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"Find Your Anchor": Navigating Mental Illness and Academic Achievement

Editors

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Abstract

Students, at all levels of learning, continue to grapple with multiple challenges including mental illness and its complications. In this paper, I set up a peer-to-peer conversation to offer plausible strategies to confront and manage the effects of mental illness on a student's academic journey. These students who contributed their perspective and experiences reinforce "finding your anchor" as foundational to building their own capacity to thrive while managing challenges presented by mental illness, and explained that such involves more than seeking medical and counselling help but requires consciously confronting the fear of social and cultural taboos and stereotypes. To interpret and clarify their explanations I utilize a case study research design, collecting data through in-depth interviews and elaborating significant meanings within that data through content and narrative analysis. Ultimately, students provide more than testimony, they map routes to take and express an encouraging voice that demonstrates how, though confronting challenges, they were able to harness available resources to help them live with mental illness and still achieve their goals as students.

Keywords: Mental illness, student achievement, tertiary education, treatment, therapy, help-seeking behaviours

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Introduction

How does a student meet high expectations, achieve tangible goals and thrive while managing the challenges of diagnosed mental illness? This paper offers a plausible strategy based in the experiences discussed by select students within the tertiary level peer group. These students reinforce "finding your anchor" as foundational to building their own capacity to thrive while managing challenges presented by mental illness, and explained that such involves more than seeking medical and counselling help but requires consciously confronting the fear of social and cultural taboos and stereotypes. This paper presents their "how to's" and the lessons they learned while applying these to their experiences.

To elaborate their strategies, I foreground their standpoint and sense making to harness the potential of personal testimony as a demonstrative research narrative. I view these students as experts of the experience in focus and capable of providing insightful revelation, recognisable voice and context, and plausible personalised connection, be it viewed as a close or far connection. Through their testimony, I set up a peer-to-peer conversation to address a research problem which I view as persistent and significant, i.e. mental illness within a specific context, a teaching and learning context. I do not claim these select experiences as prototypical or representative, noting that such claims would be impractical and invalid because of the variability and complexity of living with mental illness.

The problem I address emerged through my experiences as a lecturer at The University of the West Indies for about a decade and a half. Each year, I encounter students, the number varying per semester, who expressed concern about their academic progress because they felt hindered by the impact of varied challenges of living with suspected or diagnosed mental illness. Though the numbers who came to me were not in the majority, the consistency of one or some individuals seeking counsel each year prompted the need for further exploration and for strategic and pragmatic efforts to assist students. My aim is to make salient the insights of the experiencing subject, and to make

accessible, to students who need to manage the effects of mental illness on their lives within and beyond their academic journey, implementable strategies which have proved 'tried and true' for those students who share their experiences.

To achieve this, I utilize a case study research design, collecting data through in-depth interviews and elaborating significant meanings within that data through content and narrative analysis. The case study design is both exploratory and descriptive, with the 'how' and 'why' of student experiences in focus as the basis of the peer-to-peer conversation set up (Baxter and Jack 2008). As case studies must be bounded by specific criteria (Harrison et al. 2017, Baxter and Jack 2008; Rowley 2002), I have defined this category of analysis by context, definition and sex category. Therefore, two students form the core sample selected, one male and one female, both being students of The University of the West Indies, St. Augustine Campus at the time of interviews, and both graduating successfully while managing diagnosed mental illness.

Additionally, though the purpose and scope of this paper accommodate to the research design, I acknowledge the pros and cons of personal testimony as discussed by Langellier (2003) for example. I also acknowledge the ongoing debates about small sample sizes in qualitative research and the validity of saturation as a standard (Malterud et al. 2015; Fusch and Ness 2015; Marshall et al. 2013; Trotter 2012; Dworkin 2012). Therefore, as a reflexive strategy, I apply respondent-driven sampling (Trotter 2012) to access additional members of the network of students who fit the sampling criteria outlined, and to use their perspectives to elaborate the demonstrative voice that is in conversation with their wider peer group. While an attempt was made to use student social network contacts to secure the participation of one additional male along with one additional female, potential male respondents from this peer network withdrew their participation during this process, therefore additional testimony is taken from two female respondents. The female voice is of significance in

context as the peer group – the student population at The University of the West Indies, St. Augustine Campus – is female in the majority.

