) constitutes a challenge or a turning point featuring the opportunity to regress or progress in one's development; a crisis thus conceptualized must contain choices, or competing alternatives. Marcia (as cited in Chickering & Reisser) concludes the way in which one resolves the crisis determines the direction of one's development.

Two crises greeting students with psychological disorders emerged in the data. First, participants face academic obstacles created by psychological disorder symptoms, stigma, and side effects of psychotropic medication. Participants experience the academic obstacle as a crisis, or challenge, and concomitant choice: to tell or not to tell professors or others about their disorder and need for assistance. While all college students face the decision to seek or not seek academic help, this decision is elevated, or more difficult, for college students with psychological disorders. For example, students with psychological disorders experience symptoms which impede their progress; in order for students to receive help they must make the decision to disclose a hidden vulnerability, their psychological disorder, and risk rejection, ridicule, discrimination, and loss of pre-disclosure identity validation. Dichotomies of this nature face those with psychological disorders. The higher education structure forces students to admit to their disorder or disability in order to receive assistance; implications for this structure will be discussed in more depth in a subsequent section.

Relationships embody a second crisis faced by participants. Participants' reports of their relationship decisions illuminated that one's psychological disorder personified the "elephant in the room" at times. There is support in literature confirming the challenge posed by relationships among those with a perceived "tainted identity." Goffman (1963) concludes relationships, even those that are fleeting, can pose a danger to individuals with a stigmatized identity as they can touch upon "secret failings" (p. 87). Participants deliberated about whether or not to enter into a relationship citing the perceived risk should they do so (i.e., perceived risk of job loss, pre-disclosure identity loss, or uncertainty about how to distinguish parts of one's personality from characteristics of one's disorder). In addition, participants deliberated about if, when, and how to tell a significant other, an acquaintance, professor, peer, or group partner about their psychological disorder. Participants responded to these recurring academic and relational crises differently; motivations for telling or revealing one's psychological disorders or entering into relationships are presented in Conclusion Three below.

Conclusion Three: Student-role prominence impacts disability disclosure and help-seeking behavior

Students with psychological disorders face recurring, competing motivations within higher education. When perceived through the lens of identity development theory, this study's findings reveal participants held (1) conflicting motivations to seek academic help from professors/campus entities and maintain pre-disclosure self-concepts, and (2) conflicting motivations to develop social relationships and be true to all parts of self and to maintain pre-disclosure self-concepts, and thus credibility.

This study found the prominence and salience allotted the "student" role correlated with the degree of risk-taking behavior. Those for whom the student identity is prominent were motivated to take a risk to obtain help and thus keep this role intact even if it involved jeopardizing this very identity through telling others about a tainted identity, that of a psychological disorder. Those for whom the student identity was less prominent, took less risks and sought help less, perceiving the disorder as an "excuse" and school as a "nagging person." Role-identity prominence appears in Stryker and Serpe's (1994) work which claims the self is comprised of multiple identities and the salience or prominence attached to each identity varies; they suggest roles are not equally important or salient but rather are arranged in a hierarchy. According to Stryker and Serpe, "the location of an identity in this hierarchy is a consequence of the support provided by the person as well as by others for the identity, the degree of commitment to and investment in the identity, and the intrinsic and extrinsic gratification associated with the identity" (p. 17). Further, McCall and Simmons (as cited in Stryker & Serpe) "assume that the more positive the person's affective response to an identity, the higher that identity" in the hierarchy (p. 17). Thus, when viewed through this literature, participants for whom "student" ranked as a prominent role exert strong commitment to this role and are motivated to take the necessary steps to maintain this identity even when faced with potential risks and costs.

Motivations for telling or revealing one's "tainted identity" in social relationships are identified in Lee and Craft's (2002) research findings. The authors conclude individuals tell others because "1) others are predisposed to accept them, 2) telling is demanded by the relationship's character, [and] 3) the secret is getting in the way of the valued relationship" (p. 282). Participants' motivations for telling others about their psychological disorder, involved telling to be more honest and enter into a closer relationship, findings confirming the above-cited literature. Participants' incentives rested in the possibility of increased understanding, self-verification, and an ability to be more fully honest with the interaction partner. In addition, this study's findings add three additional reasons individuals with psychological disorders tell others about their psychological disorder, including telling to: avoid being ascribed a more tainted or tarnished label (i.e., lazy, irresponsible), reciprocate sharing marginalized identity information out of empathy and acknowledgement of a shared identity, and be perceived as the "expert" and educate others about the disorder (here the "teller" is in control of how the information and explanation of the disorder is delivered and has the power; power-shift is thus enacted).

Conclusion Four: Renaming the disorders contributes to more positive self-concepts

Study findings suggest an evolution occurred in the way participants viewed and understood their psychological disorder(s) from the time of their initial diagnosis/diagnoses to their present point in college. By renaming their disorder, participants thus reconceived themselves in a more positive light resulting in the establishment of more positive self-concepts; participants described themselves as survivors, as challenged, as different, rather than crazy, bad, and hopeless (i.e., black hole) grounded in the public's definitions of psychological disorders. Table 3 illustrates this evolution by contrasting participants' self-thoughts immediately following their psychological disorder diagnosis/diagnoses with participants' current conceptions of possessing a psychological disorder.

