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Abstract

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As colleges consistently document rising rates of mental illness and counseling centers struggle to keep up with rising demand for services as well as increasing acuity of symptoms, university mental health systems have adopted various techniques and best practices to respond to students who are struggling with mental illness. Yet there is a profound lack of in-depth qualitative research understanding the nuances of student experiences within these mental health systems and the various ways that stigma, injustice, and *misfitting* take place within these sites of supposed support. Briefly tracing some of the dominant forces that shape our cultural understandings of mental illness, I argue that Emory University's mental health system is characterized by the influence of historical and contemporary forces that have long submerged the mentally ill subject to the psy-complex's discourse of pathology, depoliticization, and biomedical clinical authority. Drawing heavily from disciplines of mad studies, critical disability studies, medical anthropology, and social justice theory, this thesis project engages with student testimonies—some anonymous, some not—about their various experiences within and against Emory's clinical infrastructure and the various moral hazards that have arisen, broadly understood as various sites of what disability studies scholar Rosemarie Garland-Thomson calls *misfitting*. This project does not seek to reject the entirety of Emory's mental health system as broken and flawed; instead, it seeks to understand its ideological underpinnings and problematize what I call a *telos of management*—a system interested in fixing, preventing, identifying and referring, and ultimately expelling students who are struggling with mental illness who *misfit* the mental health system and our broader Emory community. Concluding remarks are offered as a general blueprint for future research and policy orientation for universities with an emphasis on the importance of developing *epistemically just* research methodologies and practices to disrupt a long-standing history of discrimination against the mentally ill. To that end, strategies and research from disability and mad studies offer crucial ways to "talk back" to the dominant clinical infrastructure and to works towards a *telos of care* that is interested in how we can resolve *misfitting* rather than responding through solely clinical means.

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Acknowledgements

Perhaps the single most important page of this entire document and, subsequently, I have absolutely no words to do it justice. I'll invoke my favorite Jeanette Winterson quote from her book "Lighthousekeeping" instead: "the true things are too big or too small or in any case always the wrong size to fit the template called language."

With more gratitude than I'll ever be able to communicate in language, music, or through any other means, this project would have not been possible without the revolutionary and life-changing kindness that my advisors and committee members have shown me. For rewriting the very fabric of possibility for me throughout this thesis process and far, far beyond: thank you for truly supporting me these past four years. This thesis would not be here—as both an incomplete process, and as an endeavor literally unable to be completed for numerous reasons—if it were not for each pivotal moment along this journey where each and every one of you reached out a hand to ground me here, perhaps with no true realization of just how much each tiny moment of resurrection meant to me.

To Caroline Schmidt: thank you for believing in me and for all of the ways that you altered the very fabrics of my reality to allow me to exist as I am and to engage in this work. To the infinite kindness, patience, and faith of Jennie Jiang: I am immensely grateful and undoubtedly saved in many ways by your grace. Lastly, to my partner through all of this, Maggie Mang: your positive audacious was undoubtedly the catalyst behind a project that dared to "talk back." Thank you for your courage, your light, and the indelible.

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FORWARD

Dear Emory

Student 1: "You're not trying hard enough"
Student 2: "You need to care more about class"
Student 3: "Have you considered just dropping?"
Student 4: "I mean, surely *you* don't want to be just charming and manipulating your way through the system by waving around your ADSR forms right? You're here to be a student!"
Student 1: "Emotionally disturbed students are beyond my pay grade"
Student 2: "I'm sorry but the rules are the rules—the syllabus has made clear from day one that you only have 3 absences because this is a discussion-based class"
Student 3: "You *have* to leave school—go home, get better, recover and then come back or you're throwing away your education"

—*Student performance*
"Once upon a time"

I just want to be left alone to be depressed in peace please

—*Cierra, first-year student*
"Untitled"

Being told you're not "normal" and that you're "broken" sometimes doesn't leave you with very many options. I just can't tell if I'm supposed to apologize for my existence the way I am or try to mold myself into something different.

—*Myself*
Journal entry

My professor told me, "Friends are important, *but* you made a commitment to be in this class. I understand that your suicidal friend made an attempt on her life, but on Tuesdays and Thursdays from 10-11:15, this class needs to be your number one priority. When I interviewed you at the beginning of the semester, I thought you were going to be the best student in this class. That's not what I've been getting from you. This is the second class that you have missed. You're welcome to withdraw."

—*Kisa, second-year student*
"Once upon a time"

It's about having to explain exhaustion.

Do your bones ever forget they're not just steel? That they're also exhausted? Those pillars of steel are tired of holding a person together. Tired of holding a dream together.

We're judged by our times in how fast we finish the race but can't you just acknowledge that standing on the finish line is in itself a miracle?

It's about having legs of steel. A will of steel. A backbone of steel. And God forbid you don't fight for yourself! Because no one else will. It's about fighting for everything you have and everything you want.

—*Alexa, first-year student*

CHAPTER 1: Constructing a "counter-diagnostic" epistemic disobedience

On navigating this text as a conduit of power

HELP ME…

…or so says the palm of the disembodied hand—implied to be that of a college student—written in faded black marker. The emotional image is positioned at the center of the grayscale cover page of the 2016 special issue report on student mental health from the *Chronicle of Higher Education*, followed by the report's declaration of an "Epidemic of Anguish" in today's college students. The included articles go on to detail a "crisis" in today's youth: an overwhelming prevalence of mental illness in students that is overwhelming college counseling centers across the nation, the high stakes for students and faculty alike as both groups foray into uncharted waters on balancing student mental health with academics, and the complex politics of higher education institutions trying to figure out how to respond.

On a surface level, it is this narrative of a mental health system—that just can't seem to get its act together in the face of staggering amounts of students expressing severe mental distress—that has been the central organizing force behind this senior thesis. But I must admit, this nature and scope of this project has changed quite a bit. Many of you readers will remember my initial fixation with some sort of novel therapy that could help students, grounded in music. From there, my attention turned to the broader Emory mental health system—the policies, structures, and research efforts. Having spent the last year and a half at the frontlines of this "epidemic," I have seen time and time again the "life-or-death importance" of these "day-to-day trenches" of student lives (Wallace 2009, p. 1).

While always true (the personal is always already the political, as feminist and social justice theorists have long pointed out), the lines between academic research and personal politics became quickly blurred in ways that were both challenging yet ethically necessary. Ethical research doesn't simply mean having informed consent forms and obtaining approval from the IRB—ethical research requires recognizing that researchers in any capacity (even undergraduate students) are "conduits for power," producing knowledge with direct material-discursive implications for human beings (Eisen and Berry 2002; Bourgois and Schonberg 2009, p. 13; Parr 2007).

Putting on a different hat, acknowledging my role as a "student leader" on Emory's campus (whatever that actually means) required a similar confrontation with the associated privilege of student power that that entails. By both chance and effort, my work in mental health advocacy had been noticed by key administrators in Campus Life who saw me as an advocate and representative of students with mental illness. Consequently, my "work"—the summative collection of this project, my efforts in student-led organizations, my coursework, and my personal life—became an unrecognizable (even to myself) marriage of real-time mental health support for peers all the while grounded in rigorous academic inquiry. What this has yielded is a senior thesis "product" that looks quite unlike what I imagine most other theses that you are reading look like. Similarly, the numerous unconventional "products" of this project—the birthing of a student organization and community space for students with mental illness, the small degree of administrative reform that we have pushed for—are absolutely relevant to what I present to you as the reader below, yet are things that cannot easily be captured in a Word document.

I write all of this out for the reader to chew on for three core reasons. First, let this serve as my advisory to the reader about both the potentially triggering, sometimes explicit content that follows. Second, a contextualized apology to my reader—unlike the neat timeline and organization of what a different project might look like, as my work has transformed it has also yielded a thesis process and final document that can, at best, be lovingly described as a beautiful mess. But thirdly and most importantly, understanding *why* this project is what it is—its ethical, personal, and political origins and context—has crucial implications for its ability to communicate its message and fulfill its purpose.

As a project that has been developed intimately alongside (rather than simply about) students with mental illness, I see this document as part of a larger effort in certain social sciences, disability studies, psychiatric anthropology, and an evolving critical psychiatry discourse to include the world-views of us mentally ill and elevate our voices (Price 2011; Parr 2007; Lewis 2006). I need to be absolutely clear to the reader / audience: this project is as much a musical composition as it is an academic essay—it is as much a performance of resistance as it is a Campus Life document with (sometimes not very clearly labeled) recommendations for improvement of the student experience. As evidenced already on the opening page, direct passages from interviews, student performances, written student work, and student narratives submitted anonymously via an online form, are selectively employed throughout this compositional process (I should briefly note that there are a few instances where I have omitted and rearranged smaller portions of longer narratives to help contextualize and illustrate distinct analytical points).

What follows is my attempt to produce a document that reflects the realities of the context of this project, that destabilizes the power relations embedded in producing knowledge about mentally ill subjects that has historically justified discrimination and marginalization, and that—both explicitly and implicitly—emphasizes the need for research to employ methodologies and produce scholarship that both accesses and includes the "voices and affectual worlds of people with severe and enduring mental health problems" without turning us into beatified caricatures or spectacles (Parr 2007, p. 115; Bourgois and

Schonberg 2009, p. 5). Perhaps this is the meta-level conclusion of this thesis: in the face of now almost three decades of counseling centers and colleges grappling with trying to make their mental health systems fit the needs of an "epidemic" of students struggling with mental illness, a new epistemic politics for approaching the issue needs to be taken seriously (Mowbray et al. 2006; Jones and Brown 2012; Nishida 2015). While obvious in theory yet elusive in practice, the starting point for this process *must* be the un-sanitized, un-tampered with voices students who are struggling.

But bringing in the voices and perspectives of those who have "lived experience" with mental illness and who have been subject to the psychiatric system is much easier said than done. From contemporary autoethnographies to personal storytelling to memoirs, the epistemic imperative of amplifying and empowering those with lived experience has been one of the primary drivers of social change both within and outside of the psychiatric system (Costa et al. 2012). Yet in much the same way as cultural critic Judith Butler argues that individuals are opaque even to themselves, the process of giving an account of oneself is a project that is fraught with risk (Butler 2005). Especially against the backdrop of a history of systemic exclusion, marginalization, discrimination, and violence, providing personal accounts of mental illness is constantly at risk of cooption, dismissal and delegitimization, and re-inscribing the very power relations that such an act may be seeking to disrupt (Costa et al. 2012; LeBlanc and Kinsella 2016; Castrodale 2017; Mitchell and Snyder 2000.)

This text is my best attempt to use what disability studies scholar Margaret Price describes as counter-diagnosis: rhetorical, compositional techniques that reclaim authority as a disordered mind not in spite of psychiatric disability but because of and through (2009). Indeed, not just with bringing stories of students with mental illness, to be writing and speaking as an openly mentally ill speaker is to leave the reader with fundamental assumptions and questions that implicate the ability for this text to be "received and respected as valid," and thus *necessitates* an attempt at constructing a counter-diagnostic gaze through my writing (Price 2009, p. 12). While the evidence-based health sciences tend to lump such phenomena into the vacuous catchall word "stigma," we might think of this more in terms of what another key figure in rhetorical and disability studies, Catherine Prendergast (2001, p. 56), calls this the "rhetoricability" of the mentally ill subject (Corrigan et al. 2005). To Prendergast's point, this has nothing to do with syntax, grammar, or vocabulary and instead everything to do with the ability to be read as a valid, credible, and rational subject.

Following some strategies that Price traces in her work, here are some of the choices I am making to gaze back at that which says we are "emotionally disturbed" and in need of "fixing" (Rosenbaum and Liebert 2015). First, subverting the rigidity of academic writing and tone is one attempt to move outside the language and affect of technical rationality. As such, this text has somewhat liberal use of informal language, avoids an objectifying analysis of student testimony as "case studies" or anything other than voices to directly insert into this text, and oftentimes includes personal voice and reflection rather than pretending to detach myself as a speaker—an insertion of the politicized *I* that actively proclaims the validity of a psychiatrically disabled standpoint (Price 2009; Menzies et al. 2013). This text also sometimes directly addresses the reader; Price describes this as a tactic of "unveiling the jury" (2009, p. 27) to engage with the *you* as an active participant in this text's endeavor in meaning-making and questioning, rather than a passive recipient of words on a page that will be filtered through existing frames of reference. Lastly, reflecting the disordered narrator, this text is *filled* with strategic incoherence and dissonance in its organizational flow and insertion of the voices of students to counter and challenge the impulse to erase the incoherence of the mad narrator (Nicki 2001).

> What happens to the "productivity" of an academic writer who struggles to achieve the linear coherence that most academic writing demands? Or whose disability affects the many self-directed stages of writing and revising—initiation, organization, seeking and applying feedback, completion? Why, indeed, is "coherence" one of the most-often emphasized features of a thesis-driven academic argument; does the demonstration of coherence indicate a stronger mind?
>
> —Margaret Price
> Introduction, "Mad at School"

Epistemic disobedience through interdisciplinarity

> I did *not* recognize for some time the fact that people who had never been labeled mentally ill – as I had been – and who were thus sane by default, had access to privileges that I did not. I was aware of the discrimination I had faced as a "mentally ill" person, but I accepted that oppression. I believed, at the time, that I was sick, and I believed that this sickness caused me to hurt myself and others. Should I not then, I reasoned, be restrained by the straightjacket of unequal treatment? It was only later when I came to reject the medical model of madness that I questioned my own internalization of an oppression I came to know as saneism [sic]. Though I began to think through the idea of saneism at the same time as I got free of psychiatry, in 2005, I only started to recognize sane privilege recently, as I have increasingly gained that privilege myself... Since people have not always treated me as though I am reasonable, trustworthy, safe to be around, and capable of taking care of and making decisions for myself, because they knew I had been diagnosed as, or they perceived me to be mentally ill, I very much notice it now that they do treat me as though I am all of these things most of the time. Now that I am experiencing it, sane privilege has become obvious to me. It is not necessarily so obvious to those who have never lost that privilege. (Wolframe, 2013a, paragraph 6-7)

Cultural studies scholar Walter Mignolo, focusing on issues of the subaltern in Latin America, the colonized, and epistemic and linguistic racism, argues for what he calls "epistemic disobedience" and a politics of knowledge that works to actively disrupt its onto-epistemological assumptions that are rooted in racist colonialism (2009). This concept resonates powerfully with a similar disruption process that occurs, as the above quotation from mad studies scholar PhebeAnn Wolframe describes, when the mad subject begins to generate knowledge about the world and herself outside the epistemic confines of the medical model's "straightjacket." More than anything, this project is an attempt to grapple with this strategy of epistemic disobedience and to use this lens to then reexamine the mental health crisis in higher education. What new solutions are suggested? What criticisms reveal themselves? What has been hidden in plain sight for so long that it has become natural and acceptable?

I do not think this unraveling process would have been possible without an explicitly interdisciplinary focus on thinking through evidence and the wide variety of literature bases that I have drawn on. This is, in part, due to the essence (or perhaps lack thereof) of interdisciplinary inquiry. As interdisciplinary studies scholar Simeon Dreyfuss (2011) describes it, the nature of interdisciplinary inquiry is not only a matter of identifying and exploring points of convergence and divergence, resonance and dissonance, between disciplines, but also as something far more ephemeral than what is visibly integrative thinking and inquiry—it's something he calls "holding in relationship different ways of knowing." As such, interdisciplinary truth, if there were such a thing, Drefyuss asserts, is necessarily phenomenological and thus necessarily partial and emergent, as opposed to fixed and complete. But the very fact that I'm "turning this in" and "defending" it seems to imply some degree of completion, fixedness, and finality to what lies on this page—in short, on its surface, the antithesis of Dreyfuss' articulation of interdisciplinary work.

To that end, if the central exploration of this paper is about mental illness, college students, and the existing and potential systems of power and epistemology that dis/empower, un/support, and in/validate these students in a university setting, an interdisciplinary inquiry mandates a prior understanding of a social history that has worked to suppress, dismiss, and deny the knowledge, experiences, and perspectives of those who are labeled as mentally ill (Jones and Brown 2012; Price 2011; LeFrançois et al. 2016; LeFrançois et al. 2013; LeBlanc and Kinsella 2016; Corrigan et al. 2005; Lewis 2002; Lewis 2006). Importantly, the long history of the exclusion and marginalization of these 'mad minds' is predominantly *invisible*—both in bodies of knowledge *disguised* as "care" and/or "cure" as well as *internalized* in the complicated, psycho-emotional ways that we experience internalized stigma, discrimination, and self-hate—creating the conditions by which we become the "agents of [our] own subjugation" (LeBlanc and Kinsella 2016; Corrigan et al. 2005; Kaufka 2009).

What this means as far as *this* text is less academic in nature: it means that it's difficult to understate the weight that I feel is carried in each and every word that I invoke—micro moments that reflect broken-glass windows and mirrors of these immaterial disciplinary disagreements "held in relationship" together that produce very material *consequences* for myself and the very many others that I'm in constant contact with who also identify as mentally ill. What does it mean to "tolerate," as Dreyfuss (2011) puts it, the conflicting, contradictory perspectives of psychiatry, mental health nursing, counseling, anthropology, and disability studies, and more when there is (or feels like there is) *so much* at stake, if only for my own relation to this text and these experiences? If discourse underlies the production of power that is creates the condition of possibility for dis/empowerment, how do I "know" or triangulate the knowledge produced by, and reflected in, each and every one of the paragraphs in this paper when the

If the above concerns are those regarding the knowledge that is the generat*ed* "end" of this project, then it's also important to reflect upon the concerns regarding the knowledge that is generat*ive* "means" that informs the atomic makeup of each thread of discursive fabric upon which this project lies. If our inquiries into "truth" are necessarily phenomenological, then Dreyfuss (2011) is also asserting a position about the nature of the inquirer—a position that I agree with and is fundamental to my approach to this project and the world. Against the hegemonic pressures to adopt the standpoint of the objective "expert researcher" who is utilizing "objective," "empirical," and "evidence-based" health science epistemologies and methodological frameworks to produce knowledge, (true *especially* in 'mental health' related disciplines), one underlying axiom of this project is that the "truths" we pursue do not come from a "view from nowhere," even we lay claim to the legitimacy and supposed "objectivity" that our contemporary society affords to evidence-based health science's "culture of no culture" (Shapiro 1998; Holmes et al. 2006; Taylor 2003). But this greatly complicates the process of this interdisciplinary balancing act and leaves me with a variety of other unanswered questions.