However, such withdrawal is notable because it not only explains the exclusion of a second male voice, it also reveals a general limitation, which affects responder participation acutely. That limitation rests in the risks associated with revealing self as affected by mental illness, a set of illnesses that remain stigmatised in many Caribbean societies. To participate in the peer-to-peer conversation I stage requires the student, who appears to excel without hindrance, to reveal a very personal struggle with mental illness. Participation involves consciously confronting taboo and secrecy and overcoming the fear of speaking about experiences often denied, marginalised or stigmatised, based on constraining stereotypical beliefs about mental illness.

Such stigma is a well-established feature of Caribbean society. For example, Ravello (2015), speaking of Trinidad and Tobago, reinforced the WHO mandate that the society needed to make a priority of the correction of misperceptions about mental illness and its treatment in the health system. In addition, Mascayano et al. (2016), in a systematic review of stigma toward mental illness in Latin America and the Caribbean, found the persistence of negative prejudices toward people with mental illness, experiences of social exclusion and functional impairment by those affected, as well as frustration, denial and grief within families with a mentally ill member. At the same time, they also found some attitudes of compassion and benevolence (Mascayano et al. 2016), which suggests that stigma is not absolute. The Trinidad and Tobago Association of Psychologists, responding to reports of suicidal ideation among preteen children, recognised in 2017 the continued challenge presented by gaps that undermine efforts to develop effective solutions to mental health problems (Julien 2017).

Therefore, efforts to fight such stigma have been persistent over time but have not yet successfully erased their relevance in Caribbean societies like Trinidad

and Tobago. A look at the contemporary period exemplifies continued advocacy. For instance, Hutchinson (2012) explained the profound impact of such stigma on the mind and on social relations, advocating for an end to such belief systems that undermine awareness in the wider society, limit comfort, trust and functionality of those needing help with experiences of mental illness, and contributes to shame, secrecy and ongoing prejudice against those affected. Similar calls were made later by Sharpe and Shafe (2016) who insisted that the Caribbean needed creative and innovative approaches which focus on negating stigma and discrimination. These calls were repeated during every subsequent yearly commemoration of World Mental Health Day with concerns expressed over lack of support and fear of stigma that prevents individuals from seeking treatment in 2017, and with calls for an end to silence around mental health, for access to mental health information and for timely care in 2018 (Ministry of Health). Phillip (2018) highlighted the nature of ongoing challenges citing depression and suicide as prevalent across Trinidad and Tobago with much stigma still associated with it, and with the continued relevance of traditional beliefs around depression, ranging from the general disbelief that it is a legitimate illness to referring to it as obeah. The statistics are indeed concerning, with Deyalsingh (2019) explaining that in Trinidad and Tobago "one in four people suffer from mental illness and though the preponderance of mental illness seems to occur in the age group 25-50, clinics are also now seeing a trend of much younger patients" (Trinidad Guardian 2019). Thus, Seemungal (2019) issued an especially poignant appeal on behalf of people who live with mental illness,

> "Does anyone ever have to argue that bowel cancer or lupus are legitimate conditions? Yet this is what people with mental illness issues face every day. This has led to social stigma associated with mental diseases. These illnesses can be so debilitating that sufferers can be confined to their homes when severe. The symptoms of these illnesses are very real to sufferers. Mental illness sufferers have to endure their symptoms and the scepticism of those around them which makes it so much worse for them." (UWI Today 2019 12).

Ultimately, this spectre of stigma and discrimination has a direct impact on who and how members of the peer group chose to participate in the conversation I stage in this paper. Therefore, I have only included respondents who volunteered with full informed consent. All four respondents were well known to me and were engaged in peer counselling activities, therefore, their comfort levels and willingness to participate were influenced positively by this relationship and by their extra-curricular activity. However, I assert that the testimony from the few and the narrative outlined provide a salient example to the peer group who, with varying degrees of frequency and intensity, continue to live with the challenges of mental illness.

Mental Illness in the UWI Student Population: A Snapshot

Research has been ongoing at The University of the West Indies to understand mental illness in the wider population and the student population in particular. At the St. Augustine Campus, the experiences of medical students, as a particularly vulnerable group, have been well elaborated and have prompted action at the policy level. Seemungal (2019) explains,

> "Medical students have higher rates of depression, suicidal ideation and burnout than the general population and greater concerns about the stigma of mental illness. In 2010, Schwench et al. reported that about 50% of medical students experience burnout and 10% report suicidal ideation during medical school worldwide. Non-random estimates of depression amongst medical students at the St. Augustine Campus vary from 30% to 40% higher in certain subsets. The Faculty of Medical Sciences took the position last year that the time has come to move beyond simply measuring mental illness in medical students and has moved to create practical approaches to implementing school based solutions." (UWI Today 2019).