Table 3. Participants' Initial and Current Conceptions of Psychological Disorders & Self-Meanings in Relation to One's Disorder

Self-Thoughts Immediately Following the Psychological Disorder(s) Diagnos(e)s	**Current Conceptions of Possessing a Psychological Disorder** (Question posed to participants: When a person has a psychological disorder, s/he has to accept being…?)
• "Crazy people are bad" • "Someone in the corner twitching and you know holding a knife" • "Someone with schizophrenia is like bad and they are unable to just cope in society" • "End of the world"	Challenged (Emily)
• "It was like jumping, like walking at the end of the earth and jumping off. It just felt that scary and that foreign to me." • "Used to feel I was bad and it's all my fault" • "ashamed, embarrasses, defective"	Different (Susan)
• "I actually felt like not relieved but just in a sense felt a little bit better knowing that there was some reason for what I was feeling, how I was acting and things, so it felt like okay I could call it something; I'm not just weird." • Initially, she said she used disability as an excuse not to engage.	Themselves. Who they are. (Anna)
• Told he was "Mentally ill" • Imagined he was "some kind of helter skelter guy with paint and blood on the wall"	Challenged (referring to ADHD) and Different from other people (referring to Bipolar) (Jason)
• "A black hole. There was no way out."	A person with a disability, but not negatively (Morgan)
• "Kinda cool" but admits his dad probably had different thoughts.	Weird ("Because, I don't know, like most of the time when people like describe me, like 'you're weird'" (Billy)
• "I think my doctor and my mom kept me out of the loop not completely but back to where I didn't make [ADHD] an excuse." • "But yeah I used to walk home from school crying because I did not feel like I was doing good in school."	Always on (Joey)

Participants' early adoption of the public's definition of mental illness is supported by literature. Link, Struening, Neese-Tood, Asmussen, and Phelan (2001), Goffman (1963), and Shakespeare (1996), conclude people develop conceptions of mental illness early in life, they are socialized to conceive mental illness as equating with negative attributes, and these conceptions take on personal relevance when one learns he/she possesses a psychological disorder. Examination into participants' early self-views of having a psychological disorder(s) (see Table 3) and their reported concealment behaviors suggests that initially participants subscribed to a medical model of disability which relies on "the traditional narratives of biomedical intervention or rehabilitation, of misery, decline and death" (Shakespeare, p. 95). Shakepeare contends such a model or a definition focuses on human difference, impairments, and comparison. Yet, participants appeared to embrace more positive and empowering self-conceptions when describing their present views of living with a psychological disorder. Shakespeare attributes such a shift to

> ...replacing one analytical framework (the 'medical model') with another (the 'social model') to lead to a more positive identity, often described as 'coming out'. This 'coming out' is the process of positive self-identification, rejecting the categorization of subjection, and affirming subjectivity and collective power. It is about developing new definitions...(p. 101)

Yet, the redefinition process emerged from participant interviews as constituting a continuum with the medical model on the left and the social-cultural model and definitions on the far right; participants moved across the continuum toward the far right yet inched back to the far left at times. For example, participants reclaimed initial, former conceptions of their disorders in certain environments and situations, suggesting the redefinition process is contextual, situational, and dynamic. Contrasting quotes in

Table Two illuminate the tension participants face between how to define and make sense of how their disorder fits within their self-concepts. Morgan reveals the active movement from one definition to the other: "I don't consider myself having a mental illness. Although I am coming to terms with having a disability and me going through the [disability services center] that's really hitting me in the face." Morgan recently read an article that claimed the issue is not about disability, it's about abilities. Morgan recalled how she saw a man with amyotrophic lateral sclerosis (ALS), often referred to as "Lou Gehrig's disease," compete in a triathlon, a feat she found "amazing…as it didn't appear that he could do it but he did." Thus, redefinition of self is a recurring process. Various situations or symptoms challenged participants' previous ways of looking at the disorder's relationship to their identities and self.

Table 4. Participants' Redefinition of Disability: Medical Model versus Social Construction Model

Medical Model/Definitions	**Social Construction Model/Definitions**
"You just try to associate like this is not me. This is just my illness. But when it comes to the hospital it's like well are you [the illness]? You're the illness. It's not like I'm Emily and I have schizophrenia but it's like I'm Emily and I am a schizophrenic. It takes an identity on to you." (Emily)	Emily describes herself as not fitting the stereotypes but that she is in touch with reality and not like a lot of those with the disorder who "are homeless and they end up like wandering the streets."
"And you are given this label. How do I deal with it? It's not as easy as 'being white' or 'being depressed.'" (Joey)	As a result of a class about psychology and physiology of the brain, Joey offered a different way of conceiving the disorder: " I don't think of [the disorder] as a disability I see that [the disorder] has happened to a large population and that maybe it had some benefits back then… Don't see it as a problem."

Conclusion Five: Sympathetic others in higher education play a role in students' abandonment of passing behaviors and contribute to relationship and trust building

Participants assessed professors' tones, gestures, degree of approachability, and way of relating to the class as a whole and to them individually. How participants perceived these "signs" or traits influenced the character of their classroom learning and interacting, decision to perform to their potential, overall feeling of ease, and their decision to remain in the class. When viewed through Goffman's (1963) lens, some professors embodied "sympathetic others" (those who share a stigma or possess special knowledge of a stigma), can express themselves so that they speak known terms allowing masks to drop and decreased thinking about parts of stigma showing (p. 20) or "the wise, namely, persons who are normal but whose special situation has made them intimately privy to the secret life of the stigmatized individual and sympathetic with it" (p. 28). These "sympathetic others" disclosed their own experiences of disability to participants, offered a blend of flexibility mixed with quirkiness and openness, and elements of friendship. Thus, participants sought to establish trust with professors enough to prove their worth and legitimacy and obtain needed validation and/or help. Once participants established trust with a professor, or "sympathetic other," he/she was then more inclined to seek help from the professor, if the participant acknowledged or recognized a need for help. Professors' proximity, position, and power in relation to participants shaped their *recurring* identity management behaviors and decision-making experiences to a different degree than campus services, such as counseling and disability services, which, while deemed important, were used more *intermittently* and in times of crises.

Participants' reports reveal an eagerness to participate more in classes where professors seemed genuinely interested in their opinions and responses, appeared not too distant, and knew and called participants by name. Such findings conflict with those from a study examining the relationship between professor traits and student participation in class. Specifically, the study's survey instrument examined college students' perceptions of their class participation, professors, themselves, and their class, including their classmates and classroom emotional climate. Fassinger's (1995) findings suggest professor traits, including whether professors appear supportive and approachability, did not explain student classroom interaction. Rather student (confidence, interest in subject, and gender) and class (class size, student-to-student interaction, participation positively affects one's grade, and emotional climate) traits better predicted classroom interaction; these two variables together explained 37 percent of the variance in class participation (Fassinger). Fassinger posits, however, that professors do have an impact on students though their course design, a finding to be explored in the following conclusion. One can speculate that such a disparity between this study's findings and that discovered by Fassinger may suggest that students with psychological disorders by virtue of the vulnerability stemming from a disability are more mindful and sensitive to professors' outward traits and tones. It thus follows that professors' perceived approachability factors into participants' classroom interaction decision-making more than students without such vulnerability.