How do I "hold in relationship" not only the aforementioned distinct discursive communities (and their takes on the "truths" related to mental illness) but also the first-hand testimonies of my peers, and myself, as generators of legitimate knowledge? Further, how do I dialogue these personal experiences with the broader meta-narratives of the discursive communities in play (in the epistemic arena of mental illness) that both inform and shape the very experiences we're speaking about (Russo 2016; Russo and Beresford 2014; Bolt and Penketh 2015)? Lastly, and perhaps most importantly, how does one account for the fundamentally *unequal* claims to legitimacy, validity, and value of these different sources of knowledge (Dreyfuss 2011; Fricker 2007)? Why are certain voices, certain epistemologies, and certain modes of knowledge production present, while others not, in the discursive communities that have formed around the topic of mental illness? To be at all effective in working towards the goal of social justice, it would seem that an interdisciplinarian's process of analysis and dialoguing contradictory perspectives must work to be as *equitable* by keenly discerning, and accounting for, the ways that knowledge is generated and judged—as both reflection and conduit of a broader context of power—*inequitably* (Bourgois and Schonberg 2009; Holmes et al. 2006; Hall 2011).

Foucault (1973) describes this imbalance as the work of "regimes of truth"—regimented, regulated, and institutionalized versions of culturally permissible "truths" that hold the privilege of authority and validity, displacing the multiplicitous nature of "truth" and working to silence alternative modes of "truth" and truth-seeking. Juxtaposed against this are what he calls "subjugated knowledges" that are disqualified as inferior, lacking in scientificity or rigor, and naïve—in contrast, these knowledges are those that "arise from below" and are particular knowledges, "local, regional, or differential" (Foucault 1973; Holmes et al. 2006). The specific manifestation of the consequences of hegemonic regimes of truth and the historically pervasive disqualification of the "subjugated knowledges" of those labeled as mad / mentally ill is perhaps not all that difficult to see (not even just because Foucault's seminal works focused primarily on the topic of 'madness' and the 'clinical gaze' of the emerging 'clinic'). Indeed, throughout this project, the consistency in which the voices of those who are deemed mentally ill—whose thoughts, experiences, emotions, subjectivities, and *knowledge* have become pathologized by the dominance of contemporary psychiatric discourse—are both chronically *absent* and also *discounted* in discursive communities and practices that are, in theory, supposed to work towards supporting these individuals was disheartening to say the least (Jones and Brown 2012; Price 2011; LeFrançois et al. 2016; LeFrançois et al. 2013; LeBlanc and Kinsella 2016; Corrigan et al. 2005; Lewis 2002; Lewis 2006).

The influence that this critical knowledge gap has had in the construction of this project cannot be understated. Combined with a "hidden curriculum" governing what "good," "valid," and culturally permissible research on mental illness looks like—the unacknowledged, informally taught norms and "rules" that students internalize that I have been socialized into long before even entering my undergraduate career at Emory—this knowledge gap has worked, from the onset of this project, to constrain and limit the epistemic boundaries and possibilities of my thinking, of my language, of my orientation towards knowledge, and thus the interdisciplinary "holding" process of this work (Margolis

2001; Hafferty 1998; Dreyfuss 2011; Appadurai 2000; Fryer-Edwards 2002). While this mostly has meant that it took me an immense amount of time and critical reflexivity to begin to truly produce research that (hopefully) "makes a difference" from a "view from below," each sentence becomes all the more supersaturated with risk of discursive violence as I have begun to recognize the dangers in how I've internalized the above "regimes of truth" (Parr 2007; Condrau 2007). I fear—no, I *know*—that the "unraveling" process is far from complete, and perhaps never can be. While I can recognize myself as quite the lowly undergraduate, I am simultaneously left wondering: to what extent is this paper merely a reflection (or worse—a reproduction) of the very discourses and claims to "truth" that have justified and undergirded the violence of saneism?

These epistemological conundrums that surround and envelop this project leaves me with the unsettling feeling of trying to settle upon a reflection of myself that feels most "true" and most "valuable" whilst walking through a daunting, frightening hall of mirrors. Fraught with distortions and illusions, the hallway projects an endless array of images back at me—images that, while they may be critiqued as problematic, cannot truly be understood as "inaccurate" as they are simply products of certain epistemic lens. Yet as much as I can discern and acknowledge the distortions, I have long since forgotten—or perhaps have never truly known—what my reflection truly looks like. How am I to figure out the distortion? Equally important is the question: how do I figure out the "right" reflection if those in the society around me, including the readers of this work, gaze at me with eyes that reflect the same line of distorted mirrors?

Misfits

Definitions and conceptions of madness are dynamic and ever shifting. From Ian Hacking's (1999) work on social construction to the postmodern critiques brought forth in

Michel Foucault's (1973; 1988) genealogical tracing of the classification of madness, critics of psychiatric discourse have challenged this historically emergent process of classifying madness as a site of inequity and violence. Although the logic of "evidence-based health sciences" may suggest otherwise, from the lobotomy table in the basements of asylums to the overly politicized construction of the contemporary Diagnostic and Statistical Manual of Mental Disorders (DSM), there has never been a neutral, ahistorical march towards an "objective" account of mental illness (Foucault 1988; Holmes et al. 2006; Lewis 2006; Clegg 2012).

As cultural critic and feminist scholar Susan Bordo has argued, a full account of the construct of psychopathology must recognize its identification and expression as a "crystallization of culture" (1993; 1997). From her perspective, interpretations of mental illnesses as explained by (and thus treated by) biological or psychological factors were failing to account for broader sociocultural problems. While Bordo eloquently and persuasively comments on the emergence of eating disorders as a prime example of a mental illness produced by deep "cultural disorders" rather than disordered individuals, many other scholars have highlighted the sociocultural influences that have led to the construction (and subsequent dissolution) of what Ian Hacking (1998) calls "transitory mental illnesses."

Extremely influential anti-psychiatrist Thomas Szasz broadly critiqued psychiatry as an institution of social control and coercion in his famous 1961 book, *The Myth of Mental Illness*, pointing out the ways that social deviants—the poor, homosexuals, women, ethnic minorities, and cultural Other—were medicalized as disordered or pathologized. Indeed, homosexuality existed as a diagnosable mental disorder in the official DSM until its removal in 1973 by the APA (Cooper 2015). Hacking (1998) traces the use of "hysteria" to pathologize women who began to challenge and question traditional gender roles as another example of transitory mental illness. As a final example (though certainly not the last), psychiatrist Jonathan Metzl's (2011) historical work tracing the changing representations and diagnoses of schizophrenia in the 1960's as a means of pathologizing "aggressive, delusional" black males protesting in the Civil Rights Movement is another excellent example of the ways that power, politics, and culture influence our not-so-neutral systems of mental health.

These histories stand in stark contrast to the onto-epistemic territories staked out by the psy-complex. Yet they are largely unaccounted for in the dominant contemporary psychiatric discourse—an extension of a broader history of battles of authority, of expertise, and of legitimate evidence in the enterprise that is modern scientific inquiry (Harrington 2008). Even with various pivots to "client-centered care," "consumer-informed" mental health systems, and theoretical turns to the widely influential "biopsychosocial" model or a "diathesis-stress" model, madness still remains quite neatly in the box of pathology—of illness, of disease, or disorder (Lewis 2006). And with the medical model fundamentally remaining intact in our dominant discourses and disciplines of madness, so too does the jurisdictional authority of the clinician and madness as a subject of study under the rational, evidence-based, yet detached "clinical gaze" become naturalized and normalized (Bordo 1993; Foucault 1973). In many ways, as Bordo (1993) writes, this medicalization occurs by design—ignoring the deep historical and cultural problems with the medical model of mental illness shields the psy-complex from losing the very basis of its claim to authority and expertise.

Thus, when returning to the questions of what Emory's mental health system looks like, the dominant biopsychiatric narrative of mental illness is all but uncontested in both formal and informal sites at Emory. Prominent sites of mental health support, like the

Counseling and Psychological Services (CAPS) as well as most student advocacy, are all inflected with biomedical psy-discourses of pathologization and depoliticization (Menzies et al. 2013). Post-psychiatrists Patrick Bracken and Philip Thomas (2005) argue that the modernist pathologization of mental illness has produced a few fundamental problems that are normatively reinforced and reproduced via clinical and popular discourse:

1. Mental illness *resides* in the individual's mind—these pathologies are disorders that are to be managed as potentially disruptive, dangerous; it is something to be "fixed" and "cured"
2. In the face of disordered patients who may not know what's best for themselves as irrational subjects, clinicians are the experts, the authorities, and the gatekeepers to support—if this denies the agency of the mentally ill subject, that's because it's necessary because the mentally ill subject is incapable of rational thought and making proper decisions on behalf of themselves

These broad forces underpin the architectural blueprints of Emory's mental health system—past, present, and future. The particular configuration of this mental health system is one that I describe as a *clinical infrastructure* for responding to student mental illness concerns. This version of mental health system is the direct product of the combined forces of biopsychiatric influence and the neoliberalization of the academy—influences that both shape the structures and discourses (related in a bi-directional manner) that take place within Emory's space. These underlying assumptions are the reasons why "destigmatization" efforts mean promotion of the medical model rather than challenging institutional discrimination (Corrigan et al. 2005). They justify the institutional management (via mandated medical withdrawals) and self-management (via therapy, medication, etc.) of mad subjects via the ableist logic that to be "abnormal" is problematic (Garland Thomson 2002).

This project focuses on the counseling center as a site of the problems of the clinical infrastructure that underpins college mental health systems, but the value of what I'm attempting to communicate here lies in the need to challenge the *entire* logic of the clinical infrastructure's *telos of management*. It is a politics of knowledge about mental illness that uses the prism of biomedical thought to preserve clinical authority over the mentally ill subject with the ultimate end of treatment and its care *about* the body as solutions to the individual's *impairment* (Davis 2002). It's about getting the individual to *fit* again, to be "normal" again, without changing the environment and structures that produce the *misfitting* in the first place (Garland Thomson 2011).

What we need to move towards is an epistemic disobedience that produces an *infrastructure of care* with its ultimate purpose being that of a *telos of support*—a system of care *for* the body that sees the problem as residing in the disabling effects of minds and bodies that *misfit* in a society, university, and community that "abhors" psychiatric disability as a failed, broken subject (Davis 2002; Garland Thomson 2011; Price 2011). While contradictory to the main focus of this paper, this means thinking about student mental illness not in terms of access to treatment at the counseling center but instead of a radical re-envisioning of the very fabric of our virtues, our discourse, and our academic structures to be more accessible, accommodating, and embracing of difference. Put more plainly: this paper is testimony to the inevitable ways that students who are struggling with mental illness will *always* misfit to some degree in the status quo's mental health system configuration. It is not meant to suggest that any individuals are incompetent clinicians, nor that these systems must be rejected wholesale. Yet we cannot, as we currently so often do, ignore the misfit simply because they are anomaly, minority, or simply not represented as meaningful voice. The conclusion of this paper discusses some of the ways that we can move *beyond* the (inevitably limited) central focus on reforming the counseling center towards rethinking what Emory can actually look like.

Yet for my conviction of the importance of reorienting the fundamental telos of how we respond to mental illness on campus as the conclusion of this work, it is important for the reader to note that this paper is not particularly clear on its vision of how to go about it. This is, to be quite frank, in part due to various setbacks and my own struggling with mental illness at the time of writing this paper, and thus the scale of my ambition to construct a clear vision of a blueprint for how to go forward had to be sacrificed along the way. But this also, in part, due to the stifled voice that has yet to be explored—and thus the importance of "talking back" even when certain clinicians or campus officials will, within the bounded rationalities of their own discourse, argue that these ideas are unproductive or simply "not useful." To that point, critique is actually the *most* imperative *starting point* for building a clearer blueprint going forward as failure to engage in such practices of epistemic disobedience will, as Mignolo (2009) suggests, simply re-inscribe the same logics that have perpetuated the status quo in the first place. This project is my attempt at giving voice back to myself, to us mad misfits, as an ethical and epistemic intervention to move Emory towards both a rupturing of existing onto-epistemologies of mental illness and a reconstruction of new questions implying new solutions, new voices bringing new perspectives, and the infinity of new possibilities that grows from radical critique.

CHAPTER 2: Misfitting in the mental health system: when madness "talks back"

The shape shifting counseling center

> I've never known someone to have a positive experience at CAPS…
>
> —*Anonymous, third-year*
> Mental Health at Emory: Anonymous Submission Form

Like most other national universities in the US, Emory's Counseling and Psychological Services (CAPS) is the flagship of Emory's response to meeting student mental health needs. As part of a larger suite of resources (to be discussed later), CAPS has established itself at the *center* of the university's mental health system over the course of its development. Like the center of a gravitational orbit, all mental health roads seem to lead back to CAPS. In some ways, this centralization has been incidental; in other ways, it has been by design.

Interestingly, while students and administrative staff of today's contemporary higher education scene may perceive counseling centers in this way—a sort of "mental health treatment center that happens to be on campus," as a Campus Life administrator once described it to me—this articulation of the role of counseling for college students is a far more recent development than many realize (Davis and Humphrey 2000; Mowbray et al. 2006). Most counseling centers in higher education institutions have their history in the post-WWII era. Facing a massive influx of veterans from the war entering colleges because of the GI Bill, psychologists worked to convince hundreds of American colleges and universities to establish counseling centers, bringing educational-vocational counseling to students who needed support with adjustment (McCarthy 2014). As the model became more widespread, national organizations worked to ensure best professional practices and standards were constructed. Starting in 1949 as the National Vocational Guidance Association, the national organization would go through a few name changes to eventually become the American

Board on Counseling Services by 1961. Throughout this shift, it expanded its function of approving, accrediting, and developing best practice standards for counseling center services to now include psychological services, a development that went far beyond the initial scope of vocational counseling (IACS 2017). As such, half of American higher education institutions had counseling centers by the mid-1960s, more than 90% of which also offered students psychological services, in addition to educational and vocational counseling services (McCarthy 2014).

Time skipping through the next few decades, the emphasis on the counseling center as an access point for students in need of psychological services only continues to grow (Gallagher 1996; Davis and Humphrey 2000). The pressure, expectation, and demand on the counseling center's role in student psychological, emotional, and behavioral health came both from below and above, with the 1980s and 1990s showing consistent increases in student's help-seeking behavior, demand for psychological services, and the university's increasing invocation of counseling centers as demonstration that their university has adequate psychological support for prospective students (Stone and Archer 1990). Yet at the same time that administrative officials were expecting counseling centers to keep pace with rising demand for services, a general fiscal climate of austerity left most university counseling centers struggling to stay afloat (Stone and Archer 1990; O'Malley et al. 1990; Bishop 1990).

The 1990s and 2000s begin to show a tone of "crisis" in the college counseling literature base. There is a sense of pressing urgency in many of the most cited papers during this time as counseling centers struggled in the face of the ethical conundrums of having to balance the clinical needs of students against both retrenchment of financial support yet increased administrative scrutiny (Gilbert et al. 1992; Much et al. 2009). Speculated as due to (1) more effective psychiatric medication enabling students who otherwise wouldn't be able to attend college to attend, (2) increases in the diversity of students who were less affluent and more racially diverse than previous generations of college-goers, and (3) decrease in perceived stigma, encouraging more students to seek help, college counseling centers were faced with a both increasing prevalence of psychopathology and increases in severity (Kitzrow 2003; Mowbray et al. 2006; Hunt and Eisenberg 2010). Who do you prioritize? Some students may be "too seriously" mentally ill to be helped, whereas others might not take the same priority as another student who is more "at risk" (Kitzrow 2003; Mowbray et al. 2006). What happens when you are still unable to accommodate all students?

At the same time as counseling centers are fumbling with these tough balancing acts, popular media attention painting universities as "struggling" or "failing" introduced a difficult public face to the precarious position of the college counseling center (Mowbray et el. 2006; Much et al. 2009). This attention was, in part, due to and exacerbated by high profile student suicides turned lawsuits against elite institutions like Brown, Harvard, and MIT (Appelbaum 2006; Kitzrow 2003). I want to highlight the Harvard case as a particularly important case in shaping future administrative discourse and liability reduction strategy in that the suing family was the family of Trang Ho, who was killed by her *roommate,* Sinedu Tadesse, who was "mentally ill." The 1998 lawsuit argued that Harvard was legally liable because of negligence and failure to adequately "monitor the troubled student" and "failing to provide a reasonably safe and secure environment" (Kitzrow 2003; Mandel 1998).

Combined with our national tendency to explain away white gun violence as pathological, high profile mass shootings at Columbine and Virginia Tech were seen as the consequence of unchecked "mental illness," leading to a proliferation of popular discussion, research, and college administrative response that centered on an emerging discourse of mental health services as a "safety net" against violence (Schuchman 2007; Davenport 2009).