Youssef has elaborated the trend in the medical students' cohort explained by Seemungal. He reports significant negative attitudes still existing among medical

students (Youssef 2018), high levels of stress and a significant prevalence of burnout and depressive symptoms (Youssef 2016), and the need for increased knowledge and education campaigns to reduce discrimination (Youssef et al. 2014).

In earlier years, Mungroo and Mohammed (2011) reported that the general population of full-time undergraduate students at the campus were mentally healthy. However, the conditions have changed over time, as Wall et al. (2014) found in a survey of undergraduate students. He reported that students outside the medical sciences also experienced depression and suicidal ideation among other mental illnesses. Wall et al. found that these students were often triggered by issues relating to family life, traumatic personal experiences, personal health, personal relationships, living expenses and arrangements, bereavement, medication side effects, sexual abuse, substance abuse, and violence. In addition, statistics collected by the Counselling Unit of the Health Services Unit at the St. Augustine Campus, show a steady increase in new student visits from 2006 – 2011.[1] While these visits indicate an increase in the number of students seeking help, they do not give definite data on diagnosed mental illness in the student population.

The prevalence of mental illness and associated challenges do have the potential to adversely affect the academic achievement of students in the peer group. Pottinger et al (2009), in a study at the UWI Mona Campus, established psychiatric illness as one hidden disability that affects students' ability to achieve academically and to develop and maintain good relationships. At the Cavehill Campus, Fayombo (2011) found similarly that psychological resilience is closely connected to academic achievement, with those students who are more resilient or more able to cope with academic stress, better able to achieve their goals at school. Informed by these findings and my own experiences as background, I craft a response rooted in the standpoint of the experiencing subject, i.e. the students who live with mental illness and who have implemented

strategies to manage their experiences to ensure they attained the academic success expected of a tertiary level student.

"Find Your Anchor" – Navigating Mental Illness and Academic Achievement

The primary respondents selected from the peer group are Michelle and George, with their peers Sheniece and Angela (pseudonyms used for all), selected as elaborating voices that contribute to the peer-to-peer conversation staged. All four students have navigated multiple stages of mental illness, from an initial state of uncertain awareness to experiencing crisis to mapping recovery and establishing ongoing strategies for maintenance of their health and wellbeing. Taken together, their testimony, while by no means generalizable to the population, reflects consistency in terms of themes raised and their explanation of how they developed their capacity to manage their mental illness. This consistency, I suggest, can serve as a form of recognition, a shared narrative from peer-to-peer, an expression of a collective experience that may reassure peers that they are indeed part of a community and thus not as isolated as their illness may make them feel in a cultural climate of secrecy and shame. The four agreed that feeling a sense of community can help an individual to proactively manage mental illness.

To interpret their testimony, I utilise the tools of thematic content analysis and narrative analysis. To foreground their particular standpoint, I focus on the content of their experiences and their reflections on these, and organize their responses through apparent themes. These themes are coded and examined for the patterns of association made by the speaker (Barkhuizen 2015). To achieve the focus and purpose of this paper – peer-developed and experienced-based strategies to address mental illness – I am especially attentive to how they give meaning to their experiences as expressed in the content, structure and context of their narratives (Esin 2011). I prioritize their experience in this paper as they express it, agreeing with Lincoln and Denzin's (2003) assertion that "experience, if it is to be remembered and represented,

must be contained in a story that is narrated. We have no direct access to experience as such. We can study experience only through its representations, through the ways in which stories are told" (240).

Introduction to Respondents

Three of the four respondents were students in one or more of my classes in different academic years. Michelle and George, like other students, had shared their experiences with the challenges of mental illness in private conversations outside the classroom. The conversations occurred before formal interviews for this paper. I approached them based on our prior relationship, and they were both willing to speak openly and have their statements recorded and shared. Our familiarity was useful in building trust and comfort, with their anonymity and confidentiality assured, and their participation secured through informed consent. I was also familiar with Angela and Sheniece, Angela being a student in some of my undergraduate courses, and Sheniece a close contact of Angela's. They too were willing to speak openly and consented to have their perspective shared. All four were enthusiastic about the conversation because of their involvement in peer counselling and their feeling that the conversation was needed to help break the stigma and secrecy around mental illness.