Conclusion Six: Stigma did not dissuade participants from engaging and contributing in class as hypothesized. On the contrary, stigma and psychological disorder characteristics often motivated participants to prove themselves and make their presence known. However, participants turned to disengagement and the adoption of a posture of silence after observing discriminatory statements from professors or treatment toward themselves or classmates with known or suspected psychological disorders, despite acknowledging that their learning is fostered by engaging.

This study found courses that feature hands-on learning and student-directed questions, courses in which professors encouraged and cultivated class participation, contributed to participants' perceived level of intellectual growth and learning. Literature establishes a connection between college students' level of classroom involvement and perceived intellectual growth. For example, Volkwein, King, and Terenzini's (1986) research indicates that a measure of classroom involvement had a statistically significant association with a scale of intellectual skill development (learning to apply fundamental principles, critically evaluating ideas, being creative, thinking analytically, and gaining factual knowledge), or, specifically, students' perceptions of their own cognitive growth. Research by Gaff, Wilson, and colleagues (as cited in Pascarella & Terenzini, 1991) shows that "regardless of academic or vocational interests, students who were most involved in the pursuit of intellectual activities reported the most progress in learning abstractions, comprehending ideas, and applying principles" (p. 147).

Less interactive courses, such as those in which the lecture-format dominated, according to participants, promoted passive learning and increased attention to disability symptoms, stigma, or disability-focused thought obsession, according to participants.

Furthermore, courses in which the professor directed questions to the students created a power-shift in the minds of participants. Student-directed questions posed by professors prompted participants to perceive their ideas as being valued and important; they had something to contribute to the teaching and learning process. Regarding the relationship between stigma and power, Link and Phelan (2001) conclude the "amount of stigma that people experience will be profoundly shaped by the relative power of the stigmatized and the stigmatizer" (p. 378). To this end, professors asking students to impart knowledge in a genuine way, increased participants' willingness to participate in class. The lecture format emphasizes the power differential between student and professor while student-directed questions established more parity between student and professor. Evidence of the power element in the classroom emerge in Auster and MacRone's (1994) work on college student participation: "[T]he normative expectations about the power imbalance between teachers and students may cause students to believe that their role is to be the passive recipient of the teacher's knowledge: the lecture format only reinforces this expected role" (p. 290). The authors conclude:

> [T]he teacher who engages in role distance from the traditional definition of powerful and all-knowing scholar and instead assures students of the importance of their questions and ideas creates a social setting that would seem to encourage participation….a social structure that emphasizes and enhances the student's role in creating knowledge. (p. 290-291)

Auster and MacRone's research findings suggest students participated most in classes in which professors often call on student volunteers, call students by name, exhibit signs of approval/interest, give enough time to answer, ask analytic questions, and encourage elaboration. The authors conclude professors' repeated engagement in these practices will help students see their expected role in this "negotiated social setting" (p. 297).

While Fassinger's (1995) research into student classroom participation found class and student traits are more of a factor in influencing participation, she notes that her findings support the role of how a professor designs the course as relating to participation. For example, Fassinger concludes "when professors create class activities that foster positive emotional climates, they are likely to help cultivate interaction" (p. 93). One solution Fassinger proposes is for professors to involve students in the developing their own norms for classroom participation and interaction:

> Professors could ask students to create lists of behaviors that build their confidence (for example, eye contact, nods of approval) and list of behavior that diminish it. Students could discuss their ideas in small groups, hear of others' insecurities, and begin to develop empathy for their classmates. (p. 93)

This role of professors in "cultivating a capacity to respond" (Baxter Magolda, 2002) emerged in this study's findings. Participants reported experiencing something akin to empowerment when professors ask their students questions and solicit their opinions and ideas. In effect, student-directed questions equalized the professor-student relationship, according to the participants, and fostered an environment where all members of the class contribute to knowledge construction.

Student-directed questions and courses in which student participation was promoted, not only increased participants' perceived level of intellectual growth but also provided a way in which participants worked to resolve identity crises (Erickson, 1980) and realign their virtual and actual selves. For example, the theme of uncertainty wove through participants' stories. Being able to "use the class as a sounding board," adopting the phrase of one participant, for one's ideas, allowed participants to clarify themselves, their ideas, and their opinions often clouded by uncertainty and receive feedback. Within such an environment, participants reported seeing themselves differently than when outside the class. Participants reported that others took them more seriously, listened to them, saw them as perfectionists and hard working, as smart, and as creative thinkers. Overall, participants reported learning more not only about the course material but also about themselves by asking questions and participating in classes; a finding confirming research by Baxter Magolda. Baxter Magolda's (2002) research contends that in active learning the self is the central learning vehicle. Baxter Magolda unveils a constructivist model of active learning featuring three key facets: (1) Knowledge is complex and socially constructed, (2) self is central to knowledge construction, and (3) expertise is shared in the mutual construction of knowledge among peers. These instructional principles or guides facilitate a community of learners where power and control are evenly distributed and students play an active role in deriving meaning from complex material presented. Furthermore, Baxter Magolda (2003), having written extensively on the role of identity and learning, argues that "participation in the 'dialogue toward truth' hinges on assuming that one has something to contribute" (p. 232). Bean and Metzner's (as cited in Metz, 2004) "personal sense of usefulness" echoes Baxter Magolda's sentiment. Further, Baxter Magolda (2003) comments that "cultivating a 'capacity to respond' requires self-reflection on one's identity and relations with others" (p. 232).