All of a sudden, there has been a proliferation of “risk management teams” and “threat assessment teams” that involve college counseling centers for the purposes of identification, prevention, and monitoring “high risk” students who may pose a threat to themselves or others (Schuchman 2007; Davenport 2009; Hollingsworth et al. 2009; Goodwin 2014). While there isn’t an in-depth study examining this claim, given the high legal stakes of potential campus violence, risk management and violence prevention justifications do seem to be an emerging component of counseling centers’ pitches for increased resources and support when speaking to higher-ups in the administration and the board of trustees, cyclically solidifying a deepening “risk management” approach to configuring the student mental health system (Farrell 2008; Bishop 2010). And regardless of whether invoked by the counseling center or not, these discourses of risk and violence absolutely have shaped the perceptions and priorities of boards of trustees and other university administrators, not to mention students themselves (Davenport 2009; Price 2011). The expansive reach of the jurisdiction of counseling centers now include burgeoning cases of sexual assault as mandated by Title IX procedures, as well as facing demands for specific programming for black students and other students of color who are organizing around the mental tolls of institutional racism and discrimination (Brunner et al. 2014).

If this feels like a mess, that’s because it is. Beneath the deeply complicated and high stakes nature of these issues, perhaps the most basic misconception that serves as the starting point for this incoherent system is the university’s decades-long expectation that college counseling centers can, and should, address this wide range of emotional, behavioral, and psychological challenges facing a college campus (Kiracofe 1993; Much et al. 2009). From psychological services for mental illness, to threat assessment teams, to community referrals, to group therapy sessions and outreach efforts, the contemporary college counseling center sounds like a mental health chimera. Counseling centers, to their credit, have done their best to keep pace with these unfair, yet inevitable expectations and roles through researching innovative techniques for students, introducing new options at the counseling center, and a variety of other administrative and campus life partnership approaches to meet a campus' mental health needs (Brunner et al. 2014).

To that end, numerous "novel strategies" and innovations in practice and structure have emerged in the contemporary counseling center. To address high demand in the face of static and (sometimes actually shrinking) staff sizes, counseling centers have introduced a waitlist system that, based off of a clinical intake process, *triage* students in much the same way a hospital might be based off of the acuity of symptoms (Hardy et al. 2011). Counseling centers have also imposed limitations to the overall amount of sessions that a student is entitled to, as well as sometimes limiting students to therapy sessions once every other week, rather than once a week (Mowbray et al. 2006). At a few colleges, counselors are encouraged to refer students who have insurance out to community providers, whereas other colleges have counselors encouraging students to try going straight to group therapy instead of pursuing individual therapy (Gallagher 2015). Crisis appointments and walk-ins are available in limited supply for students who are experiencing an emergency but do not have an appointment ahead of time (Mowbray et al. 2006). Outreach services tend to be done through workshops, psychoeducational programming, and public health-informed strategies for prevention tactics and messaging to promote help-seeking (Gallagher 2015; Parcover et al. 2015). Lastly, according to the most recent survey of national counseling center directors (Gallagher 2015), one of the most important developments has been the increase in campus collaborations across divisions and departments (in partnership with Campus Life divisions that focus on minority students, international students, and offices of health promotion and sexual assault prevention).

Emory's mental health system

Emory's mental health system finds its current configuration in the above forces and developments. I will briefly summarize the major players and services available for students as important context.

Emory's CAPS and the broader mental health system at Emory reflects many of these changes and shifts in college counseling, as well as many of the problems that affect counseling centers across the nation. Emory's CAPS has a consistent waitlist that is addressed in a variety of manners that parallel practices at other universities. According to the assistant director of Emory CAPS, there are currently nine full-time senior staff members with seven trainee, yielding a grand total of 16 staff supposed to be addressing the mental health needs and challenges of all of Emory's undergraduates *and* graduates. Of course, with accreditation standards recommending a 1:1000 ratio as an *aspirational* "best-practice," it's difficult to complain that this is anywhere outside the norm (IACS 2017).

> When I asked what was being done to increase CAPS's capacity to host students, I am told that this is "how counseling is at college campuses" and told how much better Emory is than other college campuses.
>
> —*Anonymous, fourth-year*
> Mental Health at Emory: Anonymous Submission Form

From talking to the administrative directors of the center as well as the experience of myself and other students, it is clear that these strategies include a shifting mix of the following: (1) limitations on total services allowed (the total amount depends on the semester—at one point in my time here, it was 10; this semester the cap is 7 sessions), (2) having some students see a counselor bi-weekly, rather than every week, (3) encouraging students to utilize alternatives to individual counseling such as group therapy, the CAPS biofeedback or stress clinic, and (4) maintaining a waitlist based on acuity, with students who would "not benefit from short-term psychotherapy" referred out to community providers. Other than individual counseling, CAPS also offers a "stress clinic" focusing on psychoeducational approaches to managing stress, a biofeedback clinic. In order to ensure that students are properly examined beforehand and appropriately placed, students who are interested in any of CAPS services—not just individual counseling—must first schedule an intake appointment where they fill out the CCAPS-62, a clinically validated questionnaire specifically designed for college counseling centers (Locke et al. 2011).

But additional mental health resources other than CAPS are part of a larger Emory mental health system. In light of the need for "case management" services to provide support to, as well as monitor, at-risk students, two other offices become involved in this process of identification. One such office, one that primarily markets itself as for crisis situations, is aptly named Student Intervention Services (SIS) and is housed in the Office of Student Success Programs and Services (OSSPS). SIS consists of a team of campus life administrators who maintain a 24/7-crisis hotline phone, managed and directed by two licensed clinical social workers who serve as directors of the office and case managers who help students. The other major office is the Office of Undergraduate Education (OUE), where academic advisors, deans, and other administrative staff are housed to help coordinate academic relief for students who are struggling for whatever reason. OUE is the primary go between for faculty who are concerned about students and students who wish for the office to communicate on their behalf if they are experiencing issues with mental illness that affects their ability to be in class. To my understanding having, discussed the topic with all three offices, CAPS, SIS, and OUE form the core of a weekly meeting where administrative staff from all three meet to discuss at-risk students.

Note that most of these folks are licensed *clinicians*; even many of the deans and academic advisors in OUE have PhD's in counseling psychology or some other form of psychology. Note also the strategies—like weekly group meetings—of working across offices to identify and develop intervention plans for students of high risk. Lastly, the weekly meetings seem to be a standalone example of cross-divisional collaboration—the exception, not the rule. Instead, because of confidentiality issues, CAPS, for example, cannot contact OUE to advocate for a student who is expressing difficulty with academics because of their mental health concerns. Similarly, if a student walks into SIS after contacting the hotline because of expressing suicidal thoughts, the most the director can do, as far as getting that student access to support at CAPS is, as she said to me in an interview, walking over the student to CAPS. And whereas a student who is going to CAPS seeking mental health support because their parents are unsupportive or financially unable to support that student seeking support from an off-campus therapist may be able to receive some financial support from SIS and OSSPS, CAPS counselors cannot contact OSSPS on the student's behalf, *nor* do they make clear to students in intake or regular appointments that SIS/OSSPS resources exist, *nor* do they make clear to students that if they are struggling with academics, CAPS *cannot* provide any written documentation, a "doctor's note," or a diagnosis for students to submit to asking professors.

These bureaucratic issues of cross-divisional coordination need to be seriously considered when working to develop a better network of appropriate care for students. The confusion and lack of transparency on all sides is frustrating to students and administrators alike, leaving students feeling lost in a system that takes, at best, weeks to navigate. This general state of disarray amplifies the individual student's tendency to default to seeking help first at CAPS, as the only clear resource that students connect to the topic of mental health is CAPS.

As noted in the introduction to this chapter, CAPS is certainly situated at the center of the above mental health system in the eye of the student. The reasons for this are wide-ranging in scope, but the two most important reasons to students seem to be the fact that (1) it's free and (2) the "mental health training" that is given to key student leaders (Orientation Leaders, Residence Life Staff, etc.) is a presentation by CAPS professionals that simply goes over CAPS services and, at best, sometimes includes training in basic identification and referral techniques (with the ultimate goal of these trainings being referrals back to CAPS).

Convenience and ease of access also matter—and with students who are studying away from home without consistent access to transportation and who may feel generally more comfortable finding support on a campus that they feel even mildly acclimated to, these are no small considerations. Add to that the high-stakes pressure that students feel and with an "elite institution" like Emory filled to the brim with students who tend to take their academics and student obligations very seriously, most students have articulated to me how difficult it is to even "find the time" to go to CAPS in the first place, let alone go off-campus to seek support. To be clear, it's worth briefly remarking that student success stories with referrals are far and few between. Frequently, there are an overwhelming amount of ethical, policy, and structural barriers that prohibit a smooth referral process (Iarussi and Shaw 2016). The idea, then, that students in the midst of struggling are able to just pick up the phone and call a variety of numbers to be successfully filtered into care is unrealistic at best, and dangerous at worst.

I will note one additional element of relevance: Emory also leverages a $78 student mental health fee that goes towards meeting the "mental health needs of students" and promising, according to the CAPS website, "improved access to services," "increased health education programming," and "more visibility and awareness of our services through a campaign to reduce the stigma students may feel in seeking the help they need." It's a small fee per student perhaps in the grand scheme of a whopping tuition cost, but I raise this factor specifically as another key detail shaping student expectations. As the CAPS website describes, "student voices were instrumental in the institution of this fee" and students had to vote in a well-popularized and widely discussed referendum. The resultant expectation was, indeed, that all students would and should be able to find mental health support at CAPS.

Unsurprisingly, when students run up against a long waitlist (again, CAPS policy suggests students can expect to wait between two and four weeks) or are referred out to community providers, students are upset, feel abandoned, and ultimately feel that what has been promised to them has not been met. In my public and private conversations working with CAPS administrators to try to work out some of these issues, the most common refrain in response to these sentiments has been the pushback that these students have "mismanaged expectations." Indeed, my conversation with CAPS assistant director focused on the need for students to move from being "uninformed consumers" to having a realistic "expectation about what therapy may be—part of the messaging needs to be you need to develop accurate expectations about what the experience can be like" (that's a direct quote from our interview).

> Dear Emory, I would like you to know that many close friends of mine have struggled on this campus with a multitude of issues that are currently impacting their mental health. They reached out to CAPS on campus and were turned away, with reasons like "you need help from another group" or "we cannot help you here". This is unacceptable. My peers need help and assistance, and you as a university have promised that to them. Fulfill that promise or clarify what you actually stand for - which is clearly not your students.
>
> —*Anonymous*
> Dear Emory Photo Project

I hope it's clear from my above articulations of the mental health system from the student perspective that I am skeptical of reducing student critique to inaccurate "expectations." My first large problem is its failure to acknowledge culpability for those "expectations." Put more simply, contrary to a bunch of students simply showing up at Emory feeling "therapeutically entitled" to unconditional, unlimited mental health support, student expectations are actively produced by the help-seeking and outreach programming of CAPS, the training programming that is interspersed by CAPS and the administration throughout our college careers, and by promises from the administration of support (Mowbray et al. 2006, p. 229). The thinly veiled shifting of blame onto students for being "uninformed consumers" is frustrating, to say the least.

But what concerns me far more is the way that this narrative—a narrative of student critique as "frustrations" due to "mismanaged expectations" coming from "therapeutically entitled" millennials who will eventually need to learn how to "face the real world" (all things said to our faces during administrative meetings reviewing student testimonies)—shuts down a critical dialogue that *needs* to take place about the confusion and oftentimes contradictory politics of the counseling centers as they themselves fumble and trip over their own set of mismanaged expectations. It's a position that, once adopted, *only* hears "false expectations" rather than legitimate critique. And it sanitizes the ways that students who are already struggling end up lost, confused, and hurt in a system that feels like a failed "meritocracy of suffering" by repainting them as solely a matter of accurate understanding of policies and services offered. Students who say, "CAPS was a terrifying experience" (Ellie), or who walk away feeling like they would "have to make a suicide attempt" before meriting a higher spot on the waitlist (Tiger) have their experiences "flattened" into what is *solely* a marketing problem: the “mismanaged expectations” of an “uninformed consumer” (Rosenbaum and Liebert 2015, p. 191).

On the contrary, it’s not that these students—that we—don’t understand that there are resource constraints, that there are policy limitations, and that (as the assistant director put it when speaking with her) counselors are “working their butts off.” It’s that students are taking on the brunt of the consequences of an incoherent, ineffective, and structurally flawed system, and they are rightfully upset and willing to challenge the normalization of these standards as “the way thing are” to push towards what “should be”—to challenge the claim that *moral fault* lies within our madness (Foucault 1988). In a different, yet related, situation where therapists were having difficulties balancing the system-level contradictions of managed care and psychodynamic clinical approaches in an eating disorder clinic, anthropologist Rebecca Lester’s (2009) conclusion seems resoundingly appropriate for describing what is happening here with students: “the philosophical and ethical incoherence of the health care system becomes displaced onto the individual client, who then carries the symptom of the system—it is she, not the practitioners or the health care industry, who is rendered fragmented, conflicted, and incapable of decisive action” (p. 293).

A few (rarely cited) voices in the college counseling center community have called for this type of critical self-reflection to happen, calling for dialogue about some of the most central, yet unquestioned assumptions of the literature base. College counseling center professionals Philip Rosenbaum and Heather Liebert, in their 2015 article “Reframing the Conversation on College Student Mental Health,” acknowledge importance of “interrogation and reflection” on the language, concepts, and theories that are invoked in the discursive community in order to hedge against the reality that even “our best intentions can become subverted, misinterpreted, and even misused by the broader context" (p. 181). The rest of this chapter attempts to take up this call.

Confronting Emory's clinical infrastructure

Pointing out the paradoxical ubiquity and vagueness of the term "mental health," Rosenbaum and Liebert (2015) go on to critique many of the unintended consequences of the de facto medicalization of student psychological experience by contemporary counseling center approaches. First, the dominance of *symptom management* is destructively reductive and "flattens" student experiences in deeply problematic ways, undercutting the therapeutic potential of counseling center encounters (p. 191). Second, there is an erasure of the *moral dimensions* of student mental anguish as experienced across different contexts interfacing with what brings students *to* the counseling center and what happens when interfacing *with* the counseling center. Third, epistemic power and agency over student bodies resides *solely* within the clinical authority—student knowledge and agency are subjugated and community support systems (i.e. peer support systems) are seen as unimportant or needing to be deterred.

What is special about Rosenbaum and Liebert's critique is not the arguments being presented but rather *where* it is being presented—from within the college counseling literature. As such, the language and discourse presented are deployed to fit the discursive community, even as they cite Foucault and Lacan. To repurpose their arguments and hold their points in relation with the other disciplines that I have been studying, what emerges is an excellent framework for thinking about different categories of consequences of our contemporary biopsychiatric discourse that permeates the psy-complexes. The above three points outline a critique of the invisible *clinical infrastructure* that naturalizes, normalizes, and justifies the college mental health system as we see it today (Lewis 2006). My intent is to insert the non-pathologizing discourse of anthropology, post-psychiatry, and disability studies to use Rosenbaum and Liebert's internal critique within the system (so to speak) to begin to collectively "talk back" to the authority that says this is "just mismanaged expectations" (Morrison 2013).

When adding in other disciplinary perspectives, an additional set of targets of Rosenbaum and Liebert's critiques of counseling center practices emerges. Rosenbaum and Liebert (2015) first introduce a somewhat cursory discussion of the different between brain and mind, between biological/neurological accounts of mental illness and subjective/phenomenological ones, and then move on to point out how the counseling literature base neglects to question some of its most fundamental assumptions about what constitutes "mental health" (and conversely, mental illness). They argue that this belies a far deeper critique of the field—a field that as a whole is awash in pathologizing onto-epistemologies of mental illness that seek to "normalize," "cure," and "fix" (Rosenbaum and Liebert 2015, p.186) the pathological mind (Menzies et al. 2013.) Stemming from these core assumptions in college counseling and reproduced by the fields of clinical psychology and counseling psychology that are feeding new professionals into college settings—as prominent researcher in the college counseling field John Bishop (2016) describes—what emerges is a set of recycled discourses and representations of the mentally ill student that naturalize and justify and even *necessitate* our marginalization and expulsion from the university community (Foucault 1988; Menzies et al. 2013; Price 2011; Castrodale 2017).

We are, after all:
"Emotionally disturbed"
"Psychopathological"
"Disruptive"
"The high-risk (disturbed and disturbing) college students"

Such securitization discourse of risk and threat management, especially when embedded in a larger system of discrimination against the mentally ill in the face of representations of mental illness as pathological "disturbance" leading to violence, justifies our surveillance, our management, and then intervention (Scheyett 2006). As Price observes (2011), it is important to understand the deeper message of SIS interventions, medical withdrawals, leaves of absences: get "normal" or get out (Rosenbaum and Liebert 2015; Castrodale 2017). Yet against the monopoly on authority that the clinical gaze holds wed in a marriage of convenience to the demands of a neoliberal academy needing to shield itself from risk, liability, and don the cover of "best practices" / "evidence-based practices," this narrative is not only seen as inaccurate—it's argued to be "dangerous" as we students do not have the clinical authority to know whether we are at risk to ourselves (and others) or not (Scheyett 2006; Szasz 1961; LeBlanc and Kinsella 2016; Castrodale 2017).