Demographic Summary

Michelle

Michelle is a 24-year old from East Trinidad who identifies as female and feminine, Afro-Trinidadian, and non-religious. She was a first-year postgraduate student at the time of the interview, having completed her undergraduate degree with a 4.0 GPA. Michelle explained that she manages the challenges of bipolar II disorder, depression, anxiety, and deliberate self-harm. Her treatment regime includes medication, talk therapy, meditation, yoga, exercise (swimming in particular), writing poetry, and tattooing her body.

George

George is a 41 year old from West Trinidad who identifies as male and masculine, Afro-Trinidadian, and Roman Catholic. He was a third year undergraduate student at the time and explained that he is slowly learning how to manage the effects of his depression, and stress and anxiety disorders. His treatment regime includes talk therapy, exercising (particularly running), and listening to music. His overall undergraduate GPA at the time was 2.08. George's explanation of his experiences mirrors many of Michelle's even though, other than in terms of ethnicity, he differs from her completely.

Angela

Angela is a 26-year old from East Trinidad who identifies as female and feminine, of mixed-race, and Roman Catholic. She was a first-year postgraduate student at the time of the interview, and stated that she is diagnosed with depression and anxiety. Her treatment regime includes counselling, antidepressants, exercise and yoga/medications. She too tells the story of her experience in very similar ways to Michelle and George.

Sheniece

Sheniece is a 26-year old from East Trinidad who identifies as female and feminine, Afro-Trinidadian and Roman Catholic. She had recently graduated from an MSc programme at the time of the interview. Sheniece is diagnosed with generalised anxiety disorder. Her treatment regime includes goal setting, organizational planning, talk therapy, spirituality, and physical activity. Her narrative of her experience also reflects that of her peers in content and form.

Awareness of Mental Illness – "I just knew something was wrong"

Michelle and George both describe their experience of mental illness before diagnosis as gradual and difficult to pin down. They both suggested that though they had a sense that they did not feel their usual self, they did not immediately

recognise the severity of the problem. However, they both "knew something was wrong". Angela and Sheniece told their story similarly, the development of their narratives following the same sequence as Michelle and George and their language expresses the same sense of uncertainty and discomfort before diagnoses.

Table One below outlines their shared narrative, their recounting of their sense of having an experience of mental illness. Each story is a profound telling in itself, asserting how their experience became meaningful as they witnessed the growing impact of mental illness in their lives. The highlighted phrases illustrate how, through language, their experiences take form in equally recognisable ways. George's story differs slightly from his female peers, classifying and evaluating his experience more than they who remained more descriptive in their account. The significance of this apparent gender difference is difficult to articulate with a small sample. In addition, the length of this paper does not accommodate extended analysis. However, what is most relevant is that these four students make salient how mental illness developed in stages over time. Their experience, as they mapped it over time, they recounted the starting points of deterioration, they recalled the moments their emotional state changed, they were aware that they could not manage their experience alone and were convinced that something was wrong. All four outlined in time how they gradually felt worse until the need for intervention became the only next step to be taken. Each tells a story of how they first got a sense of their illness, then they observed physical and emotional symptoms, followed by a gradual reduction in their interest to act, and in their capacity to act in their own interest. Their narrative builds their experience as it unfolded over time, with them sequencing how their illness became more real as their everyday functionality became more negatively affected even though they could not fully understand their experiences. What is significant about this mapping is that it reveals to their peers the process that mental illness can take in an individual's lives, and that this process becomes observable to self as it directly affects the things in their lives that they value.