In summary, professors and course designs promoting student participation provided avenues for participants to see themselves as experts, as knowledgeable, as an equal in shaping knowledge, as important, and as worth listening to. Participants found such highly interactive, student-centered courses as meaningful and not a waste of time. The class provided an opportunity for participants to be around people who do not only see them one way (i.e. goofy, on medication, etc.) but as smart and creative. The class represented a sounding board for the exploration and testing of ideas for participants. Professors "tossing questions" to students validated participants' identity and worth – as individuals within an environment in which knowledge developed from a process of shared meaning making.

Yet, participants turned to disengagement and the adoption of a posture of silence after observing discriminatory statements from professors or discriminatory treatment toward themselves or classmates with known or suspected psychological disorders, despite acknowledging that their learning is fostered by engaging. Such reported behaviors can be traced to literature findings which hold (1) when a negative stereotype attached to a group becomes personally relevant, the individual then knows he/she can be judged or regarded in terms of this negative stereotype eliciting a certain degree of vulnerability (Steele, Spencer, & Aronson, 2002; & Goffman, 1963), and (2) individuals tend to disagree with other's views of them when these views include negative identities which exist outside of their own self-views (McCall, 2003). Participants' periods of isolation and lack of classroom involvement were attributed to a classmate exhibiting visible signs of their shared negative social identity for which harsh treatment was imparted by the professor or peers and the time immediately following the period of initial diagnosis of the psychological disorder when there was less perceived control of symptoms.

The next section will examine the steps taken to establish the trustworthiness, rigor, and verification of the study's data and data analysis.

Trustworthiness and Verification of Data

Establishing a study's trustworthiness is critical when making claims regarding data and findings. This next section will explain the verification techniques espoused by various qualitative researchers and employed in this study. First, however, it is important to distinguish standards and terms applied to judging the quality of quantitative data from that of qualitative data. Rather than transferring standards and terms crafted for quantitative research, such as validity and reliability, verification terms and procedures shown to apply to qualitative studies within a postmodern framework will be used (Creswell, 1998).

Creswell and Miller (as cited in Creswell, 1998) unveil a classification of procedures, namely eight verification techniques developed following a review of multiple studies; these procedures are fitting for a naturalist versus a positivist study. Padgett (as cited in Lietz, Langer, & Furman, 2006) asserts that "establishing a set of strategies to increase rigor in qualitative research will help qualitative researchers to manage reactivity and bias, legitimatizing qualitative findings" (p. 443). Creswell advises that researchers employ at least two of the techniques in any particular study.

Of the eight techniques advanced by Creswell and Miller, I engaged in three, including: prolonged engagement and persistent observation, triangulation of data sources and theories, and finally, partial member checks. According to Creswell, prolonged engagement and persistent observation entails "building trust with participants, learning the culture, and checking for misinformation that stems from distortions introduced by the researcher or informants" (p. 201). Prolonged engagement, by nature of the amount of time spent with participants, allows the researcher to achieve saturation of the data (Lietz, Langer, & Furman, 2006). To develop trust and gather deep information from participants, I met with participants on four separate occasions in one on one settings over the summer and early fall 2007. Meeting multiple times over a relatively short period of time and allowing dialogue to extend beyond the close of the official crafted interview questions fostered researcher and participant rapport along with increasing levels of participant trust, comfort, and self-reflection.

The second strategy, triangulation of data sources and theories, "involves corroborating evidence from different sources to shed light on a theme or perspective" (Creswell, 1998, p. 202). I engaged in triangulation of data sources and theories to strengthen the rigor and trustworthiness of the data and analysis. Specifically, two primary theories, namely Identity Theory (Stryker & Burke, 2000), Chickering and Reisser's (1993) vectors of student development, and a tertiary theory, social identity theory (Hogg, Abrams, Otten, & Hinkle, 2004) were employed as separate lenses through which to examine the data. Furthermore, rather than simply relying on one data source, interview transcripts, I drew from direct, personal participant observation, personal and course-related writings, college records and disability documents, and written assessments (e.g. "Who Am I? and Who Am I Not?" and "Pre and Post Diagnosis Roles'" exercises).

Lastly, I turned to partial member checking as another mechanism to verify the accuracy of the data gathered. Member checking, as conceptualized for this study, involves "taking data...back to the participants so that they can judge the accuracy and credibility of the account" (Creswell, 1998, p.202). I relied upon a reconceptualization of member checking for this study, one in which participants checked the accuracy of parts of the raw interview transcripts and provided select expansions and explanations; participant comment on data analyses and interpretations was omitted due to the delicate nature of the study's topic and deliberate act to avoid any impression of a therapeutic role or relationship ascribed to the researcher and participant. Thus, participant oversight of data accuracy was thus achieved through partial member checking. Stake (as cited in Creswell, 1998) provides additional support for partial member checking in his acknowledgement that he "usually receives little back from actors in [the] process" of soliciting participants' feedback on rough drafts of his writing (p. 213). Nonetheless, credibility and trustworthiness of the data findings are enhanced by engagement in multiple verification strategies.

Patton (2002) further espouses an iterative approach to verifying a study's naturalist data and analysis. Patton concludes, "what is discovered may be verified by going back to the world under study and examining the extent to which the emergent analysis *fits* the phenomenon and *works to explain* what has been observed" (pp. 67, emphasis is original). I adopted Patton's approach of moving from an inductive approach to that of a deductive mode, being open to the unfolding data and then focusing and narrowing my analysis through the discovery of themes and association with theories. By repeatedly moving back and forth between the raw transcripts, observation notes, and written exercises and existing literature findings and theories, I was able to verify 1) a fit between the study's themes and findings with the data and 2) explanation of the behaviors and questions being studied.

Limitations

The following section will discuss the study's limitations and actions taken to lessen the impact of these limitations.