I guess what I'm trying to do here is strip away the "view from nowhere" that those in power over the mentally ill subject claim as a source of authority—to reclaim the voice of madness to begin to "talk back" (Shapin 1998; Scheyett 2006). This means calling out what anthropologist Janelle Taylor calls biomedicine's "culture of no culture," deeply linked with its source of power, authority, and claims to expertise (2003). Attempting to "talk back" has always, and will continue to, be met with a great deal of powerful resistance. As Susan Bordo already pointed out, the psy-complex has a deeply invested stake in positioning itself as apolitical and ahistorical in so far as "clinical best practices" used by these mental health centers (like the college counseling center) are the products of cutting edge, evidence-based standards on how to help people (1993). In perfect example of Fricker's (2007) concept of *hermeneutic injustice* (where the linguistic or conceptual templates to describe oppressive forces are missing), the truth is that this entire project struggles just to find the words and concepts to even begin to articulate these counter-truths, something especially true as a "disordered" mind (LeBlanc and Kinsella 2016).

But what lies at the heart of this project and the below analysis of experiences within Emory's clinical infrastructure is a politics of "talking back" that grounds our collective epistemic disobedience to the psy-complex's narratives of madness, necessitating that we begin to re-insert our voices. Literally, our voices. Not as testimonial objects to be measured in self-reports, case studies, or as sanitized storytelling promoting recovery narratives that don't fit our experience. But instead as human beings who deserve to misfit.

> And at what point will you recognize me
> Beyond a statistic and as a human being
>
> —*Ellie, first-year*
> "Untitled"

Treatment without healing

I am not a clinician. Yet we have to discuss clinical encounters. To that end, it is important for me to begin this subsection by flagging that there is an incredible degree of nuance, complexity, and skill that goes into the study, research, and implementation of evidence-based practices like Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) that I do not pretend to understand. I also want it to be abundantly clear to the reader that I do not mean to argue (1) that cognitive-behavioral therapies like CBT and DBT are not potentially incredibly rewarding and even life-saving for folks who struggle with mental illness, many of whom might (and probably do) include students at Emory or (2) that CAPS should simply disengage from these practices. Indeed, both CBT and DBT have been well documented to be effective (whatever that means) and both pair well with other evidence-based approaches like mindfulness-based stress reduction (MBSR) and other behavioral interventions such as exercise (Dimeff and Koerner 2007; Beck et al. 2015; Singh et al. 2008). But given these caveats, it is equally important to question the consequences of the dominance of these practices at Emory. In line with Rosenbaum and Liebert's (2015) broader critique, it is clear from conversations with students about their time in the therapy room, my own experience, and triangulating that against what CAPS administrators and counselors have shared with me that CBT, DBT, and other cognitive-behavioral therapeutic practices seem to best describe the types of practices that occur within the CAPS setting; that is not without its reasons.

For this discussion, a brief (and oversimplified) description of CBT is a necessary starting point. CBT is a short-term psychotherapy that focuses on changing patterns of maladaptive behavior and thought by identifying and then managing them by shifting people's appraisal of their thoughts and creating space between the individual and their afflictive emotions and behaviors (Beck 2011). In part because of its focus on tangible "skills" that one can practice and train in, it is often perceived as pragmatic and hands-on (Beck et al. 2015). As one of the most extensively studied methods of psychotherapy, CBT has established itself as a bastion of "evidence-based practice" (Butler et al. 2006).

A few things should stand out to the reader in the context of Emory's clinical infrastructure. Against resource and staffing constraints, CBT as a proven "evidence-based" short-term practice lends itself as a perfect fit for CAPS' interest in controlling overflow of student demand for mental health services by limiting the aggregate amount of sessions per student (described by their website as a "time-limited model of therapy"). Especially given those limitations, the feeling of tangible skills that one can practice outside the counseling center is also important for student satisfaction and feelings of control over their mental health—some students have verbatim said as much to me in conversations (Cushman and Gilford 2000). Lastly, CBT affords the counseling center a defense of its value as it offers students evidence-based, effective, and rigorously scientifically proven best practices. From the university's ever-cautious perspective, this accreditation of best practice is an important hedge against possible lawsuits, especially after several high profile cases against counseling centers in elite colleges taking place in the 2000s (Appelbaum 2006). As Rosenbaum and Liebert put it, "one purpose of the counseling center is to alleviate the anxiety of not only students, but also the college" (p. 186).

All that being said, many of the negative experiences that students have expressed can be linked to the misalignment between CAPS' over-focus on *symptom management* (as described by Rosenbaum and Liebert) and the dangerous reductionism that erases the cultural, social, and moral dimensions of what means to experience (any sort of mental distress, but especially) mental illness. Against the pressures of efficiency and administrative scrutiny, the student's subjectivity is lost in the long symptom list of the CCAPS-62 and the focus on the "objective" psychological symptoms that a clinical triage system necessitates focusing on in order to appropriately place students on a waitlist—in the process, the complexity of mental distress is reduced, standardized across different individuals, and is prevented from being understood by both the student and the therapist as *meaningful* (Rosenbaum and Liebert 2015, 186). A variety of problems ensure.

> Dear Emory, I would like you to know that it isn't just stress. That it isn't 'normal' for me to feel this overwhelmed. That it isn't fair that you made feel like I should just wait until January because I seemed 'okay'.
>
> —*Anonymous*
> Dear Emory Photo Project

> I was feeling like my world was collapsing last semester. I was never happy. I never did anything. I could not even get out of bed because it was too much. I felt empty. All the time. I went to CAPS and they said it was just because of finals and others are feeling the same way. **They made me feel like my problem was not a problem. They made me feel like I did not matter.** (emphasis added)
>
> —*Anonymous, second-year*
> Mental Health at Emory: Anonymous Submission Form

Emphasized by these students is the dissonance between the magnitude of the experience of mental distress and the language of symptom management that packages these complex experiences into more digestible psychological symptoms like “stress” and depressed mood. Especially in the second example, the clinician’s labeling of what is clearly a meaning-filled experience of suffering into an objective symptom of academic stress “because of finals” was deeply painful to the student who was clearly looking for something different from the clinical encounter.

> While Emory appears to place an emphasis on mental health on the surface, the university's approaches to confronting issues related to mental health on campus have failed to meet the expectations of countless students.
>
> As a student who struggles with ADHD and related learning deficits, I felt criticized by the psychologist in Emory's CAPS office when I tried to express my frustration with my faltering academic achievement and to seek strategies for overcoming the anxiety and self-esteem problems that stemmed from that frustration. The psychologist just appeared confused when I discussed these problems and really didn't display any sympathy; without offering any help or pointing me to any other resource, he ended up suggesting breathing exercises in order to mitigate some of the stress associated with schoolwork.
>
> **I was so disappointed and felt that my problems were invalidated** by this professional who, at the very least, had a responsibility to express concern about the actual issues I was discussing and to refer me to a more qualified individual. After that appointment, I felt a damaging sense of being "broken" – as if my problems were unheard of and there was no hope of reaching a solution that would allow me to live a happier and productive life. I never expected to feel this degree of insensitivity during a counseling session.
>
> **This particular encounter discouraged me from seeking further help for such a long period of time**, during which I turned to destructive thoughts and behaviors in order to deal with the emotions I was feeling. When these unresolved problems emerged again the next semester, I had turned to Student Intervention Services and initially received some better guidance through that department. My contact in SIS, however, eventually stopped responding to my communications and failed to follow up on the promises that she had made during our meetings in order to get me connected to the right resources.
>
> Moving forward, I believe we must strive to create a fundamental feeling of compassion and openness in all of the offices across the university that deal with mental health so that students can share their experiences and feel understood by a thoughtful and caring professional. Although I understand that my experience is not representative of all Emory students, I also don't feel like my experience with an ambivalent counselor was an isolated incidence based on my discussion of the mental health programs with other individuals on campus. (emphasis added)
>
> —*Anonymous, third-year*

Mental Health at Emory: Anonymous Submission Form

What this particular student's narrative adds is an explicit reference to the impact that these moments of reductionism have. The student describes what he felt was a lack of "sympathy" and "insensitivity" during the session stemming from the student expressing some of the deeper emotional and moral aspects of coping with his ADHD to be boxed back into "stress." Hearing that "breathing exercises" were supposed to help him control and manage his deeply meaningful experience of mental distress left two impacts. One, a feeling of "invalidat[ion]" predicated off of both the oversimplification of his distress to "stress" that could be solved by "breathing exercises" as well as, I would argue, the implied moral fault embedded in reducing the gravity of his frustration, anxiety, and self-esteem problems to something that could be resolved by breathing exercises (implying a small enough problem to be within the purview of his agency to control merely through such simple exercises). Yet, feeling that such advice was unhelpful, the flip side was also experienced after that encounter where the student felt "too broken"—the dissonance between feeling the magnitude of his distress and yet being told by a *clinician* that the best he could do were breathing exercises left him feeling like there were no solutions that would "allow [him] to live a happier and productive life." Ultimately, this experience caused the student to feel deterred from seeking help.

Tiger is a senior who struggles greatly with self-harm. With her somewhat dark sense of humor, that's why she specifically requested to be called Tiger in this paper. Tiger first sought support from CAPS her sophomore year, but was waitlisted and deterred from seeking help (the passage above from her testimony suggests this was the most salient reason for not following up: "I remember walking out of that session wondering if I had to make a suicide attempt for me to get off of the waitlist. I ended up getting a call a few weeks later from CAPS but I never called them back"). Two years later in her senior year, I had to doggedly chase after her to encourage her to seek support for her self-harm before she eventually agreed. The session didn't go well, to say the least. Between a few cultural comments that made Tiger feel reduced to a cultural caricature and her therapists' comment "sounds like you're going through an existential crisis" in response to her articulations about self-harm and other emotional concerns, the experience was deeply negative for her, to say the least. She never went back.

Whereas the literature (and really any human being) acknowledges the deeply psychological, emotional, and *meaningful* act of self-harm, Tiger's writes about her experience in her clinical encounter as her therapist responded to self-harm within the reductionist problem-fix logic of symptom management:

> Fast forward to first semester of my senior year. Things got to the point where I escalated my self-harm and my suicidal ideations. With the encouragement of a friend, I ended up making another appointment at CAPS. During the intake, I made sure to articulate my self-harm--and its escalation since coming back to school--and my suicidal ideations. My intake counselor in response to that recommended that instead of cutting, I hold ice cubes or just use a red marker next time. She made some implications regarding medication. I tried advocating for myself and made a specific request for a counselor over at CAPS. I was very surprised that I got a call from them within the next few business days to make an appointment. During my appointment itself, things went well for about the first half. I told my counselor of my escalating self-harm and in response they pulled out a book from their shelf and photocopied me two pages from the book. The pages, entitled "A big list of pleasurable activities", were for the next time I wanted to self-harm, and contained things like "read a trashy magazine", "masturbate," and "make a list of ten celebrities you'd like to have sex with and list why." My assignment, as I was told, was to work on cutting half as much and spend the other time going through the list and checking things off. If it didn't work the first time, I was supposed to go through it again.
>
> —*Tiger*
> Mental Health at Emory: Anonymous Submission Form

Because Tiger has insisted on sharing this journal entry that she wrote after this experience, I will simply insert it here instead of reproducing the same problematic reductionism of labeling, compartmentalizing, and mitigating Tiger's expression of suffering to some third-party laundry list of Tiger's emotional world. It stands as just a snapshot of a deeply meaningful psychological and emotional world that informs her self-harm and emphasizes the truly damaging interaction for her that took place at CAPS.

> These days, I hate myself more and more, and these days, I don't think I deserve to be here. I feel like a failure. I feel ugly. That I'm not "pretty". That I'm not worthy of being alive, that I'm not worthy of being a human being. That I spend too much time in my own muddled head and thoughts, wading through them as if they were a swamp with a viscosity so high it's bordering on being a solid. Or maybe a thick and dense patch of trees and vines that I do not have the strength to cut through. That my mind feels like it's been injected with an industrial-sized amount of anesthesia that I can't fight off and that rest is only an ephemeral break in the haziness and fog that is creeping into my life…
>
> …I just felt as I didn't belong in that space. That my problems weren't like theirs, that I didn't deserve to occupy the spaces that they do. That I don't belong. That I'm just making things up or calling out for attention. That I cut because I want attention.
>
> That I just want someone to look at me and sit me down and ask me how I'm doing. I just want to cry and sob and bleed to someone and have them tell me it's okay. That I want someone to take me somewhere and sit me down and tell me that it's okay. That they won't let me crawl back into bed and under a blanket of silence and "I'm fines" until I've sobbed until every inch of me hurts, that I've spilled to them everything that hurts. That everything fucking hurts. I want someone to look at me and realize that when I say "I'm okay" it really is a cry for help, a desperate cry for help. A scream masked by smiles and nods and really really *really* convincing ways to reassure people that I'm perfectly okay. Because it takes effort for me to open up; it takes a million and one genuine "No, really, how are you's" for me to even begin to open that lid. And who the fuck would do that, right? It's not fair for me to expect that, or even want that, out of anyone else. In an ideal world, it should take only one question—genuine or not—for me to break down to them and tell that I'm really struggling. That existing is hard. That it's a struggle. That it's like quicksand that, day after day, becomes quicker and quickersand. That who knew small things like just walking around and between people is enough for me to feel this despair? That who knew just the fact of waking up in the morning is an open invitation of this despair to hit me. There is no reprieve.
>
> And sometimes when I think I'm a shitty human being I need to cut myself to prove to myself that the blood is a validation of my being human. That I'm still human because I bleed, right?
>
> That maybe this despair is more than just an existential crisis. Unless an existential crisis truly means silently sobbing in the front row of your Philosophy of Literature class while your professor lectures on Vico. Unless an existential crisis means sitting on the bathroom floor of your best friend's bathroom with a knife you swiped from the kitchen and cutting your thighs and upper arm and being so satisfied that you were able to draw blood from yourself. Unless an existential crisis means being nanometers away from sobbing opening in front of your thesis advisor when he asks "how are you?". Unless an existential crisis means sitting in the corner of a [meeting] listening to other people talk about voting and the current political environment and internally thinking of ways to kill yourself. The logistics are so hard, too. Do you jump off of Carlos? Probably not high enough. Do you overdose on pills? Has to be the right amount and in the right dose. Do you hang yourself, but only if you find a place where you can tie the rope and know what knots to tie in the first place? Do you cut yourself, deeply this time, vertically and not horizontally, in the bathroom or the bedroom next door to the very residents you promised to watch over? Do you jump in front of a train that runs past the new Kaldi's?

> Unless an existential crisis means not reaching out to those around you, because you don't want to a burden to them. Unless an existential crisis means hating yourself, the way you look, the way you carry yourself, the way you simply exist. Unless an existential crisis means that you don't deserve to ask for help, because asking for help takes away the space for others to ask for help. And those deserve help more than I ever could and would. Unless an existential crisis means rubbing your cheeks raw from the tears you want to be soaked into your jacket sleeve instead of evaporating from your face. Unless an existential crisis means feeling inadequate. Being a bad friend, a bad student, a bad daughter, a bad human being. Unless an existential crisis means not feeling like your existence is subversive enough so therefore it's not meant to be.
>
> —*Tiger*
> Personal journal entry; October 14, 2016

For some brief context about the "big list of pleasurable activities," it is an exercise taken out of a DBT handbook. And to be fair, DBT has a large evidence base that supports its efficacy with patients with bipolar disorder—something that Tiger has never been diagnosed with and certainly doesn't self-identify as. While it's conceptually feasible that the single intake appointment that preceded this appointment included some sort of diagnosis, from my conversations with CAPS administrators it doesn't seem to be the case that the intake appointment—a single session and a the CCAPS-62 results which is *not* intended on producing diagnoses—is supposed to be the basis of some sort of formal DSM diagnosis that then leads to a particular intervention style. Instead, as Tiger shared with me about why this particular incident was so difficult for her, the photo-copied pages *out* of the DBT book was almost cherry-picked because she mentioned self-harm.

Beyond these individual instances of violent reductionism, there is also a broader critique of the *telos* of management and normalization upon which these practices are theoretically founded. By localizing the "problem" as residing (quite literally) within the confines of an individual's negative thoughts, negative behavioral patterns, negative emotions, etc., cognitive-behavioral practices reconstruct the mentally ill subject as one whose cognition *is* the source of suffering, needing to be managed, regulated, and beaten back into shape. The ultimate goal, then, is to return to a state of "normal" cognition—or at least, not "disordered"—to work towards erasing psychiatric disability in an overt will to normalize (Price 2011; Garland-Thomson 2002). Additionally, by managing an individual's mental distress as a product of their cognitive *reactions* to the world around them, we fail to critique the ways that the world produces psychosocial suffering (Menzies et al. 2013). In the context of power inequities and social injustices, as noted earlier, this issue takes a particularly sinister, even if well-intentioned, role as a potential mechanism of social control that stifles much-needed critique of structural violence (Fox 1999; Ussher 2010; LeFrancois et al. 2013).

In the context of Emory and college settings, this means tacitly accepting the legitimacy of a system of moral value that sees a "good life" in, as one of the students described it, the ability to be "happy and productive" again (Rosenbaum and Liebert 2015, p. 187). This cultural glorification of high performance as success, mental health as success, and the neoliberal academic mandate of hyper-productivity as success permeates our academic culture as moral referendums on what it means to be a "good subject" (Nishida 2015). And in the face of a college ranking system that rewards schools for producing more of these hyper-productive, "good subjects," it makes a great deal of sense why "students and administrators turn to models emphasizing relief and symptom reduction" (Rosenbaum and Liebert 2015, p. 188). It's a way to treat the symptom without questioning the underlying causes.