Table One: Awareness of Mental Illness
Michelle
I started losing my grip on my happiness, I didn't realise it, I was just in this rut and I was just doing everything, I had no time for myself, I was just going going going going…It's almost like your emotions don't exist, like you have a paper in front of you, you do the paper, you have no feelings about this paper, you not anxious about it you don't think that its good or bad you have no feelings you just do what you have to do and then ***I started sleeping a lot****, at the time I didn't know that oversleeping was a symptom of depression, and I was really, I was just, I ended up in this state where I didn't know what to do…I wasn't eating* ***I was crying all day*** *I got really small…I was either not sleeping or I was sleeping too much…because I was living on my own my family didn't know and for better or for worse I don't like to tell people things…I was miserable,* ***I couldn't do anything****, everything was going downhill, I was going to classes and I was doing things and I just couldn't make and I just kept trying to do it and my boyfriend was like you cannot keep doing this because he saw it happening he said I know you want to I know you want to keep doing this but you can't do it, you going to wear yourself down and you not going to be able to finish…he saw me cracking…I had an assignment to do but I was looking at this assignment and I just couldn't do it, I couldn't understand the words, I would sit down take up my pen and not be able to write and…I am a writer, it doesn't matter if I don't know anything about a subject I can write about it. I have been a writer for my whole life I love books I love words I've been writing stories for my whole life…so when I picked up a pen and I could not form a word on a paper I realised something was wrong…I couldn't write, nothing was coming it was like my mind was blank…people were talking to me and I would be like, what? What did you say? And I was asking people to repeat things over and over again and I'm not accustom to that I'm accustom to my mind going like…I'm here and we're talking here and my mind is here and people are talking to me and I don't understand the words that are coming out of their mouth and I was just like no,* ***something is seriously wrong****. And the other thing that made me realise was I had this dress, I really liked this dress, and I put on the dress and it fell off my shoulders and I was like ok so then I said you know what I'm going to go on the scale so I went on the scale and I was 130 pounds which sounds like a normal weight until you take into account that I'm 5'10", and I called my boyfriend and I said babe am I really this small and he said yes you*

are tiny you have not been eating and I open my fridge and there was nothing in the fridge and I realise I couldn't remember the last time I ate something…and I was having some huge lapses in memory …and there was a day I had a midterm and I slept through the midterm, I slept for 16 hours straight and when I woke up I realised…and then I called my boyfriend and said I need to see somebody and I went to CAPS [Counselling and Psychology Services] at HSU [Health Services Unit]."
George
I found myself feeling very overwhelmed and feeling despondent, getting feelings of less than, feeling devalued in some way, feeling disappointed in some way…the thing about University life I realise that everything happens so fast pace, it's very dynamic so you faced with a situation and before you know it there is more load coming on and there is more load piling up and for me that was the greatest factor, I was feeling like there is load coming on and load coming on so, before you know it the semester start before you know it it is over, if you miss a week it means that you have to dig deep and somehow I found myself not getting the drive to dig ***deep and I found myself covered in my sorrows and feeling sorry for myself*** *and finding to reframe it in a way and say here what happen you have life it can't be that bad… there was lot of mixed emotions, there were times that I was very angry with myself, there were times that I tried to compartmentalise it there were times that I felt sorry for myself but most of the feelings were one of disappointment and anger…****all you want to do is just sleep…****I say I will start tomorrow, I get up tomorrow I feel more overwhelmed I go back to sleep again I'll start tomorrow and every day you become more overwhelmed because time is going you not taking those steps and you become just so overwhelmed and overwhelmed and overwhelmed…I got into a sense of acceptance with my less than ambitious behaviours so you start feeling comfortable in your sorrows and that is also associated with the depression, I tell myself you know maybe you can't do this and then I started to become very reserved not setting goals because I know I'm going to fail anyhow so I'm not going to set this goal…and that is part of the disease too I believe sometimes you have to go through those stages before you actually come to that place where you know you get up, there is that ah ha* ***moment I can't take this anymore****, you feel like you're disembodied you feel like you floating but yet your legs are heavy, it's a whole set of emotions you confused you angry and those mixed emotions they can do things to you.*

Angela
Well my first experience was in Form 6, it was very strange….that was a time of a lot of change among my peers and ***I felt like I was just stagnant*** *because I wasn't changing like everyone else and I didn't want things to change but I wasn't aware that I was feeling a certain way about it, um, and then randomly eventually* ***I would just sit in class and start to cry*** *and I couldn't understand why and it gradually became worse…so I could just be in a normal class and this feeling of sadness would just overtake me and the tears would come and I would have to put my head down on the desk and is not like something I could have stopped, is not something like I was oh I'm feeling this way let me leave because I didn't really have a reason to feel like that…no to my awareness at the time…and I didn't really decide to go for help, um well I went to a Catholic all girl school and of course there were nuns and I was in girl guides and one of the nuns was actually the head in my school so she knew me very well and word got around that something was going on with me because my teachers saw it as well and I exploded on a teacher, that's the point when they were like something was up, and it was something so silly, looking back on it now, but I exploded and then she came and asked me what was going on if I was ok and I just told her everything, and at that point she said ok we do have a school councillor, who I was not aware of, because it was an outside person who would come in twice a week and I was introduced to her and when I told her all my symptoms and stuff she suggested that I go to my current psychiatrist…****I definitely thought that something was wrong because I've always been in tuned with myself*** *and I was always classed as a very sad person growing up, I would cry like that, and I was always really anxious as well and I thought this was just me growing and its growing with me so I could tell like something was wrong, like I shouldn't be this sad and I always tried to fight it but I couldn't explain it but then I was aware too of the possibilities because my grandfather had schizophrenia which was diagnosed really late and so did my uncle and so I was like ok, I wonder if its connected to* ***that so I thought ok something is up its very possible that something is wrong I never doubted*** *that but the feeling that something was wrong with me like I'm going crazy was always there too because you never want to admit that something is up, you want to believe that you normal, I'm one of the normal ones and I saw what schizophrenia did to my grandad and my uncle and I was like I'm not going to get there. So one part of me was open to any type of intervention but the other part of me was like no because then I'm admitting….*