- Purposeful, criterion sample method: This study is limited to seven, purposely selected, participants at one, four-year public institution of higher education in California. A selective sample could be construed as a biased sample; however, a purposeful sample was chosen due to the study's intent. I adopted a purposeful, criterion sampling strategy to locate participants meeting set criteria and exclude those with whom I had met or worked in a professional capacity to avoid any trace of a conflict of interest. Purposeful sampling methodology permitted data rich sources, something not guaranteed through random sampling procedures. Patton (2002) lends support for the purposeful sampling methodology, claiming "the validity, meaningfulness, and insights from qualitative inquiry have more to do with the information richness of cases" (p. 245). The purpose of a purposeful sample research design is to study information rich cases in depth to better understand the phenomenon rather than generalizing from a sample to a large population (Patton, 2002).
- Sample drawn from, and limited to, college's disability services unit: All participants who were purposefully selected to participate in the study were registered with the college's disability services center implying that these participants possessed (1) a level of resourcefulness and knowledge about campus services, (2) identified as having a disability, and (3) possessed documentation indicating the presence of a psychological disorder. There may be differences between this sample of students

and those who opted not to register with the college's disability services unit. For example, some students with psychological disorders may not identity as having a disability and thus would not feel that they met the eligibility criteria for the disability services unit. In addition, some students may not have medical insurance needed to obtain documentation and be eligible for services, perceive the need for disability documentation as burdensome, or fear possible loss of confidentiality or release of documentation or diagnoses information to others within the campus community. These factors present possible deterrents to students' registration with the college's disability services unit. Thus, these findings need to be absorbed with this discussion in mind. It should be noted, however, that some of this study's participants did not identity with having a "disability" even though they had registered with the disability services unit. Furthermore, some participants registered with the disability services unit yet never met with a counselor there or sought or received any assistance, services or support from the disability services unit. Such findings prompt one to consider that individuals may register with the disability services unit despite not believing he or she has a disability; there may be more homogeneity between students with psychological disorders registered with the college's disability services unit and those not registered. These individuals may recognize that "disability" thus conceptualized is how the college or society defines them and that they need to have some surface level conformity despite not aligning themselves with having a disability internally. In addition, parents play a role in first-year students' registration with the disability services center. As is evident from the study, two participants registered with the disability services unit prior to starting their first year in college suggesting their parents' prodding influenced their registration in the university's disability services unit. These same students never returned to the disability services unit following the initial session. Thus, evidence suggests a disparity within the sample perhaps reflective of that found in the larger body of students with psychological disorders.

- Researcher bias: The researcher's own assumptions, experiences, background, and philosophies may factor into how data is processed and understood. I sought to limit the threat of researcher bias by writing about my own epistemological perspective thereby alerting me to signs of possible bias in my analysis and conclusions.
- Observations: Researcher's presence may affect the participants' behavior influencing participants to act in an atypical fashion (Patton, 2002). In addition, observations are limited as the researcher has only access to what he/she is seeing occur on the outside of the participant, externally, and not inside the participant (Patton).
- Interview data: Limitations presented by interview data include possible inaccurate or distorted responses due to "personal bias, anger, anxiety, politics, and simple lack of awareness" (Patton, 2002, p. 306). In addition, interview data is also limited due to potential recall error, impact of the interviewer on the interviewee, and false or self-serving responses (Patton). Stigma induced embarrassment, fear of rejection, judgment, or breach of confidentiality may also impact participants' responses in terms of accuracy and depth of information provided. Lastly, in addition to limitations inherent in interview data, documents may be incomplete or inaccurate.

Given the limitations inherent in each data source, Patton (2002) asserts that "by using a variety of sources and resources, the evaluator observer can build on the strengths of each type of data collection while minimizing the weaknesses of any single approach" (p. 307). Thus, I engaged in multiple data information sources to reduce the limitations and threats to data credibility and trustworthiness presented by individual data sources. The following section is divided into two subsections, namely future areas of study, and summary and implications for professional practice in higher education.

Future Areas of Study

Replication of this study in different settings will be helpful in illuminating the existence of other factors and issues unique to students with psychological disorders in higher education. For example, replicating the study in the following settings is suggested: (1) a rural community, (2) non-commuter, residential college campus, (3) two-year community college, and (4) sample of students not registered with a college's disability services unit. In addition, this study suggests a benefit to conducting an experimental design featuring a traditional higher education classroom, the control group, and a learning community classroom, the experimental group. Here, students with psychological disorders would be followed in each group and assessed for changes regarding perceived learning and intellectual development and persistence. Investigating the research questions with a sample tracked over a prolonged period of time throughout their journey in college, namely a longitudinal study, or a case study featuring a larger sample, may yield still other important quantitative and qualitative findings.

While this study concentrated on one dimension of the sample's identity formation, namely psychological disorders within the context of higher education, the sample comprises more than one target group (i.e. gender, race, religion). Given the literature surrounding the intersection of multiple identities (Torres, Howard-Hamilton, & Cooper, 2003), the interrelationship of these multiple roles and identities on one's identity processes poses a new topic for future studies. Furthermore, differences in life experiences among the participants, and how participants interpret these experiences, may be attributed to the participants' disparate ages, which range from 19 years to 43 years. Literature may be further enhanced by a future study which examines how the age of participants may influence how they make meaning of their experiences.

Summary and Implications for Professional Practice within Higher Education

This section presents summary points for consideration among higher education practitioners, including faculty, staff, and administrators.

- There are distinct factors to consider that relate to identity development among students with psychological disorders in higher education. Torres, Howard-Hamilton, & Cooper (2003) assert that those in higher education need to "understand what conflicts students must resolve to develop their sense of self and in turn how we can assist them in resolving those conflicts" (p. 3). Students with psychological disorders face academic and relational crises, the resolution of which determines the direction of their identity development. This study suggests it is the resolution of these conflicts which relates to students with psychological disorders' identity development as conceived through Chickering & Reisser's (1993) theory of college student development.