The CAPS waitlist and a "meritocracy of suffering"

> **How long does it take to get assigned to a therapist?**
>
> Following a student's initial assessment appointment, a recommendation will be made for services either on or off campus. If clinically appropriate, students can be referred for brief individual, couples, or group therapy at CAPS. There are also a variety of alternative and immediately available resources on or near campus.
>
> **In general, an assignment for brief therapy at CAPS will be made within 2-4 weeks** of a student's initial assessment. It is important to keep in mind that therapy assignments are made based upon a number of factors such as the time of the semester, a student's schedule

> of availability, and the urgency and severity of their concerns. If a student waiting for therapy assignment experiences a shift in circumstances, they may contact CAPS (either the clinician who conducted their initial assessment or the case manager) to update their information and discuss options for more immediate care either on or off campus. **Students who choose to remain on the waitlist** for assignment to a CAPS provider should talk with their initial assessment clinician for an estimated wait time, which in some instances **may take up to several months depending on various factors**. In addition to psychotherapy, CAPS offers classes on Mindfulness, Emotion Regulation, and Distress Tolerance. Students waiting for assignment to a therapist are welcome to attend any of these drop in classes to begin working on skill development in these areas. In addition, students can ask their initial assessment clinician about a referral to CAPS' Stress Clinic that utilizes state-of-the-art biofeedback equipment to help participants develop individually tailored stress management skills. (emphasis added)
>
> —*Emory CAPS*
> Frequently Asked Questions

Reading the above answer to "when can I expect to get help" makes my stomach churn. When the answer in the FAQ section to "how long" I might have to wait to see a therapist *begins* with a short paragraph about "alternative," "immediately available resources on or near campus," it's not a particularly encouraging sign from the perspective of the student. And while it's great to see that the website has been updated to reflect a more transparent estimate of wait times since we've started being more vocal in our critiques, it is also heartbreaking.

> She told me someone would call me within the week to schedule my first real appointment. I nodded and trusted and walked back into the lobby. **Two weeks and over 20 cuts later CAPS called me.** (emphasis added)
>
> —*Charlotte, first-year*
> Mental Health at Emory: Anonymous Submission Form

> For the initial assessment appointment, the prospect of it was the only thing keeping me going through my hardest weeks so it was frustrating that it wasn't sooner. So that kind of got to me, but what really got to me was when I heard that it was going to be at least two weeks for the next one…just kind of got upset because I didn't understand why I would have to wait that long after already waiting for a long time. So I actually started crying; it's not a good feeling.
>
> —*Anonymous, third-year*
> Interview

In general, students can expect to wait "2-4 weeks," based off of limited availability. While that might seem reasonable (given resource limitations), I'm less interested in whether it's "justified" and more interested in its consequences as students interface with the waitlist as some sort of neutral means of organization but as a *moral text*. When students who are feeling "depressed to the point of difficulty to function" (American College Health Association 2015, p. 21), we cannot write off the way students experience being told they have to "wait until January" (when asking for an appointment in October or November) as simply "frustration" born out of "mismanaged expectations."

> My first experience with CAPS came during my first semester sophomore year, where a bunch of events compounded itself to the point where I realized I should probably reach out for support. I ended up taking that quiz online one day when I was supposed to be studying for my orgo test and a few days later a counselor emailed back saying that she recommended I come in. I made an appointment and did my intake appointment. In retrospect, I didn't know how to articulate what was wrong or why I felt off (and didn't really feel comfortable doing so anyway), so I probably sugar-coated things or brushed things off when answering her. At the end of our session, she said that they didn't have room and would have to put me on the waitlist. **I remember walking out of that session wondering if I had to make a suicide attempt for me to get off of the waitlist.** I ended up getting a call a few weeks later from CAPS but I never called them back.
>
> —*Tiger, fourth-year*
> Mental Health at Emory: Anonymous Submission Form

In the face of a long waitlist and a triage system that is supposed to prioritize clinical need, Tiger's commentary represents the widespread phenomenon that I have seen where students internalize being placed as "low priority" on the waitlist as "I don't deserve support." What emerges from these student perspectives is clarity that, even though it's supposed to be an "objective" clinical assessment, it is difficult for students to not relate to the waitlist as a *moral text*—as an arbiter of a "meritocracy of suffering" (to borrow a term from humanitarian aid distribution). The logic follows that if the waitlist is produced via the clinical intake assessment that listens to my suffering in the context of others who are also suffering, if I'm lower on the list then I'm just not suffering as much and am less *deserving* of scarce mental health resources. This internalization of "I'm not actually ill enough to merit professional support" becomes further translated as *moral fault*—as that individual not trying hard enough, as simply seeking attention, as simply being weak (Rosenbaum and Liebert 2015).

On the other hand, in the face of the large waitlist, some students who do end up receiving counseling feel immense amounts of guilt—as if they are "taking someone else's spot" at CAPS and given that they feel they can simply "push through" or perhaps because they believe themselves to not be worth the trouble—as the mentally ill tend to feel—these students feel deterred from accepting or continuing services at CAPS when they might desperately need it.

> I have never felt that CAPS was an open resource without a diagnosis. Instead I have worked with the office of health promotion to promote wellbeing…
>
> I didn't know at the time that there were so many students being wait-listed for help and when I found out, I felt like crap. I didn't feel like I deserved to get help, yet I keep going in because it helps…
>
> —*Anonymous, third-year*
> Mental Health at Emory: Anonymous Submission Form

> I did start going to CAPS, but unfortunately did not find it very helpful. I felt guilty for "taking someone else's spot" given the waiting list. My therapist tried to assure me that if someone "really" needed help, they would be put on a priority waiting list. But I knew quite a few people who "really" needed help and were not being taken seriously. While I was in CAPS, three of my friends at Emory made suicide attempts. Additionally, I knew that there was a lot more that I needed to work through than could be covered in seven weeks, which made it hard to find meeting effective.
>
> —*Charlotte, first year*
> Interview

In response to this, CAPS administrators have pointed out that other factors affect when a student is able to start seeing a therapist, primarily the availability of the student's class schedule. Beyond the fact that I find that argument in direct contradiction to the clinical logic of the triage system (does that mean a student who is in need of prioritization who still wants to go to class has to wait?), it's also a non sequitur. Unless the clinicians at CAPS are *actively* working to frame their interactions with students who are being placed on a waitlist in a way that counteracts the internalized narrative of "lower priority," students will continue to be impacted in these ways. In the same moral fault logic criticized earlier, it is *not* the responsibility of the struggling student to be a more "informed consumer" on this issue—to have to navigate through that understanding by themselves, *especially* given the already established power imbalances between the clinician and the student.

An additional problem that emerges from attempts to both prevent a student from being added to the waitlist, as well as a strategy for when students feel "turned away," has been the suggestion to visit psychiatry at Emory's Student Health Services. My stance isn't that medicine isn't helpful nor is it inappropriate for such a referral to take place. But multiple individuals have expressed that, in the face of long wait times, they felt "pushed" by the offer to seek psychiatric support instead of counseling services through CAPS not because of a judgment that it would be more appropriate for them but rather because it was more accessible than therapy.

> Once in the door, things don't seem any better. The students who do intake appointments are generally under qualified. My friends have told me they felt like they were having antidepressants and leaves of absence pushed on them before they got the chance to even explain their situation.
>
> —*Anonymous, third-year*
> Mental Health at Emory: Anonymous Submission Form

> I went to CAPS in April last year. My cousin took me. They told me, "you know you're going to be going away for the summer, so we can't do any therapy right now. But you can go see a psychiatrist and they can give you some medication to get by over the summer." And I was like, I'm not just going to take medication without seeing anybody. I don't think that's an acceptable practice to just push people away and try that method.
>
> —*Anonymous, second-year*

With fears of the DSM-5 turning "normal" human life into pathology in part due to increased influence of psychotropic drug companies influencing the construction of diagnostic criteria and the public health messaging of mental illness experience as a neurochemical disorder, this trend that we must approach with extreme caution (Frances 2013; Rose 2003).

> Yeah, because so many people say "oh just go to CAPS"—that's the end to everything, as if it will fix everything. So when it didn't work for me, it made me feel even worse. What must be wrong with me that they can't help me?
>
> —*Natalie, fourth-year*

A final large theme that arises from student testimony about experiences at CAPS comes from those who are rejected from the waitlist but because their priority is *too high*. Citing their own limitations both in type of treatment offered as well as resource constraints, 83% of counseling centers, including Emory CAPS, maintain the right to "refuse treatment to a student whose problems are beyond the capabilities of the center staff" (Gallagher 2015). It makes sense, but that reality—and the frequency with which it seems to happen—is deeply problematic when combined with the large-scale messaging and training that students who are struggling with mental illness ought to seek help from the counseling center. To then be turned away as "too serious" translates to students as a different type of moral conclusion about themselves: that they are "too messed up" to be helped. This conclusion is *especially* salient given the general focus on symptom management in CAPS—to be too "serious" for symptom management strategies implies something "deeply wrong" and an inability to "return to normal."

> I have been to CAPS 2-3 times in the past year, and every time it is discovered that I have health insurance, I am simply given a list of names to call. **Additionally, I am told that I have too many problems for CAPS to handle – made to feel like I'm "too messed up" to be helped.** I have called every person on the lists provided, and have received no calls back. Even after expressing this difficulty in contacting outside mental health professionals, I am still simply given a list and told that Emory simply does not have the resources to handle all students, and to try again. (emphasis added)
>
> —*Anonymous, fourth-year*
> Mental Health at Emory: Anonymous Submission Form

> Once they are able to articulate their mental health issues, several of my friends have been sent away (or given a list of psychiatrists to call (not even a referral)) with the idea that they are "too complicated" for CAPS to handle if they have issues beyond simple exam stress. This also plainly sucks and leaves my friends feeling abandoned and beyond help.
>
> —*Anonymous, third-year*
> Mental Health at Emory: Anonymous Submission Form

It is with these students in particular that a mental health system in university that prioritizes accessibility, accommodations, and support is crucial for their ability to remain in school (Price 2011).

Encountering the "culturally competent" counselor

One other consequence of the symptom management approach lies in the way that counselors are trained in thinking about, integrating, and acknowledging a student's culture as it intersects with the meaning of their experience of mental illness and psychic distress. Demand for, and research into, "culturally competence" training programs for medical professionals and the health care industry seemed to proliferate in the 1990s and 2000s (Taylor 2003). In contrast, yet in parallel, interest in culturally sensitive practice for psychotherapists, social workers, and counselors seems to have arisen much earlier with multicultural theory giving rise to multicultural counseling theories and therapies that have long been taught, studied, and refined in psychology programs (Sue et al. 1992; Sue and Sue 1990).

Both of these trends were especially important in the context of college settings where the demographic makeup of students was becoming less and less dominated by upper-class, white students, leading to demands for college counselors to be adequately trained in multicultural counseling (Stone and Archer 1989; Kitzrow 2003). Rising populations of international students, especially from East Asia, also demanded shifts in college counseling center strategies for both outreach and therapeutic encounters given frequently vast cross-cultural epistemological differences in understanding and experiencing mental illness (Chen 1999; Mori 2000). A large focus of student affairs as well as counseling psychology literature consequently began to focus on the unique challenges that international students faced, acculturative stress that posed mental health risks to international East Asian students, and culturally derived barriers to help-seeking (Liu 2009; Han et al. 2013; Huo 2014).

Emory's counseling center has been, on face, attentive to these distinct cultural challenges. As the rest of the higher education world began to challenge itself to focus on diversity and inclusion, the administrative demands on the counseling center merged with longstanding student criticism that mental health resources needed to be sensitive to their cultural differences. Recently, the cultural sensitivity argument leveraged against CAPS' services has been somewhat dormant, at least at Emory.

Taking up the call of the CAPS' website's proclamation of an "ongoing self-examination of our worldviews and values to foster cultural competence," I'd like to argue that, in line with Stewart's criticism of the technical rationality of an "achievable" diversity or inclusion, I believe there is inherent tension in the theoretical frameworks of "cultural competence" and "ongoing self-examination of our worldviews and values" that the above statement of intent describes. I believe these theoretical contradictions are what underlie some of the negative cultural experiences that myself and other peers have experienced in the therapy room. Let me begin my briefly sharing as close as what I can remember from my intake appointment with an intern at CAPS:

> "I notice that you marked that you're of mixed ethnic heritage," Angela remarked.
>
> "Yes, my mother is Taiwanese."
>
> "CAPS offers group therapy specifically for students struggling with their ethnicity and race. Do you think that might be what you're looking for?"
>
> I held back my tone only just enough to thinly-veil my frustration. We were barely 15 minutes into our intake session before my distress was being linked to my racial background when I hadn't once thought, nor expressed, it to be relevant to what I was experiencing.
>
> "No, I don't really think that's a huge part of what I'm feeling here. I feel pretty comfortable being mixed race at Emory."
>
> Her face looked sour and she paused for a bit before asking me about my parents and what it was like living with two different cultures at home. About whether I had a good relationship with them or not. About the academic pressure coming from my mother.
>
> "Actually, my mom gives me no academic pressure, although I can understand why you might assume that." I tried to pivot the conversation elsewhere—really, anywhere away from the all-too-often imposed narrative of a "Tiger Mom" crouching behind whatever hidden psychological distress existed inside me. "You know, I really don't think this is that relevant to what's going on…"
>
> —Personal recollection from CAPS Intake Appointment, Spring 2016

In retrospect, my initial appointment with Angela typifies many of the problems that cross-cultural psychiatrists Arthur Kleinman (1988; 2007), Laurence Kirmayer (2007; 2012), and other proponents of cross-culturally sensitive psychiatric services outline in many contemporary clinical settings. These scholars have keenly noted that it has become quite “fashionable” for clinicians to become trained in “cultural competency,” even though there is no operational definition for what this term actually means when it comes to operationalizing it in a clinical setting (Kleinman and Benson 2007, p. 1673). Even as the importance of culture in clinical settings is acknowledged and becomes codified in psychiatric residence training programs and even the DSM-V itself as the Cultural Formulation Interview (CFI) is included in the updated version, these dominant approaches to legitimize “expertise” and “training” in culture have fallen short in several ways (Carpenter-Song et al. 2007). Central to these shortcomings is that such an approach—indeed, the very language of a “competency” to be cultivated in “culture”—implies that culture might be “reduced to a technical skill” (Kleinman and Benson 2007, p. 1673). Both the rosy language of “[multi]cultural competence” and its legitimacy based on clinician’s “building expertise” in such “competence” can be found extensively throughout the eloquent prose of Emory CAPS’ *Statement of Social Justice and Diversity* on their website.

Medical anthropologist Elizabeth Carpenter-Song and colleagues outline some of the resulting problems of a cultural competence approach in their synthesis of anthropology-based critiques of such a model (2007). Beyond reifying culture as a static and fixed entity to be accounted for in clinical practice, the cultural competence model leads to a variety of other fallacies including (1) reducing culture to a “property” of an individual, fallaciously conflating “culture” as only present in, and synonymous with, those whose race or ethnicity is “not like us” (to borrow the lovely language from the CAPS statement) and (2) essentializing culture, race, and ethnicity into stereotypes (Carpenter-Song et al. 2007, p. 1363). All of this is simply, yet importantly, to make the somewhat obvious point that just because a clinician is "trained" doesn't necessarily make them *meaningfully* attuned to cultural difference in a way that bolsters the efficacy of the clinical encounter *and* avoids perpetuating much of the same epistemic injustice done to cultural minorities in higher education (Beagan 2003). "Culture" is quickly refashioned by some therapists into an essentialized, reductionist blunt tool that is deployed at the first encounter of any sign of ethnic, racial, religious, or cultural difference (Engebretson et al. 2008; Kirmayer 2007; Kirmayer 2012; Kirmayer and Ban 2013).

From my interviews and dialogues about student experiences inside the actual therapy room, Tiger—American-born Chinese female—stands out as a particularly good example of these problems.

> Fast forward to first semester of my senior year. Things got to the point where I escalated my self-harm and my suicidal ideations. With the encouragement of a friend, I ended up making another appointment at CAPS. During the intake, I made sure to articulate my self-harm--and its escalation since coming back to school--and my suicidal ideations. My intake counselor in response to that recommended that instead of cutting, I hold ice cubes or just use a red marker next time. She made some implications regarding medication. I tried advocating for myself and made a specific request for a counselor over at CAPS. I was very surprised that I got a call from them within the next few business days to make an appointment. During my appointment itself, things went well for about the first half. I told my counselor of my escalating self-harm and in response they pulled out a book from their shelf and photocopied me two pages from the book. The pages, entitled "A big list of pleasurable activities", were for the next time I wanted to self-harm, and contained things like "read a trashy magazine", "masturbate," and "make a list of ten celebrities you'd like to have sex with and list why." My assignment, as I was told, was to work on cutting half as much and spend the other time going through the list and checking things off. If it didn't work the first time, I was supposed to go through it again.
>
> I tried to be vulnerable and open with my counselor and told them that I felt so, overwhelmingly guilty for being here when just the other day, my friend had expressed surprise when she had heard I got an appointment within days when she had to wait about a week or two. My counselor looked over at me and said, in quite an accusatory tone, **"That's quite collectivist of you. Really?" But apparently it wasn't that surprising, they said, because those mentalities were common for people of East Asian descent.**
>
> Toward the end of the appointment, I ended up opening up about feeling anxious about what I was going to do post-Emory and they said, in response, "Sounds like you're going through an existential crisis." At the end of the meeting I didn't really feel better, and in fact, felt invalidated and even more guilty. **So I cancelled the rest of my meetings and never went back.** (emphasis added)
>
> —*Tiger*
>
> Mental Health at Emory: Anonymous Form Submission

Speaking with Tiger later, she vocalized a similar dissatisfaction with the "cultural competency" of her therapist. She mentioned that after bringing up that she was afraid of going to medical school but wasn't sure how to say that to her parents, her therapist responded with "oh, that makes a lot of sense, you're coming from an East Asian household so of course there would be a lot of parental pressure" (directly quoting Tiger from our conversation; as Tiger admits, the exact phrasing during her CAPS session may have been different). More upsetting to her beyond the default assumption of her own set of "tiger parents," however, was the moment where her therapist told her "that's quite collectivist of you." As Tiger describes it, this ascription of her emotions to this cultural phenomenon that was "common for people of East Asian descent" felt both inaccurate and belittling, ultimately affecting her general discomfort with that therapist and driving her decision to not return.