Sheniece
In terms of clinical, it was when I was around 20, 21 years old, and it was something ***I chose to go because it was getting to a point where I couldn't function****, like I would have panic attacks, I would have anxiety, I would physically get sick all the time, nausea all that. So I decided to go to the UWI Clinic that they have, which was free, and is there that I went through the whole process and they would have diagnosed me there. In terms of inclinations, it was probably when I was doing SEA, um I didn't have the language to express I had mental health issues but* ***I knew something was definitely wrong*** *in terms of how I dealt with certain situations, how I would get anxious, like students usually get anxious for examinations but it was to the point where I would vomit every morning and I would have like this breakdown every morning before I go to school and I would just be overthinking things all the time, things that a 10 year old does not think about I would be thinking about so…I found it hard to trust persons because I wasn't sure of their intentions, also I would obsess about death a lot, not to the point of suicidal thought, but just like if I enter a car I would think of five different ways I could die in this car, I would think what if my mother dies, what will happen to me, or I would worry about my mom and her capability of financially raising me, so I would do things to suppress that, if I wanted something I would stop talking, I would be very reclusive, it just affected how I communicated a lot, and even up to this day I can't express my emotions properly ….and it comes to a point I would find it very exhausting…I realised my anxiety came to an intense part when my grandmother died because then someone had left me* ***and there was a point where I would just cry****, and it wasn't just grief I couldn't wrap around the fact that someone was no longer there…my ground zero was before she died, which would have been when I was 20, 21,* ***I remember just like not feeling to get out of bed*** *and then I realised this is not even just anxiety this is like a sort of depression that I'm feeling and depression came with my anxiety over failing at school,, and that was a new thing that happened for me, like I never felt that, and because UWI was a new, I wasn't aware of the structure, there are times when the classroom is large, you are just like an ant in the entire eco system and there are times when you question your own capability so I started to really like not want to go to class, want to stay in my room, cry, I even wanted to take a year off, my father refused for his own reason, and* ***I just thought to myself I can't do this*** *and because I'm so attached to achievement I couldn't see myself just flunking out of University.* ***So I knew, I said I need to go and get help, I need to talk to somebody****, I need to*

express to somebody how I'm feeling and like why is this so intense to the point where like I can't even function, and then you know the chest pains and then feeling like I can't breathe and the paranoia that I had, and I just said that ***I cannot do this anymore, I couldn't fake through or function through it anymore****. Up until that point I knew something was wrong but what?*

Resisting Cultural Stereotypes and Expectations:"Everybody, Somebody, People"

In Table Two below, Michelle, George, Angela and Shiniece all express a clear awareness of the persistent relevance of social and cultural perceptions that affect how mental illness is viewed as legitimate or not. They describe the feedback from others outside of self, they express frustration, and they assert some resistance. George again differs from his peers, he recognises the impeding effects of stereotypical beliefs but he does not assert his negative evaluation similarly to his female peers, rather he suggests that it reflects his own self-evaluation, "I felt that way too". Again, this difference is noteworthy but I do not claim its significance as an indicator of a particular gendered perspective. What is clear from these accounts of the perspective of the other is that for the three female respondents, they clearly reject such stereotypes and expectations, and evaluate such as a lack of understanding, which negates the relevance of any advice or commentary based on these. The value of their perspective in this conversation with their peers is to offer them a plausible attitude to the insidious influence of dismissal, marginalisation or stigmatisation, discussed earlier as factors which continue to undermine treatment of and respect for individuals living with mental illness. I suggest they legitimize, in their assertions, the ability to reject limiting beliefs, and this could be a very useful step in address the challenges of mental illness because it opens up more possibilities for self-motivated action by the individual.