- Students with psychological disorders manage identity information through secrecy, passing, and withdrawal.
- Classrooms following Baxter Magolda and Tintos' call for joint construction of meaning may go a long way in maximizing students with psychological disorders' self construction, motivation, perceived learning and intellectual development, and persistence.
- Classrooms may represent the only place in college in which students with psychological disorders engage with other students and form relationships, thus suggesting a benefit to more research in this area as it relates to students with psychological and other disabilities.
- Students with psychological disorders actively manage their stigma and identities daily, making decisions about what to present and conceal about themselves, navigating and negotiating various social settings in higher education.
- Students with psychological disorders in this study longed to no longer conceal their disorder yet perceive a world in which this is for the most part not possible.

Professor Adoption of the following practices may further cultivate student with psychological classroom participation and belonging:

- Taking time to get to know students' names
- Avoid language that embraces and perpetuates stereotypes of mental illness
- Whenever possible, support flexibility in the "how" of students' achievement of leaning outcomes.

Student Affairs' and Administration Recognition and Incorporation of the following may further build a more accepting campus climate:

- Greater education of psychological disorders across the curriculum, for example including disability awareness curriculum in general education courses and in student affairs programming
- Greater sensitivity to the place students with psychological disorder are at in learning of their disorder.
- Promote the development of sympathetic others among faculty and student affairs professionals. Toward this end, establish a disability/psychological disorder competence assessment and training as an extension to cultural competence initiatives and efforts currently in practice.

Closing Summary

The purpose of the study was to investigate the lived experience of students with psychological disorders in higher education. Research questions sought to provide insight into participants' identity processes and perceptions of their learning experiences. The research involved two phases; the first phase involved a pilot interview and subsequent literature review, the results of which were incorporated into the revised interview protocol. The second phase included the full study with seven purposefully selected participants meeting set criteria. All seven participants were registered with the university's disability services center at one public university in the Western United States Coast and had documentation verifying the presence of an Axis I psychological disorder(s).

The study illuminated participants' perceptions of their lived experiences through an existential approach examining four lifeworld categories, namely temporality (lived time), spatiality (lived space and place), corporeality (lived body), and lived human relation (lived relationship to others, communality). Such findings yield greater awareness of how these participants perceive and experience time, their physical selves, their environment and place in society, and their relations with others. Such findings suggest that these experiences may bear elements which differ from college students without psychological disorders.

The findings of the study suggest (1) there is a pervasive yet varying effect of stigma on participants' identity and impression management behaviors, (2) crises resolution pertaining to seeking help and forming relationships associates with identity development, (3) student-role prominence may influence help-seeking behavior offering possible implications for college student persistence, (4) renaming and reconceptualizing psychological disorders may contribute to more positive self-concepts, (5) "sympathetic others" play a part in fostering a positive classroom emotional climate and relationship trust and building, and finally, (6) stigma and concomitant impetuses to proving one's self prompted participant classroom participation yet outward signs of professor and classmate discrimination stifled this very participation.

The richness of participants' stories reveal a vulnerability, a yearning to succeed in life, and a resistance to being perceived as "other" or linked to medical definitions of psychological disorders. Yet, participants simultaneously admitted to wrestling with how to fit their disorder into their sense of self and distinguish parts of their personalities and self concepts from aspects of their disorder. It is in encountering participants' stories, and their perceptions of their experiences surrounding their time in college (offered in Chapter IV) that the reader witnesses the competing and unique choices students with psychological disorders face when making decisions to initiate or elevate relationships and succeed in college academic endeavors or participate in the classroom. Yet, building mature interpersonal relationships embodies a critical aspect of college student identity development (Chickering & Reisser, 1993) and classroom participation contributes to increased intellectual and cognitive growth (Tinto, 1997; Volkwein, King, & Terenzini, 1986). Thus, higher education practitioners are called to play a critical role in facilitating the identity development and learning experiences of this growing student populations through serving as "sympathetic others," infusing classrooms and co-curricular activities with more opportunities for self-reflection and interaction with classmates in safe and open settings, and embracing definitions of psychological disorders which maintain the humanity of the individual and not the failing of the disorder. This study affirms and extends the charge bestowed upon higher education practitioners proclaimed by Chickering and Reisser (1993), who write in their seminal work *Education and Identity*:

> Just as individuals are not just consumers, competitors, and taxpayers, so students are not just degree seekers and test takers. To develop all the gifts of human potential, we need to be able to see them whole and to believe in their essential worth. (p. 41)

For students with psychological disabilities, the challenges that make them question their worth and place exist not only in themselves but reside in current higher education practices. Practices which stifle students' participation in the classroom, in the construction of meaning making, and perpetuate prevailing stereotypes about psychological disorders threaten students' identity formation and learning. Higher education leaders can promote these students' identity formation, self-esteem, and intellectual development by validating students' experiences and ideas, affirming their journey, recognizing needs for assistance and creating supportive and student-centered learning environments.

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APPENDIX A. INFORMED CONSENT

(PRINTED ON UNIVERSITY OF THE PACIFIC LETTERHEAD)

INFORMED CONSENT

The Intersection of Identity Construction & Learning Approach:
The Experience of College Students with Psychological Disorders

Dear (Name of Student),

You are invited to participate in a research study. The research study will look at the experience of college students with psychological disorders. My name is Shauna Moriarty. I am a doctoral student at the University of the Pacific. I am conducting research for my dissertation.

The purpose of this research is to meet with college students with psychological disorders. I want to understand their learning experiences. If you decide to join this study, you will be asked to participate in two to three confidential interviews with me.

The study will also involve one classroom observation. During the classroom observation I will sit quietly in the back of the classroom. To protect your confidentiality I will not approach you during, before, or after the class.

I will also review your disability paperwork, (name of University) academic records, and other documents you may wish to provide. All information gathered in connection with this study will remain confidential. So too, any information that can be identified with you will remain confidential. No information you share as part of this study will be included in your (name of the disability services unit) file or shared with any (name of the disability services unit) or (name of the University) employee. A fictitious name, and not your real name, will be used when presenting your story in the dissertation.

You participation in this study will last from June 2007 through October 2007. I will tape record the interviews. The recordings will be transcribed. You will be identified only by a fictitious name in the study. Your identity, and that of the University you attend, will remain confidential.