The comment on collectivism is itself an especially relevant example of cultural essentialism and the dangers of a cultural competency based on perceiving a set of pre-known, discrete characteristics of an individual based on their racial or ethnic background (Kleinman and Benson 2007; Kirmayer 2012). To be quite frank, grafting the interpretive lens of a "collectivist" model of group relations onto any ethnically Chinese client—even and especially those who are American born and have grown up in various cultural borderlands—can be described, at best, as inappropriate and reductionist, even notwithstanding a plethora of academic research that debunks such homogeneity and linearity in studies that look at the "collectivist tendency" of the Chinese (Sue 1994; Hui and Yee 1994; Lau 1996; Fiske 2002; Miller 2002; Cohen 2009). Beyond cultural complexity, there is also an unaccounted for element of temporality in knee-jerk explanations of "collectivism." The influential Chinese anthropologist, Yunxiang Yan, writes meticulously and extensively about the dramatic shifts in contemporary Chinese society marked by dramatic influx of Westernization, globalization, and market capitalism, and radical shifts in the moral and social landscape of the Chinese individual, giving rise to values of individualism and complicating more static notions of "collectivist" values (2008; 2010). More specifically to this context, these changes are documented to have striking impacts on the ways that mental health is both expressed and diagnosed in clinical encounters, with the once dominant interpretation of neurasthenia now a "rarely used category of subsyndromal depression" for Chinese psychiatrists (Kleinman et al. 2011).

It is no wonder, then, why Tiger balked so much at her therapists' comments. And while they may be small or subtle, the impacts of these culturally-infused clinical encounters are anything but. For those who study multicultural counseling and cultural competency in the psychology literature, there is ample research that links students' perception of the cultural sensitivity of their counselor to their overall satisfaction with counseling services (Constantine 2002; Casas et al. 1986; Fuertes et al. 2006). Especially important to note is that in psychologist Madonna Constantine's 2002 study, all students that were surveyed were students of color who both sought and then *terminated* mental health treatment at the counseling center. In other words, these were students who, in part because of their dissatisfaction with services significantly linked to their perception of the cultural sensitivity of their therapist, were deterred from getting help. While, to be clear, it was not solely because of the "collectivist" comment, Tiger's experience was the same: "I cancelled the rest of my meetings and never went back."

Let me make clear that I do not believe all of Emory CAPS, nor even the clinicians that both Tiger and I worked with, to be wholly culturally insensitive. Nor do I mean to imply that these issues are pervasive; I haven't spoken with enough students to know. Lastly, it's important to also note that there are a variety of researchers and counseling centers actively critiquing these very same issues and attempting to improve services in ways that I believe Kleinman and others would approve. But I do want to raise this line of critique to highlight this as an important target of improvement for CAPS that is worth discussing in its own right and, in my view, linked very much to the issues of efficiency pressure, symptom management, and the structural image of "cultural competency" that fits in with the broader clinical infrastructure that I'm critiquing.

Concluding this subsection, to improve our mental health services, we need renewed focus on cultural barriers to effective care that take place *inside* the center. We might think of this as a broader issue with the literature's general disinterest in the question of *retention*—a problem that is best represented by studies of culturally Other students and how their culture affects "help-seeking behavior." With the limited operational definition of "help-seeking behavior" as solely getting one's foot in the door, rather than an ongoing process (an issue mentioned earlier in my discussion of stigma and its measurements), we neglect the cultural barriers to help-seeking that exist *inside* the counseling center.

As such, as much as the counselor needs to be self-reflective, so too must researchers who study student mental health "help-seeking behavior" be cognizant of the easy slippage into an elision between "barriers to *entry*" and "barriers to *care*." Kleinman's critique of the "culturally competent" clinician can also be mapped onto the methodological errors of the broader counseling and student affairs literature base. Researchers study a culturally Other student population, essentialize those students into a distinct cultural cohort with describable characteristics and beliefs related to both the mental distress and help-seeking behavior (i.e., Chinese express symptoms somatically and thus won't seek psychological services, international students are expressing distress because of acculturative stress, etc.), and then produce recommendations for outreach and proper multiculturally-sensitive counseling. This tendency towards cultural essentialism needs to be disrupted if we are to move beyond cultural competence.

But so too must we redirect our focus on the ways that encounters *within* the center are producing barriers to student care. Tiger's experience is a prime example of this. The supposed collectivist tendency of Chinese students to avoid seeking individual, one-on-one counseling is imposed on Tiger as a Chinese female and inserted as an interpretive filter for her expression of "guilt" for what Tiger described as "jumping the waitlist." I am not a clinician, but from listening openly to Tiger describing her experience, it is fairly clear that the counselor ended up missing what was far more relevant to Tiger's distress—the *moral* experience of feeling like she was somehow "bad" for taking up scarce mental health resources and the general feeling that she was only self-harming for attention. Her personal journal entry about the experience, something she felt comfortable with me sharing here, speaks volumes to this point:

> All those things perpetuate and reinforce the notion that I am fine, that I have things going for me. That maybe it's not an act that I smile and pretend that I'm okay.
>
> What scares me is the question of what if the act is the notion that I am suffering? That what if things are, in reality, flipped? That the act is not me smiling and being radiant. What if the act is me cutting because I want attention? What if the act is me crying because I have nothing better to do? What if the act is me staying in bed because I'm just too lazy? What if my suffering is just an act, a really really good and disparate act, and that I should step off the stage and let the real people occupy it instead of me, a fraud? If I'm a fraud, then I truly do not deserve to be here.
>
> Fuck you, my therapist, who looked at me and, with such a biting and accusatory tone, pointedly said, "That's so collectivist of you. Really?!" She looked angry, almost, accusatory. As if I'm just sitting there taking up space and screaming for attention. That maybe I'm just bored and want out of my responsibilities.
>
> I'm not looking to be a martyr. Because that would imply recognition and remembrance, no?
>
> —*Tiger*
> Personal journal entry; October 14, 2016

Even though Tiger, like the other students studied in Constantine's 2002 study, ended up terminating services at the counseling center, measurements of help-seeking (at least as conducted by the broad student health survey done at Emory) totally fail to capture her experience by solely measuring (a) "service use"—whether or not they received services from CAPS as a provider and (b) "mental health help-seeking" as "would consider seeking help" (American College Health Association 2015).

CHAPTER 3: Concluding remarks

Towards epistemic justice in theory and praxis

As an advisor insightfully pointed out, the above narratives—and in many ways, different sections of the text of this very paper—contain a variety of seeming internal contradictions. Students balk at having deeply moral, emotional experiences reduced to clinical symptoms while simultaneously wishing for improved access to clinical care. Students feel deeply hurt when a counselor normalizes their experience while, in other cases, balk at a diagnostic label of difference. As far as this text goes, depending on the discipline and theory invoked in any given sentence or section, the politics I am forwarding might seem to range from a total rejection of psy-complex discourse and practices to one of reform working "within the system." There is no simple resolution to any of these concerns—instead, the complexity of these questions and experiences *is* the point (it very well may be the only one). And with more conviction in the following than any other sentence in this project, I conclude: in this terrain of internal contradictions, ideological tensions, and competing demands for a revised mental health system at Emory, we need *engage*, rather than ignore these complexities.

Because what *does* unify these student voices is a shared sense of *misfitting* within a mental health system that is supposed to support these students—from feelings of invalidation and rejection to feelings of guilt and feeling lost, each and every student did not receive the help for their struggling that they were looking for. If there is no other takeaway point from this research, it should be that these student voices (1) exist and (2) should matter to those in power to influence our system at Emory. Each student's experience through the mental health system—whether positive or negative—can, and needs to, be understood by administrators at CAPS and beyond as a rich window through which we might explore the different, complex, and dynamic ways that our mental health systems either fits or misfits student needs. While it may stand against the logic of defaulting to clinical expertise to construct these systems, as "service-users" there is a deep wisdom, intuitive and experiential understanding of complex nuance, and wide range of "subjugated knowledge" that the student voice can offer to those who dare listen (Garland-Thomson 2011).

To my knowledge, there are few—if any—attempts to solicit meaningful feedback about student's experiences with Emory's mental health system, reflecting a broader trend in the literature to over-rely on public health-style epidemiological surveys of student self-reports of symptoms and "help-seeking behavior," neglecting to produce in-depth qualitative studies that listen deeply to student voices of their experiences once they have a foot in the door. As such, negative experiences that reproduced disempowerment, marginalization, and "stigma" that occur *inside* the counseling center are simply not really researched. As critiqued by one particularly prominent researcher on mental illness stigma, Patrick Corrigan, in a mental health terrain dominated by the biomedical narrative of mental illness as "brain disease," this failure to turn our attention inwards is both a strategic choice and one that arises when (as the "public health model of stigma" suggests) we equate "stigma" with "failure to use the medical model of mental illness"—consequently, stigma can only ever take place outside clinical institutions (Corrigan et al. 2005). Yet when we view stigma as a social justice issue, as he and his colleagues suggest, we see the ways that "stigma" as excluded voices, as voices seen as valuable not as credible speakers but only as data points, as a population that has no ability to participate in any of the decision-making processes that affect them, we begin to note the ways that stigma is "promulgated" through the "rules, practices, and processes" of mental health systems themselves (Corrigan et al. 2005, p. 365).

Taking all of this and somewhat meshing it together into a blunt recommendation, if we are to move beyond a "one-size-fits-all" approach to our mental health system dominated by a clinical infrastructure that misfits certain student experiences and needs, one *starting point* would be an internal (at Emory) and broader college counseling community shift in research method, focus, and targets. In the face of, we students experience first hand the sometimes-negative consequences of the creeping influence of what sociologist and scholar Max Weber termed "bureaucratic rationality" that pressures the counseling center into efficiency, outcomes, and verifiable best practices to manage all sorts of risk for the university. Even if the administrative forces pulling the strings of divisional territory and budget wars remain black boxes to us students, the savvy CAPS administrator would *want* to listen closely to the student voice to help reveal some of the ways that genuine therapeutic effectiveness might be sometimes undercut in the face of unsupportive administrations and boards of trustees to advocate for more support and resources. That's, at least my more pragmatic justification for integrating the voice of students. The ethical imperative of doing so is much clearer (and, to me, much more important). Students who have negative experiences at these mental health systems tend to be unintentionally silenced, to accept moral fault for their negative experience, and to be erased as "data points" in "objective data measurements."

The most salient example of this is the CAPS Client Satisfaction Survey. In response to some of the concerns that I raised, I was frequently by CAPS administrators that "98% of students had positive experiences" at CAPS and, as such, I was probably talking to only a *few* students who happened to be the outliers. That conclusion definitely didn't quite match the broad consensus among dozens upon dozens of students whom I have known to express the opposite sentiment, and upon closer examination of the document, the discrepancy made more sense to me. First, while the website for some reason suggests otherwise, the survey is not anonymous as it requires students either hand-deliver it to the office or send it via email. Sure, there are anonymous workarounds to both, but most students would find that more trouble than its worth—especially if all the survey asks are brief Likert-scale type questions that don't quite capture the complexity of a student's experience. But far more importantly, the survey is only administered to those students who made it to the "mid-semester" and "end-of semester" points in their therapy process—in other words, the seemingly rare "ideal world" of (1) access to support (2) in a timely enough manner where the student is starting early enough in the semester to reach enough sessions. Students who didn't end up going back or who, after the initial intake appointment, were referred out, are unlikely to be represented in any of their data, even though the administrators assured me that everyone can take the survey. Unsurprisingly, I have not met a *single student* who has actually filled out this survey. Indeed, what happened to the other 608 students not represented in the survey?

But perhaps most important is the general trend in internal evaluation efforts and the literature base to reduce these complex experiences that—not to belabor the point—are potentially laden with stigma, contradictions, and misfitting narratives of illness into objective data points. While absolutely an important strategy in public health and epidemiology, the *dominance* (to the point of monopoly) of this type of data that then informs our mental health system construction and configuration produces what feminist philosopher Miranda Fricker (2007) calls *testimonial injustice*—the reduction of complex subjectivities into data points that produces the *illusion* of a representative conclusion while in reality the outliers, the non-"average," and the non-normal subjectivities and their experiences are simply erased (LeBlanc and Kinsella 2016). The CAPS Client Satisfaction Survey is one example of this. Another example might be the way that an administrator in the mental health system, in response to us sharing a variety of student concerns including their narratives verbatim, suggested that for us to provide administrators “data to work” we would need to “survey the entire population” including “graduate data as well” in order for the data to be “holistic and inclusive of all students and their needs.” Such a large-scale epidemiological approach to data-gathering about student needs is absolutely important for certain research projects and certain efforts. But it was a non-sequitur, really—if every single other student had an outstanding experience, would the “outlier” students who expressed negative experiences somehow be less valid, less “real?”

Which brings me to my last point in regards to the need to both explore more seriously and *take* more seriously student voices. Produced by the various historical forces and logics that have imbued themselves within our clinical infrastructure, administrative responses to student narratives (including but not limited to the ones shared in this text) have ranged from dismissal as “outlier” to pushback against these narratives as the “frustrations” of “therapeutically entitled” students, and over-emotional, “over-sensitive” mentally ill students who will eventually need to learn how to not be coddled and deal with mental health treatment “in the real world.” Again the message of “mismanaged expectations” as an explanation of student distress was iterated over and over again. Worse, these criticisms were seen as “dangerous” grounded in the view that students who shared these experiences would “deter help-seeking” and insinuate that students “shouldn't trust the administration.” These responses are inseparable from a clinical infrastructure that values sees emotional disturbance inside of these students thoughts, and also understands clinical authority as the sole decision-making power that “isn’t dangerous” (because of clinical training and thus more expert, more informed, and more valid) (Bracken and Thomas 2001).

Let me concede a few things. To some extent, that mistrust is absolutely there. Similarly, I'll concede the point that there are definitely misunderstandings of CAPS policy and "mismanaged expectations" about what CAPS has to offer. Certainly working on these aspects of what filters into students' negative experiences is an absolutely crucial aspect of improving the status quo. Yet communication about wait times and resource abilities, transparency about policies and services, and building "trust"—are these the responsibilities of students or administrators who are paid to do so? I certainly don't think the answer is students, although against resource constraints and an overstretched workload I can also see the answer being not completely the opposite either. What is clear to me, however, is that attempts to shift responsibility onto students who had negative experiences as the source of breeding mistrust, the source of incorrect understandings of what to expect, and as "dangerous behavior" instead of owning up to the challenge of figuring out why these students had these experiences in the first place is deeply problematic, if you ask me.

All of these are examples of what Fricker's (2007) concept of epistemic injustice—the invalidation of the speaker sourced to an aspect of their identity (in this case, mental illness). Price's (2011) and Prendergast's (2002) points about the stripping of the mentally ill student's *rhetoricitiy* articulate a similar issue. These defensive reactions to student experiences need to shift in favor of listening openly, compassionately, and with a willingness to engage in the complexities that these student voices highlight. Such a redress of these sometimes subtle, sometimes overt ways that those in positions of power tend to dismiss the epistemic value of the student is absolutely crucial if (1) we are to listen openly to critique as a site for improvement for those who misfit with our current system's configuration and practices and (2) we are to effectively pursue the endeavor of including student voices in decision-making, knowledge production, and the mental health community at Emory. Failure to rectify these (honestly sometimes not so thinly-veiled) overtones of stigma and epistemic injustice will lead to the "inclusion of student voices" as a sort of "add mental illness and stir" approach, reproducing the status quo while (worse) providing the illusion of improvement (Costa et al. 2012). To reiterate just once more Corrigan's (2005) ever-so-important point: just because you are a clinician does not automatically mean you are not capable of reproducing stigma and disempowering those you seek to help.

These points are equally true *within* the clinical encounter itself. In the face of overlapping ideologies and administrative systems that might encourage reductionist encounters to symptom management techniques, (as strange as it sound to say) we might consider ways that we can bring therapeutic back to therapy, especially in ways that provide direct opportunity for the student's voice to enter into the clinical encounter, provide direction for therapy, and make clear what fits and what misfits. In the context of cultural Others, we tend to have a variety of strategies and therapeutic methodologies that help the therapist both acknowledge and begin to work with what a patient's idiom of distress, its moral meanings, and the deep experiences embedded in the patient's subjectivity beyond "symptoms." To bring back some of my earlier points, because every individual is part of a "culture" that influences what idioms of distress they use and that affects their moral experiences of illness, these strategies provide an interesting starting point for rethinking the CAPS clinical encounter.

For example, to redress some of the conceptual missteps and blind spot in embedded in most cultural competence training programs, Kleinman's groundbreaking 1988 text, "Rethinking Psychiatry: from Cultural Category to Personal Experience," lays out his recommendation for how to integrate socioanthropological methodology into the clinical encounter with a deceivingly simple step-by-step method that he calls a *mini-ethnography*.

Although it has its own limitations and critics, the mini-ethnography might offer an effective *starting point* for reshaping the clinical encounter by bringing to the counselor's attention the need for compassionate listening, for setting aside "technical disease categories," and emphasizes the need to skillfully discern individualized "local cultural worlds" rather than seeing essentialized "trait list" approaches to understanding culture—i.e. Chinese students express mental distress somatically, are collectivist, are subject to more academic pressure from tiger parents, etc. (Kleinman and Benson 2007, p. 1674). Again, these "local cultural worlds" are conduits for shaping *all* of our experiences, culturally Other or not.