Table Two: Resisting Cultural Stereotypes and Expectations
George
"Everyone believed I had the ability so the feedback was like George you playing the ass you need to get this, George what is wrong with you, you know, and that kind of reinforced the feelings that yeah something was actually wrong well, something was wrong with me you know…I think in terms of depression ***people don't take is serious****, they tend to categorise it under different problems, you lazy what wrong with you, I can only speak from personal experience, and I felt that way too"*
Michelle
"Honestly if somebody today were to come and be like it's all in your head, I would be like how you so sure what is in your head because…you don't know and as rude as that might sound that is what I would tell them because first of all you have no way to judge ***you don't know****…I don't want to hear go and pray about it or God will help you because I feel like if I'm told that I would try to strangle someone"*
Angela
I think people have always had problems. But if I look at my parents who would have had certain problems but they were taught to deal with them in a certain way but you know coming into the 21st Century the problems aren't the same but we have the same solutions which doesn't make sense, it's not the same people, the world is changing, we have new things hitting us as young people like social media, that they did not have long ago, ***how are you going to tell us to deal with it now****, something that you may not have had to go through, you can't just give us old tools to fix new problems, and I think we were not taught the proper coping mechanisms you know.* ***They don't understand*** *what we're going through and until they sit and have a conversation with us and really get to the bottom of things they're always going to think that we're making up things because you've never felt what we feel now, you can't really help.*

Sheniece
At the end of the day, people's mental health issues have to exist in a space where people don't care and if you're in a culture where people really don't understand how difficult it is for you to even get up in the morning appear in a workplace or appear in a classroom and function to the capacity which is of their standard you have to find some way or else you will crack, you need to go in St. Ann's, something wrong with you, "everything always wrong with allyuh children" you know like "allyuh too soft, we never had no anxiety long time and thing and we had to tote water" and not understanding…but you have to understand that the expectations of us have risen…and the first thing, for me as a woman is that woman is emotional and you pms-ing, and all these comments happen and, "shake it off na", if I could I would. It is the most internal excruciating thing you can ever feel because it's like you cannot get rid of it.

Strategies for Managing Mental Illness as a Student: "Find Your Anchor"

The evaluations asserted in Table Three below by the four students are profound in their juxtaposition of what works for them personally, what does not work and what is necessary to successfully manage living with mental illness. With varying degrees of detail, they cite their personal support system or supportive factor, alongside clear psychiatric intervention. What is quite revealing in all their stories is how they clarified how, through a clear "anchor" and help-seeking behaviours1 they moved from considering the finality of suicide to successful treatment. This testimony builds a clear path for their peers, offering strategy and admitting to challenge simultaneously, it lays bare the profound experience that mental illness is, but it offers hopeful solutions and the possibilities for a better life experience.

Table Three: Strategies for Managing Mental Illness
Michelle
"I went for counselling but I didn't like the counsellor ***so I decided to try to fix me on my own and that didn't work… do not self-medicate****, medication is dangerous to play with and some medication can make you worse…in the same frame if your psychologist tell you to take medication please take it…I hate medication and at a point of time I stopped taking it, I was on like four medications and I hated it and they were trying to figure out what works, it took me almost a year and a half to find a medication that works for me so I stopped taking that medication and it made me drowsy and that was a mistake, it made me a lot worse and that's how I ended up in the hospital because a lot of time when you taking medication and you stop it can take you into suicidal thoughts…if you think meds not working for you just tell the doctor and if you don't have a good doctor you need to find a new doctor****. I would say to use your support system you need a person or two or three not a big support system, but you need two people****, why I say two people is because expecting one person to support you all the time isn't fair and it could actually endanger their mental health…have people and have a professional…****I think you need to find an anchor****, it could be a very small anchor, like my anchor was my academics I know a person whose anchor is drawing another person is reading another person who is just going out and sitting down and looking at the sky and holding on to that anchor is what stops you from disappearing, from the time you lose that you're gone, I think if there was a point where I failed all my courses that would have been it like I would have had no anchor after that because that was what I was holding on to, I think for my other friend if somebody were to go in her library and burn all her books so you need to find that thing where nobody is around to judge you it's just you and that one thing, whether it is going out and swimming, whether it is talking to that one person, whether it is some random game on your phone that you want to play, whether it's a book whether you can draw or not, maybe its music, maybe it's this one song, that was something else, one song that you listen to for three hours use it find something and use that to escape and even if you barely holding on you will still be holding on until you not barely holding on anymore"*
George
*"****You should never diagnose yourself*** *you need to go to a professional, if you self-diagnose you continue the state of isolation and depression doesn't work well in*