There are some possible risks for participants. Possible risks include anxiety as a result of being interviewed. Benefits of participating include reflecting on your experience in college. You will receive a ten-dollar Visa gift card at the conclusion of the interviews.

Your participation in this study is on a volunteer basis. If you decide to participate, you will not lose benefits to which you are otherwise entitled. You may withdraw from the study at any time without penalty.

If you decide to be a part of the study, the services and accommodations you receive through (name of the university) (name of the disability services unit) or other (name of the University) program or department will not be affected.

My role in this study is not connected to the (name of the disability services unit). My role is as a graduate student researcher when engaged in this study. Any (name of the disability services unit)-related discussions will be reserved for your appointments with your counselor at the (name of the disability services unit).

Your signature below indicates the following:

- ☐ You have read and understand the information provided above
- ☐ You willingly agree to participate
- ☐ You may withdraw your consent at any time. You may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled
- ☐ You will receive a copy of this form
- ☐ You are not waiving any legal claims, rights or remedies.

You will receive a copy of this signed form.

If you have any questions about the research study at any time, please e-mail me at shaunamori@yahoo.com.

If you have any questions about your rights as a participant in a research project, please call the IRB Administrator, University of the Pacific, 209.946.7367. You can also contact my dissertation committee chair, Dr. Delores McNair, at 209.946.2674 and (name) Associate Vice President of Graduate Studies and Research, (name of the University), at (phone number).

Signature ______________________________

Date ____________________

APPENDIX B. INVITATION TO PARTICIPATE IN THE STUDY

(PRINTED ON UNIVERSITY OF THE PACIFIC LETTERHEAD)

Date

Research Participant Name
Address

Dear (Research Participant Name):

You are invited to participate in a research study. The research study will look at the experience of college students with psychological disorders. My name is Shauna Moriarty. I am a doctoral student at the University of the Pacific. I am conducting research for my dissertation.

You participation in this study will occur during (time period listed here) at a time that is convenient for you. You will be identified only by a fictitious name in the study. Your identity, and that of the University you attend, will remain confidential. You will receive a ten dollar Visa gift card at the conclusion of the interviews should you decide to participate.

The purpose of this research is to meet with college students with psychological disorders. I want to understand their learning experiences. If you decide to join this study, you will be asked to participate in two to three confidential interviews with me. The study will also involve one classroom observation. During the classroom observation I will sit quietly in the back of the classroom. To protect your confidentiality I will not approach you during, before, or after the class.

If you would like to participate in this research study, please e-mail me at shaunamori@yahoo.com or call me at (925) 360-2433. I will also contact you via phone to follow-up on this letter and to see if you have any questions.

Sincerely,

Shauna Moriarty
Doctoral Candidate
Benerd School of Education
University of the Pacific

APPENDIX C. INTERVIEW PROTOCOL

Interview Protocol: Part 1

The following statement will be read aloud to participants at the commencement of the first interview:

Please note that if at any time during the interviews a study participant discloses a threat of harm to self or others, the interviews will end and I will be obligated to contact the University's Counseling Services for immediate crisis intervention.

Intro Questions – To Build Rapport and Ease Into Interview:

- What motivates you to participate in this project? What do you hope to gain?
- Any fears that you have about participating in this project?
- What is your class standing, for example, are you a sophomore, junior?
- Tell me about your most significant learning experiences in college this past year?
- Any others?

Interaction & Relations with Others

- Have you ever been in a situation in college where you felt you needed to tell others about the psych disorder)? What was this situation like?
- How did their reaction(s) to knowledge of your psych disorder impact you (for example, did you notice yourself acting, behaving, or thinking differently in class?
- What did telling others about the psych disability do for you? What effect did it have do you think?
- What are times in college when you felt it better to conceal your disorder from others?

- What types of relationships (people) are most challenging for you to tell about your psych disorder?
- Have you ever been in a class where you felt really encouraged and free to contribute in class (to class discussion and involvement)? What made it so comfortable? (i.e. class/instructor/subject). What was it like contributing in class?
- What about the opposite? Has there been a class in which you remained silent in class for the most part? What made it this way (i.e. class/instructor/subject). What was is like keeping silent?
- In what environments is your psychological disorder a factor to consider? Where is it relevant for you?
- How is the character of your relationships with others in the classroom shaped by (insert the name of the psychological disorder)?
- Do your relationships differ depending on whether or not they know about the (insert the name of the psychological disorder).

Learning Approach

- What do you expect from instructors to help you learn effectively?
- Has there been a time when the knowledge of (insert the name of the psychological disorder) was significant or profound for you in the classroom or university-related academic endeavor?
- In what ways is the manner in which you learn and obtain information related to (insert the name of the psychological disorder)?
- Has there been a time when just knowing about, being aware of the psychological disorder, impact how active you are in the classroom (e.g. the level of raising your hand to ask or answer a question? Volunteering to be a group leader? Way in which you work with others in a class project or paper? In and out of class involvement overall?
- How do the side effects and symptoms of (insert the name of the psychological disorder) impact how active you are in the classroom (e.g. the level of raising your hand to ask or answer a question? Volunteering to be a group leader? Way in which you work with others in a class project or paper? In and out of class involvement overall?
- Have there been times in which the (insert the name of the psychological disorder) has interfered negatively with your ability to perform academically?

(e.g. meet assignment deadlines, take an exam, participate in class).Any positive? Was there a time when (insert the name of the psychological disorder) led to withdrawal from the university? What helped you return?

- What are the optimal conditions for learning outside of the classroom for you? How about optimal conditions for learning for you in the classroom?
- Do you participate in class more or less now than before you found out that you have (name of the psych disorder)?
- How has that way in which you interact in class and learn changed since the diagnosis?
- How has your interaction in class and learning changed since telling someone in class about your psych disorder?
- If a classmate thought less of you because of the (psych disability), how would you react? (i.e. would you avoid him/her?)

(To understand if the participant is self or other directed in her way of knowing and learning and determine which factors control decision making in the classroom. Hand the participant the card with the comment A typed on it.) I'd like you to read this aloud and then comment on it (Belenky et al, pgs. 234 to 235).