But to reiterate my above concerns about the "add student voices and stir" risk, the implementation of reflexive therapeutic tactics such as Kleinman's mini-ethnography, the *ethos* of symptom management counseling itself must first open itself up to self-reflection and critique or risk replicating and masking the same conceptual errors (Kleinman 2007; Taylor 2003). I find medical professionals Melanie Tervalon and Jann Murray-García's (1998) distinction between competence and *cultural humility* especially useful for thinking of what virtues of a meaningfully sensitive therapist might look like. For them, whereas cultural competence falls within biomedicine's logic of technical skills to be "trained" in—with requirements for continued education in the skill grounded in the asymptotic goal of moving towards an eventual "detached mastery" of "theoretically finite knowledge" on what it means to be culturally sensitive—cultural humility might be seen as a more specific application of the aforementioned approach of critical reflexivity, forwarded by LeBlanc and Kinsella (2016) and previously discussed. According to their article, they broadly define cultural humility as:

> Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing

> mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations. (p. 117)

What stands out to me as particularly important about this framework is that it reorients the patient-clinician dynamic in a way that flattens power imbalance and moves towards epistemic justice. This framework, including this reorientation of the power relationship between clinician and patient, are broadened and updated in a broader framework called *structural humility* as described by psychiatrists Jonathan Metzl and Helena Hansen (2014). The inclusion in both of these emerging frameworks of this reflexive critique of some of the cultural hallmarks of biomedicine are no small detail, and I think *this* is perhaps what's lost in some of CAPS' noble efforts to actualize culturally sensitivity, manage student symptoms, and address student mental health concerns. An ethos and framework of humility *mandates* active that therapists work within the clinical encounter and beyond to illuminate and challenge the intersections of *biomedical culture* and its potential to contribute to insensitive clinical encounters, "cultural" or "not" (Tervalon and Murray-García 1998; Metzl and Hansen 2014). In the broadest of senses, these frameworks *force* us into practices that move away from reductionism and towards engaging complexity.

Beyond the biomedical idiom of distress—embracing misfits

The above is perhaps the most important conclusion for improving the mental health system—in other words, for reform "inside the system." But when integrating the broader disability studies-informed critique of the "will to normalize" students and biomedicine's focus on mental illness as residing solely within an individual who expresses symptoms needing treatment (as opposed to critique and reform of the systems that produce the conditions that lead to such psychic distress in the first place), it is imperative that mental health professionals and the administration writ large begin thinking about solutions that can take place *outside* the counseling center. Yet our world of "neurochemical selves" and an increasing tendency to medicalize all psychological and emotional distress, the dominance of what I'm going to call the *biomedical idiom of distress* (to emphasize the contingent, culturally-bound nature of the medical model itself) produces the administration-enforced logic that all emotional, psychological, and behavioral issues that students are facing are all "mental health issues" that need the attention of a clinician at CAPS. As noted in the college counseling literature base, counselors are noticing this expectation and are deeply uncomfortable with it (Much et al. 2009). Yet this gets messy quite quickly: if students who are struggling might not be "mentally ill" insofar as they have a disorder that requires a clinician's attention and potentially a visit to Emory's Psychiatric Services, how do we respond to these students? If, from the disability studies perspective, this is a question of forced normalization of certain bodies and minds, how are professors supposed to respond to a student who can't make it to class because of their depression—is the response no longer suggesting they medically withdraw?

Stemming from these thoughts, I conclude with two broad areas for us to work on going forward: (1) beginning to develop and conceptualize (to borrow Peter Sedgwick's word for the political strategies used to advocate for care for those who are mentally ill) a psychopolitics of "misfitting" and "struggling" and (2) refocusing our critique on disabling forces and structures that are inaccessible to difference.

(1) In a convincing, insightful article titled "Medical Anthropology and Mental Health: Five Questions for the Next Fifty Years," Arthur Kleinman (2012) both predicts and encourages several important pivots in research focus and our understanding of mental health. One particularly standout point in this article is his articulation of our current failure, and need to address, the distinction between mental illness and what he calls *social suffering*—a term coined by himself, Veena Das, and Margaret Lock to articulate the "normal" (as in

non-pathological) and defined the misery, sadness, emotional pain, and *struggling* that is part and parcel to living life and being human. This distinction is certainly an important one in light of some of the broadest trends in the psychiatric community as "diagnostic inflation" continues to increase against a backdrop of pharmaceutical influence and the DSM-5's comparatively expansive reach in medicalizing "normal"—or at least, so says Allen Frances (2013), one of the main authors of the DSM-IV whose outspoken critique about the need to "save normal" attracted a great deal of support form inside the psychiatric community and attention.

But what tends to fall short in critiques of the medicalization of "normal suffering" is something that Kleinman (2012) addresses head-on: social suffering and mental illness, while neither guaranteed to overlap with the other, nevertheless are intricately related and *both* deserve serious attention and care. Kleinman keenly points out that we have a wealth of evidence suggesting these deep connections: economic depression and psychological depression are deeply related, the political economy "creates suicide just as surely as genetics does," and forces of neoliberalism, politics, identity marginalization, and other forms of social suffering both "underpin" and "provide the structural basis for" psychological distress (Kleinman 2012, p. 182). To that point, Kleinman hopes that we both research and clinical communities come to see that even though not all mental illness is social suffering and not all social suffering produces or amplifies mental illness, there are many cases of "mental illness" that are both *forms* and *consequences* of social suffering. Similarly, the symptoms—depressive behavior, anxiety, suicidality, etc.—that we believe to be telltale signs of a psychiatric disorder that merit a formal diagnosis are just as likely to be a response to social suffering as they are due to a psychiatric disorder (Kleinman 2012). As grafted onto the embodied experience of both of these complexly interlinked forms of emotional and psychological pain, his real point is as follows: both matter.

The overlap, interlinked nature of mental illness and social suffering absolutely needs to be further studied to understand its nuances and implications. But in the short term, what it means in college is we need to establish systems of support that are accessible to *students who are struggling*—in other words, students who may have a diagnosable mental illness or who may be suffering in similar ways without, perhaps, the same genetic of neurobiological phenomena underpinning that suffering. In some ways, this is one advantage of a symptom management focused approach (although let's not be too quick to gloss over the other problems in its implementation.) Yet ironically that symptom-focused perception of who is "struggling" is a lens that disappears outside the counseling center. I believe that this is due to the overwhelming monopoly that the medical model of mental illness has in the "narrative ecosystem" of students and, thus, becomes the only available subjectivity for us students to embody in our pain.

Put differently and with its implications more crystallized, as far as official Emory policy goes, if a student needs any sort of relief (academic, accommodations, withdrawals, etc.) a student *must* provide clinician-approved documentation of a diagnosis and proof of "substantial disablement" from their psychiatric impairment. In other words, biomedical idioms of distress are the *sole* legitimate currency in the eyes of the university's gatekeepers to services and resources. Furthermore, this policy is replicated in the classroom as many faculty require some sort of formal documentation from either the disability services office or a clinician's note to allow students extra absences if they miss class because of their depression, absolve grade penalties for late assignments if they were feeling suicidal and weren't able to work on their assignment, or make-ups and rescheduling for quizzes or tests that they might have missed if they were having a panic attack or were perhaps in the hospital for suicidality. Finally, even though CAPS is an open resource even without a diagnosis *and* oftentimes students with serious diagnoses are immediately referred out to the community for long-term care, the lack of resources and general staff shortages combined with burgeoning waitlists filled with students of increasing acuity *combined* with their decision to utilize a triage-based system of priority has essentially resulted in a de facto "mental health clinic" where students might require (or at least perceive that they require) a diagnoses to get access to timely care at CAPS. Let me return to one student narrative from earlier (this time, a longer version).

> **I have never felt that CAPS was an open resource without a diagnosis.** Instead I have worked with the office of health promotion to promote wellbeing…
>
> **I didn't know at the time that there were so many students being wait-listed for help and when I found out, I felt like crap. I didn't feel like I deserved to get help,** yet I keep going in because it helps…
>
> I had some really bad breakdowns two weeks ago and [my therapist] brought up potentially seeing if medicine for depression and anxiety would help. However, I never thought of myself as depressed or having anxiety. **I have friends that experience these things and have told me I don't and since they do, I believed them about myself.** So I just kept telling myself I don't and I didn't need it, but with the holidays approaching and having to see my family, it's been harder and harder each day to get out of bed. Sometimes I just feel empty. I am back to refusing help after that suggestion. Not that it was wrong on [my therapist's] part, it probably would help, **but it just reminded me how just my occupying her office was taking away from other people and I suddenly didn't want to be there anymore whether it was helping me or not, I just didn't feel like I deserved it anymore.** So now I see [her] every two weeks instead of weekly. The off weeks are hard, but I can't tell anyone that.
>
> —*Anonymous, third-year*
> Mental Health at Emory: Anonymous Submission Form

What's especially important in this student's narrative is also the *peer-based* enforcement of the idea that this student didn't fit the biomedical idioms of distress "depression and anxiety." For this student, like many others, the feeling quickly became one of "guilt" in the context of the CAPS waitlist for "occupying her office" and "taking away from other people" who apparently "deserved it more." Implicit in this is the rigid idea that is transmitted to, and through, students that those with biomedical idioms of distress (diagnoses) "deserve" services more. Those are the "real" mental illnesses. Others who are struggling are struggling with "normal" stressors like "existential crises," academic stress, finals, etc.

Thinking about this in the context of famous medical sociologist Talcott Parson's (1951) sick role theory helps explain some of the background of this: indeed, part of the power and usefulness of the medical model is that it reduces an individual's agency over their symptoms (and in the context of school, that means that the culpability for struggling in class lies in their mental illness, not student decisions) (Corrigan et al. 2005). Ignoring for now both research (Perry 2011) and student experience suggests that, in the context of mental illnesses like anxiety and depression, there is a surprising (or perhaps not so surprising) reduced effectiveness to invoke the "sick role" and reduce culpability in the eyes of most teachers and peers, what *is* clear is the flip side of the message. To deserve support at Emory (from teachers, from disability services, from friends) means you must have a *real* mental illness—otherwise, you're just like everyone else and everybody else can get over it, push through it, and overcome it—so why can't you? Or so the feeling goes.

As messy as it is, so long as the University's official position that guides its resource distribution and accommodation process is wed to the biomedical idiom of distress as the sole benchmark of "legitimacy," students who are struggling and experiencing psychic distress in ways that deeply impact their lives as students and individuals will (1) be structurally unable to access the support that they need, riding solely on the kindness of certain professors who subvert the documentation system and (2) will continue to internalize interactions ranging from peer conversations to being told that they are on a CAPS waitlist as a moral referendum on whether or not they're "making it up" or not. To return to another set of previous narratives, Tiger's experience was a particularly salient example of this—for all her self-harm and struggling in much the same way I experience my depression (at least that was the shared conclusion that came up through our conversations), Tiger doesn't feel like her experience is "serious enough" to merit being called a "mental illness." This context certainly is partly why her narrative, in seeming contradiction, shows both a sense of invalidation at the therapist who *normalized* her experience as an "existential crisis" (and thus reaffirmed her own internal narrative of her not having a *real* mental illness) and frustration at the clinical reductionism that used a dialectical behavioral therapy handbook to address her "symptom" of self-harm.

I don't mean to get too off track, but the reason I raise these points in this conclusion is for the reason that this rigidly enforced line of "legitimate mental illness" as "medical mental illness" is one particularly important aspect of the complex moral experiences that students are entering into CAPS with. And more to the point here, the biomedical idiom of distress as the *only* permissible subjectivity for a student who is struggling in the wider Emory University system of support *outside* of CAPS is one invisible consequence of a clinical infrastructure for our mental health system. These are students that show up in those epidemiological assessments as part of the population that reports that they feel "too depressed to function," yet can't get formal accommodations and are unsure of how to explain to professors why they missed class.

What this requires is a psychopolitics that is *accessible* and *inclusive* to those students who are would fall into Kleinman's category of "social suffering" as we make demands on our university to provide an infrastructure of care for students struggling with mental illness. The point is that these two analytical categories, while separated for the purposes of writing, are *not* discrete political factions. Indeed, I would vehemently argue that for any student in a college setting it is *always* some mix of both, never merely one of the other. And if the university is to truly provide more effective support to its students who are struggling with the experience severe mental distress, regardless of its "pathogenesis" or diathesis, we must account for all students who are struggling—who are *misfitting* and find ways to remove both policy (documentation mandate) and discursive (dominance of medical model in peer-to-peer interactions) obstacles to accessing support and relief.

(2) All of this brings me to my final point as a future direction for both research and university reform: the importance of critiquing systems that produce mental distress—mental illness *and* social suffering in all of its gradients—in the first place. In an increasingly diverse university setting, such critique absolutely requires a framework of intersectionality: one that understands that identities are not additive but relational and that sees focusing on intersecting systems of oppression and marginalization as central to the project of supporting students who are struggling with mental illness (Gill and Donaghue 2015; Costa et al. 2012). Drawing from the (oftentimes disconnected and disorganized) parts of this paper that speak to the various critiques of the cliniciziation of mental illness and the psy-complex's localization of mental illness solely to the brain and psychology of the individual, one of the most important research agendas that those interested in student mental health ought take is a disruption of the "profoundly individualist framework" of a "crisis in student mental health" and instead begin to ask the question: what system(s) of power does this narrative serve to naturalize and justify? Asking these questions does *not* ignore, erase, nor delegitimize the experiences of mental illness, psychiatric disability, and social suffering that students face—it is not an either/or approach (Gill and Donaghue 2015). Yet from this lens, we might infuse our psychopolitical demands on the university with a far more equitable, socially just, and more accessible lens.

Pursuing the line of disability studies emerging application of the social model of disability onto mental illness / psychiatric disability will help us understand many of the ways that a system of saneism, ableism, and *normality* dominate our lives as individuals, perpetuating stigma, discrimination, and adding to the sense of moral failure that underlies much of our experience in the context of being *students*. The "good" Emory student, like the "good" neoliberal subject, is productive, hard-working, self-disciplining, and "flourishing" and (Gill and Donaghue 2015). The cultural demand of cheerfulness also intersects with what "good" students / "good" friends are—a demand that, in the case of depression especially, requires an active erasure of one's psychiatric disability (Nicki 2001). These visions of the "good" Emory student, the "successful" Emory student, are abounding within our university's public discourse and the ways that private interactions amongst peers and amongst teachers take place. It is no wonder so many faculty members are quick to suggest medical withdrawals any time this ideal Emory student subjectivity begins to slip away—psychiatric disability, mental illness is seen as equivalent to moral failure.

While we students don't use this language to describe these experiences, these high stakes moments of moral referendums on ourselves—both self-imposed and externally reinforced—*need* to be accounted for in how we think about formulating responses to students expressing mental distress (Yang et al. 2007). Such an approach might also help us think through the complexities of student's interactions with clinicians and the broader mental health system, accounting for some of the internal inconsistencies students present. It means understanding that, just as the social model of disability suggests, instead of medical tragedies that exist inside of individuals, the disablement process comes about when an individual misfits with their surrounding environmental infrastructure (including attitudes, beliefs, virtues in addition to space and time expectations and demands) (Price 2011;

Garland-Thomson 2011). And while I agree with Price that from the ways that we—from classrooms to student organizations—value participation, rationality, efficiency and productivity, and cheerfulness in ways that truly "abhor" mental disability, I also firmly believe that a psychopolitics of "struggling" and "misfitting" will open up entirely new discourses and ideas that can radically reshape what the university looks like. It is a politics that constructs the university's role as building not a clinical infrastructure but an *infrastructure of care*—one that explicitly foregrounds a *telos of care* where, instead of *treating* individuals to return to "normal," the primary question of research, policy, and the university's mental health system is how to make sure Emory is working to *fit* the student to the point where we *misfits* can survive and be valued, too (Garland-Thomson 2011). Indeed, with faculty at the proverbial front lines of these negotiated boundaries of misfitting every day, the seeds of hope and kindness, patience and flexibility, and ultimately acceptance, are already there.