*isolation as a matter of fact I think isolation encourages it to grow because you all by yourself you start to get those thoughts and there is nobody to express it to kind of identify what you going through…Get help get help you need to communicate…**I realised that my techniques were wrong,** you may feel the task is so unachievable and insurmountable but my technique was trying to do everything at the same time, which was totally wrong so what would have usually happened I try to do everything at the same time and end up not doing anything all the time"*

*"**I would have seek out help earlier**, from day one, and clarity too to get a clearer picture of what is really affecting you makes a whole lot of difference…you not alone…it's an illness and it can be treated, there is help, the feelings and the thoughts that you get, they are not strange because I remember at a time I did feel suicidal but **there were other things to ground me** like my family and so forth so I'm thinking ok you can't do this this is not a way out but for a student who may believe that's the only way out its real however help is available…**what would make the difference is that support system**, which was always there mind you, but you know you take it for granted, you need to make use of it…so you want to get help so you can be properly diagnosed and a treatment regime could be designed instead of you just there"*

Angela

*In my experience, from where I am coming from, **you need to be willing to sit with yourself, but before you can sit with yourself you need to sit with somebody else** who can help you to sit with yourself because yourself is the hardest person to be with, especially if you're dealing with like self-hatred and doubt and all these things, looking in the mirror is hard, and until somebody is willing to sit and listen to everything and ask the hard questions, are you feeling this way, can you admit that you're feeling this way, what is really going on, how are you feeling, which is a question that I ask all the time, and all the time it might be a different answer, but until you can sit with yourself and call your emotion out for what it is you will always be battling with what the world is saying and how I should feel and you know it's bad for me to feel like this and I mean sadness is not a bad emotion but it's the behaviour that you attach to that. Confront yourself….**Sometimes you do need medical intervention**, sometimes you do need to be on the medication and you need other kinds of advice because I also had to start exercising as well and its all of those things mixed together that really got me out from where I was. Because I have definitely got to that point where you know like I was done and I got close to that point many times but there was that one time where I couldn't really bring myself out of the*

darkness and I was ready to end it, and I mean I was so close because I mean I had antidepressants at my disposal, I mean you hear all these stories of people overdosing and I was like this might be the least painful way to go, at that point I didn't care, I was like I had a whole box I could just take it but ***my faith was always something I could cling to*** *and I always found some peace in that quiet and there have been times where I have experienced that relief and comfort that it will get better, that's where I found my escape.*
Sheniece
I agree with them *that you have an anchor and it is that thing now that helps you to function, it helps you now to feel grounded, it helps you now, I shouldn't say that, to come off as normal because you don't feel normal, you are aware of yourself and what you go through. For me I've only had one point where I had a thought of taking my life but because of* ***how grounded I am in my spirituality and my sense of self I was like ok, no, and then I would have gone to my therapist*** *and talked about that and we would have discussed what really went on there.*

Conclusion

These students together tell stories that clarify the experience of mental illness, how they came to terms with the experience, what social ideas they now confront and how they applied treatment strategies that worked to improve their lives. These students establish how close individual experiences can mirror each other. They carve out routes for action and they present an encouraging voice, a voice that demonstrates how, though confronting challenges, they were able to harness available resources to help them live with mental illness and still achieve their goals as students. Crucially, their shared experiences demonstrate the necessity of readily available and reliable treatment options for students who need help or need to understand how to seek help within their learning environment and beyond. The support systems – the anchor - they refer to as conditional to their thriving, and the need for professional services to enforce their healing, demonstrate the necessity for sustainable investment in

and development of trusted mental health services on university campuses. I contemplate here my starting question, how does a student meet high expectations, achieve tangible goals and thrive while managing the challenges of diagnosed mental illness? While the peer-to-peer conversation I stage in this paper is a crucial mechanism, a teaching and learning environment that recognises the complexity of the psychosocial conditions that mediate students' lives is mandatory.

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[1] Figures collated by Dr. Sarah Chin Yeun Kee, Student Counsellor - Student Counselling and Psychological Services. Details suggest increasing access to CAPS – Counselling and Psychological Services.

Students Accessing CAPS Services	**2006-2007**	**2007-2008**	**2008-2009**	**2009-2010**	**2010-2011**
Total # of Consultations Offered	547	2100	1355	2046	2226
Total # of Students	584	670	459	515	606
# of **First Time** Students	257	309	314	364	424