"In areas where the right answers are known, I think the experts should tell us what is right. But in areas where there is no right answer, I think anybody's opinion is as good as another."

Probing questions:

- In learning about something you really want to know, can you rely on experts?
- How do you know someone is an expert?
- What do you do when experts disagree?
- What do you do when you disagree with the professor's opinion on something in class?
- What do you do when you disagree with a classmates opinion on something in class?
- What factors influence whether or not you express your opinion? Conceal your opinion?

- How would you think your opinion(s) will be received in a class? In a class where people knew of your (psych disability)?

- How do you think your opinion(s) will be received in class? How would you think your opinion(s) will be received in a class where people knew of your psych disorder?

- How do you know what it right/true?
    - Has this always been this way for you? Any changes since the diagnosis? Since navigating college with the psychological disorder?

- Do you agree with this person who says that where there are no right answers anybody's opinion if as good as another's?

Interview Protocol: Part II

Identity

Please think back for a moment now to the time before you received your diagnosis.

- How much did you know about (name of psych disorder) before you were diagnosed?

- Where did you find that out (source)?

- How did you feel about the possibility of you having (name of psych disorder)?

- Before you received the diagnosis, did you talk to anyone about the fact that you might have (name of psych disorder)?

- Probe: Who did you talk to and how did you tell them?
  What was their reaction?

Self-feelings/Self-Meanings

Now let's discuss discuss some your thoughts you have about yourself when you were diagnosed and how you think about yourself now.

Self-feelings/self-meanings at the time of diagnosis IN or BEFORE college.

Please think back to the situation you just described, when you learned about the (name of the psych disorder)?

- At that time, how did you think having (name of psych disorder) would affect your experience in college and your relationships to other people in college?

- During the time soon after you found out you had (name of psych disorder) how often did you think about it?
- When did you tend to think about it? Were there particular situations or other people which seemed to trigger thoughts of (name of the psych disorder)?
- When you thought of the (name of the psych disorder) what specifically did you think about?
- In what ways did the diagnosis impact how you saw yourself?
- About that same time, the time shortly after you found out you had (name of the psych disorder), what did you think of yourself?
- What terms did you use to describe yourself?
- And what did you feel about yourself?

NOW, Self-feelings/self-meanings at the present (in college)

- How often do you find yourself thinking about (name of the psych disorder) in college?
- When do you tend to think about it?
- When you think about (name of the psych disorder) now, what specifically do you think about?
- What do you think about yourself now?
- What terms do you use to describe yourself now?
- And what do you feel about yourself now?
- How would you say your feelings about yourself have changed from the time just before you found out you had (name of psych disorder) and the present

Please complete this statement for me:

- When a person gets (name of the psych disorder) he/she has to accept being _______.
- Since attending college, has there been any change in the way you see yourself since the first time you were diagnosed with (insert the name of the psychological disorder)? What do you think contributed to this change in how you see and define yourself?
- Have there been other turning points in college?

- Do you have different roles (for example, student, daughter/son, dancer, writer, athlete)?
- What are your various roles? Can you write them down for me and then rank them according to their importance to you, from 1 to 10. (Refer to Appendix E)
- How important to you is your role as a college student?
- How does the role of "person with (insert the name of the psychological disorder) affect your role as "student" (or grad student)? (and other college-related roles)
- Has being in college changed the way you think about yourself?
- How have you come to know yourself as a "learner and a knower"?
- What has been influential in this?
- How has the process of living with (insert the name of the psychological disorder) contributed to how you define yourself?
- How does keeping the knowledge of (insert the name of the psychological disorder) from others affect you?
- How does keeping the knowledge of (insert the name of the psychological disorder) from others affect your perception of yourself in college?
- How do you come to know that your thoughts (e.g. suicidal, obsessive-compulsive, or anxious) are different from those of others?

Relationships with others

Now let's focus on your social relationships and classroom learning experiences in college. When I say social relationships I mean all kinds of relationships you have to people including relationships that are very important to you and relationships that are less important. For example, I mean your relationships to family members, friends, classmates, professors, and other people you meet in your everyday situations.

At the time you learned of the (name of psych disorder) ...

- Do you think having (name of psych disorder) has affected your social relationships? (If in college - classroom relationships? School learning?)
- What relationships have been affected and how?

Link with persons who may have been mentioned earlier:

Probe:
Ask about specific types of relationships such as

- What about your relationships to family members
- What about your relationships to friends
- What about your relationships to classmates
- What about your relationships to professors and professionals at your university
- What about your relationships to people you meet in everyday situations
- What about your relationships now? Does having (name of psych disorder) affect your relationships now? In what ways?

Again, probe as above.
Present:

- Do you see particular kinds of people more or less **now** than before you found out that you have (name of the psych disorder)?

- How have things changed?

- In what ways does having (insert the name of the psychological disorder) impact your relationships with classmates? Professors? Others in the University?

- What kinds of interactions with your professors and experiences have been the most positive when an issue related to the (insert the name of the psychological disorder) emerged?

Other MISC. questions:

- Looking back over the time right after learning about the psych disorder, are there people who have been especially helpful and supportive for you?

- Which people and how have they supported you?

- Are there people who are especially helpful and supportive now in college?

- Which people and how do they support you?

- Are there any things I haven't asked about that are important to your experiences with (name of the psych disorder in college and your reactions, decisions, and learning experiences?

APPENDIX D. ME AND NOT-ME ASSESSMENT

Who am I?

Who am I not?

APPENDIX E. ROLE IDENTIFICATION AND PRIORITIZATION

My Roles

Before diagnosis

After diagnosis

The roles others see me as having

APPENDIX F. CLASSROOM OBSERVATION RUBRIC

Classroom Observation Rubric

Student Name:
Course Title:
Date:

Freq. of Hand Raises	Seating Location	Arrival Time to Class	Nonverbal Comm	Interaction with Peers

Other
Overall Character of Participation