> Dear Professor,
>
> I can't tell you how long I thought about whether or not to tell you about my struggles with depression. I felt so guilty for turning in my homework assignments late, missing class, and my zombie-like behavior when I did attend. I felt especially guilty because when I had your class last semester my depression was still relatively "high-functioning," and I'm sure I seemed like the "happy, hard-working student" I've been known as for so long. I wondered about whether it was appropriate to tell you I was struggling. I was afraid you would think I was just making excuses. I was afraid you would merely shrug your shoulders, tell me you're sorry, but there is nothing you can do. With all of these fears flooding my mind, I can't tell you how grateful I was when you said you understood and knew I was trying my best. Yes, I am trying my best. We all are. Thank you for understanding that.
>
> Sincerely,
> Struggling Student
>
> —*Anonymous Student*
> "Dear Professor": A Letter Project

> Dear struggling student,
>
> I want to see you. I want to know you. I want to understand your experience, but on your own terms. I want to be able to support and listen to you in the ways that suit you best. I know some times it is hard to know exactly what it is that will help you in a moment, but I hope that you find the will to reach out to a classmate, resident, RA, SA, professor and staff you trust when you feel alone. We are here for you. We may not always know the right thing to say but we do want your light to keep shining. We want you to keep appreciating that YOU matter and that YOU deserve health, happiness, and community. We love you even if

> we do not know you because we are you. We all struggle but in our own ways. For that reason, I hope, when you are ready, you will reach out for a hug, to vent, to laugh, to cry, for company, to break your patterns. We will forever be stronger together.
>
> Sincerely,
> A professor
>
> —*Anonymous Professor*
> "Dear Student": A Letter Project

The topic of the overstretched, likely equally emotionally drained, empathic professor is also one that the disability studies literature base is beginning to address. In many ways, as Price (2011), Nishida (2015), and others like Gill and Donaghue (2015) all remark, there seems to be a great deal of overlap and similarities in the issues faced by University faculty and staff. This is to comment on both the possibility of real difficulty in finding support in faculty, yet also a point of unity and promise for potential coalition-building. Universal design theories and scholarship in disability studies offers an excellent starting point that is profoundly low emotional investment on behalf of the faculty as a way of making classroom spaces, discussions, and *virtues* of what it means to be a "good student" in our academic spaces more accessible to difference (Price 2011). As Price (2011) eloquently argues in her book, this does *not* require throwing out grading systems like participation, attendance, and other aspects of grades that might be genuinely inaccessible to students who are struggling; there may, indeed, be times where medical withdrawals might be for the best. But to Price's point and the point of disability studies/universal design in a broader sense, there is *so* much more work to be done on the part of the faculty member *before* a student reaches that point—and inaccessible classroom policies and infrastructure oftentimes are active contributors to a spiraling process that pigeonholes students into having no choice but to withdraw (Price 2011).

These starting points, to the point of these brief concluding thoughts, absolutely need to include a fundamental rewriting of the primacy of biomedical idioms of distress as the currency of legitimacy. And more profound than rewiring how we respond to the struggling student at baseline, what such a pivot does is emphasize the importance of building an *infrastructure of care*—embedded with a *telos* that *requires* all community stakeholders (clinicians or not) get involved. As the above faculty letter remarks: in these ways, "we will forever be stronger together."

Beyond faculty, such a (re)vision of our community infrastructure also requires an expansion of peer support, community-building efforts, and moving away from the notion of "destigmatization" towards meaningful efforts for building a campus community that truly accepts, embraces, and *legitimizes* the value of our mad misfits. Especially in the context of a clinical infrastructure system that simultaneously is not *accessible* to all students and also doesn't *fit* all students on a more onto-epistemic level, one of the most important means of responding to these complexities is through our peers.

> Finally, as an Orientation Leader, I'm supposed to be a good reference and resource for my orientation group. However, having to "talk up" CAPS as a good resource for mental health on campus felt disingenuous and downright wrong.
>
> **How could I lie and tell these new first-years that their mental health mattered to Emory administration if the best, and most accessible support one can receive on campus is through their untrained, equally-struggling friends?**
>
> —*Anonymous*
> Mental Health at Emory: Anonymous Submission Form

And while the clinical logic sees these efforts as dangerous, this is a tautological view that self-justifies fear of students helping students, as Rosenbaum and and Liebert (2015) argue as their last point in their article. Perhaps most important to recognize is that these oftentimes invisible communities of support exist *regardless* of whether or not students are supported in their efforts to do so or not. From ResLife staff members to roommates, from romantic partners to long-time friends, with staggering rates of us struggling to survive on a daily basis the emotional tolls that peer support roles absolutely do entail are an *inevitable* product of living in close proximity to each other and having a heart as a human being. This is *especially* true for those of us who know what it's like to suffer from these experiences; we know what it's like to "feel like no one is listening even when [we] scream."

> At Emory, we're always asked to consider where we can make the greatest impact. I joined ResLife because I felt it was where I could best serve the people and the communities that I cared about. **I will always set aside my needs for you, because I know how terrifying it is to feel like no one is listening even when you scream.**
>
> When you come to me with something difficult you're dealing with, I'm above all else thankful that you're in a position where you feel comfortable reaching out for help and that you realize you don't have to carry your burden alone. I am here for you, always. I have pulled all nighters and skipped classes and missed assignments for you, but I want you to know that I do it willingly. No matter how heavy the weight you carry might be, you will never be a burden to me. Who am I to turn you away when you need help? How can I justify ignoring you, as a fellow human being, when you struggle through an emergency crisis for the sake of finishing a reading or getting a few extra hours of sleep? This is by no means a complaint. This is not an admittance of defeat or a plea for recognition. I mean it when I say I will do anything for all of you - 26 people whom I've been so blessed to know and love over the past few months. But I am only human. And even writing this, I realize that I have been tired for so long that I've almost forgotten what it feels like to not be emotionally drained. Being an RA has been more challenging and more rewarding than I could ever have imagined. I am in this position because I love what I do and I love the people I work with--you. Every sacrifice is worth it to me if it makes even the smallest difference for you. I will never tell you if I am tired because I cannot be yet another resource that turns you away from help. I've been told, "It's okay to say no." And I've been preached to about the values of self-care. But I was hired to be your RA because I want to serve you in the best way that I can, and that means I will always put you first. (emphasis added)
>
> —*Cora, third-year Residence Advisor*

To the decision-makers who see student efforts to speak to each honestly, to support each other lovingly and devotedly, and to begin to reshape our community *outside* the counseling center in a way that genuinely cares *about,* not just cares *for,* students who are struggling: how do we turn a blind eye to our people when they are suffering? How are we supposed to tell our suicidal friends that they shouldn't call us if they need company? How are we supposed to look at our first-year residents, who live next door to us, that holding them when they are crying because every time they look in the mirror they want to purge and self-harm that it will have to wait until we're done studying for our physics exam? Indeed, how are we supposed to avoid "playing therapist" as you so often berate us for doing, when CAPS is telling students to expect anywhere between 2-4 weeks and, in some cases, *months*? Right now, we're in the worst of both situations—students taking on large costs (with good reason) yet instead of being supported by community-building efforts and administrative policies to support them, they are being both informally and actively punished via the moral discourse of "you should 'put your oxygen mask on first'" and "you're here to be a student." We understand that these things are messy, fraught with legal liabilities and risks, and are taxing on all of us. Yet, as the Residence Advisor's letter states clearly, we are human beings before students—and we are here to care.

I close with some lines from a spoken word piece that I wrote and performed for Orientation this past year. I am a composer by trade and a pianist if I have to perform. Having to perform spoken word in a ragtag social justice theater group called "Issues Troupe" was one of the most nerve-wracking experiences I think I'll ever have. The prompt was to write a piece that first spoke to times in your past where you had been targeted because of an identity trait that was stereotyped or misunderstood in discriminatory ways; afterwards, your response.

I return to it now as I see no more fitting way to conclude this project as I believe, though at the time I did not realize, that it was *this* moment that I first articulated the vision of Emory that has driven this entire research process. One where we who misfit are not studied, judged, and morally condemned under saneist and pathologized systems and discourses. One where we who misfit are equally deserving of being here. And one where we who misfit are allowed to "talk back"—to proclaim our right to epistemic disobedience—and to rewrite not ourselves but "this world."

> That's right. High-performing, highly social, and generally uplifting people can't possibly have depression.
> Depressed people don't smile ever; they're toxic to be around because they just
> Drag you down into
> The depths of oblivion with them.
>
> Hey, it's been 5 months;
> Are you even trying to get better?

You *used* to be kind and thoughtful and make everyone feel loved
Now you're just *selfish,*
You're constantly cancelling, always late, never around

And you just keep saying "I can't"
But what you're really saying is "we don't matter to you anymore"

Good luck to you; one day I hope you'll recover and overcome this "darkness"
Because right now you're just a vampire
and until you find a way to resurrect yourself
I don't want anything to do with this horror story anymore

Maybe you're right.
Maybe I am a vampire.
I mean that's the thing about vampires, isn't it?
We blend in rather nicely and are used to disguising ourselves among the living
Just pretending
to be okay
in a world full of flourishing, fearful friends
careful to not infect themselves with
my darkness
making sure the conversation never goes beyond
"hey, how are you?"

Since when did that become a rhetorical question?

Yes, most days the
Graveyard gravity of the emptiness inside of me pins me into my coffin bed
So most nights
I haunt the library, trying to piece together the broken shards of
My decomposing life

They say that one day I'll "recover"
I'll be "myself" again
Things. Get. Better.
That night precedes the day
That darkness slips away
They say

"There is a light at the end of this tunnel"
Beyond the depression

But don't they see?
That light is a *mirror*
That light is me. All of me.
I am the dark, I am the light
The yellow and the white.

I don't want the wooden stakes of their well-wishes;
I just want them to stop assuming that
This vampire can't see his reflection

Because no matter how much society tells me that they see me as weak, selfish, a monster:
maybe it's just because they can't see in the dark.

I am mentally ill.
Sure, I am a vampire.

But I am not a monster.

I am still here because I am strong.
Strong enough to rewrite this world so that
We vampires don't have to live in exile anymore.

References

American College Health Association. (2015). American College Health Association-National College Health Assessment II: Institutional Data Report Fall 2014 Emory University. Hanover, MD: American College Health Association.

Appelbaum, P. S. (2006). Law & psychiatry: "depressed? Get out!": dealing with suicidal students on college campuses. *Psychiatric Services*. *57*(7), 914-916.

Archer, J., & Cooper, S. (1998). Counseling and mental health services on campus: A handbook of contemporary practices and challenges. San Francisco: Jossey Bass.

Beagan, B. L. (2003). Teaching social and cultural awareness to medical students: "It's all very nice to talk about it in theory, but ultimately it makes no difference." *Academic Medicine*, *78*(6), 605-614.

Beck, J. S. (2011). Cognitive-behavioral therapy. *Clinical textbook of addictive disorders*, 474-501.

Beck, A. T., Davis, D. D., & Freeman, A. (2015). *Cognitive therapy of personality disorders*. Guilford Publications.

Bishop, J. B. (1990). The university counseling center: An agenda for the 1990s. *Journal of Counseling & Development*, *68*(4), 408-413.

------. (2010). The counseling center: An undervalued resource in recruitment, retention, and risk management. *Journal of College Student Psychotherapy*, *24*(4), 248-260.

Bishop, J. B. (2016). A wish list for the advancement of university and college counseling centers. *Journal of College Student Psychotherapy*, *30*(1), 15-22.

Bloom, S. W. (1988). Structure and ideology in medical education: an analysis of resistance to change. *Journal of health and social behavior*, 294-306.

Bordo, S. (1993). Feminism, Foucault and the politics of the body. Up against Foucault: Explorations of some tensions between Foucault and feminism, 179.

------. (1997). Psychopathology as the Crystallization of Culture. *Food and culture: A reader*, 226-250.

Brunner, J. L., Wallace, D. L., Reymann, L. S., Sellers, J. J., & McCabe, A. G. (2014). College counseling today: Contemporary students and how counseling centers meet their needs. *Journal of College Student Psychotherapy*, *28*(4), 257-324.

Butler, J. (2005). Giving an account of oneself. Oxford University Press.

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical psychology review*, *26*(1), 17-31.

Casas, J., Ponterotto, J. G., & Gutierrez, J. M. (1986). An Ethical Indictment of Counseling Research and Training: The Cross‐Cultural Perspective. *Journal of Counseling & Development*, *64*(5), 347-349.

Castrodale, M. A. (2017). Critical Disability Studies and Mad Studies: Enabling new Pedagogies in Practice. *Canadian Journal for the Study of Adult Education*, *28*(2), 49-66.

Chen, C. P. (1999). Professional issues: Common stressors among international college students: Research and counseling implications. *Journal of College Counseling*, *2*(1), 49-65.

Clegg, J. W. (2012). Teaching about mental health and illness through the history of the DSM. *History of psychology*, *15*(4), 364.

Cohen, A. B. (2009). Many forms of culture. American psychologist, 64(3), 194.

Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. *Journal of Counseling Psychology*, *49*(2), 255.

Cooper, R. (2015). Must disorders cause harm? The changing stance of the DSM. In *The DSM-5 in Perspective* (pp. 83-96). Springer Netherlands.

Davenport, R. (2009). From college counselor to “risk manager”: The evolving nature of college counseling on today's campuses. *Journal of American College Health*, *58*(2), 181-183.

Davis, D. C., & Humphrey, K. M. (2000). *College Counseling: Issues and Strategies for a New Millennium*. American Counseling Association, Office of Public Policy and Information, 5999 Stevenson Ave., Alexandria, VA 22304-3300.

Dimeff, L. A., & Koerner, K. E. (2007). Dialectical behavior therapy in clinical practice: Applications across disorders and settings. Guilford Press.

Dreyfuss, S. (2011). Something essential about interdisciplinary thinking. *Issues in Integrative Studies*, *29*, 67-83.

Eisen, A., & Berry, R. M. (2002). The absent professor: Why we don't teach research ethics and what to do about it. *The American Journal of Bioethics*, *2*(4), 38-49.

Engebretson, J., Mahoney, J., & Carlson, E. D. (2008). Cultural competence in the era of evidence-based practice. *Journal of Professional Nursing*, *24*(3), 172-178.

Farrell, E. F. (2008). Counseling centers lack resources to help troubled students. *The Chronicle of Higher Education*, *54*(25), A1.

Fiske, A. P. (2002). Using individualism and collectivism to compare cultures—A critique of the validity and measurement of the constructs: Comment on Oyserman et al.(2002).

Foucault, M. (1973). The Birth of the Clinic: An archaeology of medical perception. *London: Tavistock Publications.*

------. (1988). Madness and civilization: A history of insanity in the age of reason. Vintage.

Fox, K. J. (1999). Changing violent minds: Discursive correction and resistance in the cognitive treatment of violent offenders in prison. *Social Problems*, *46*(1), 88-103.

Frances, A. (2013). Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma and the medicalization of ordinary life. *Psychotherapy in Australia*, *19*(3), 14.

Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: A study of therapy dyads. *Psychotherapy: Theory, Research, Practice, Training*, *43*(4), 480.

Fullagar, S. (2009). Negotiating the neurochemical self: anti-depressant consumption in women's recovery from depression. *Health:*, *13*(4), 389-406.

Gallagher, R. P. (1996). National survey of counseling center directors 1995.

------. (2015). National survey of college counseling centers 2014.

Garland-Thomson, R. (2002). Integrating disability, transforming feminist theory. *NWSA journal*, *14*(3), 1-32.

------. (2011). Misfits: A feminist materialist disability concept. *Hypatia*, *26*(3), 591-609.

Gilbert, S. P., Stone, G. L., & May, R. (1992). Ethical Issues in the Treatment of Severe Psychopathology in University And College Counseling Centers--Comment/Reply. *Journal of counseling and development: JCD*, *70*(6), 695.

Gill, R., & Donaghue, N. (2016, February). Resilience, apps and reluctant individualism: Technologies of self in the neoliberal academy. In *Women's Studies International Forum* (Vol. 54, pp. 91-99). Pergamon.

Goodwin, A. (2014). Threat assessment: are we using the wrong nets?. *Journal of College Student Psychotherapy*, *28*(4), 252-256.

Hacking, I. (1999). *The social construction of what?*. Harvard university press.

Hafferty, F. W. (1998). Beyond curriculum reform: confronting medicine's hidden curriculum. *Academic Medicine*, *73*(4), 403-7.

Han, X., Han, X., Luo, Q., Jacobs, S., & Jean-Baptiste, M. (2013). Report of a mental health survey among Chinese international students at Yale University. *Journal of American College Health*, *61*(1), 1-8.

Harrington, A. (2008). The cure within: a history of mind-body medicine. WW Norton & Company.

Hollingsworth, K. R., Dunkle, J. H., & Douce, L. (2009). The high‑risk (disturbed and disturbing) college student. *New Directions for Student Services*, *2009*(128), 37-54.

Holmes, S. M. (2012). The clinical gaze in the practice of migrant health: Mexican migrants in the United States. *Social science & medicine*, *74*(6), 873-881.

Hui, C. H., & Yee, C. (1994). The shortened Individualism–Collectivism Scale: Its relationship to demographic and work-related variables. Journal of Research in Personality, 28, 409 – 424.

Hunt, J., & Eisenberg, D. (2010). Mental health problems and help-seeking behavior among college students. *Journal of Adolescent Health*, *46*(1), 3-10.

Huo, R. (2014). " Eating bitterness": mental health help-seeking and Chinese international students in the United States (Doctoral dissertation, Smith College, School for Social Work).

IACS. (2017). International Association of Counseling Services, Inc. Retrieved April 2, 2017, from http://www.iacsinc.org/home.html

Iarussi, M. M., & Shaw, B. M. (2016). A Collaborative Process Model for Promoting Successful Referrals in College Counseling. *Journal of College Counseling*, *19*(3), 261-275.

Keenan, E. K. (2001). Using Foucault's "Disciplinary Power" and "Resistance" in Cross-Cultural Psychotherapy. *Clinical Social Work Journal*, *29*(3), 211-227.

Kiracofe, N. M. (1993). Changing demands on counseling centers: Problems and possibilities. *Journal of College Student Psychotherapy*, *7*(4), 69-83.

Kirmayer, L. J. (2007). Cultural psychiatry in historical perspective. *Textbook of cultural psychiatry*, 3-19.

------. (2012). Rethinking cultural competence.

Kirmayer, L. J., & Ban, L. (2013). Cultural psychiatry: research strategies and future directions. In *Cultural psychiatry* (Vol. 33, pp. 97-114). Karger Publishers.

Kitzrow, M. A. (2003). The mental health needs of today's college students: Challenges and recommendations. *NASPA journal*, *41*(1), 167-181.

Kleinman, A. (1988). Rethinking psychiatry: from cultural category to personal experience. Free Press. *New York City, NY.*

------. (2012). Medical anthropology and mental health: five questions for the next fifty years. *Medical anthropology at the intersections*, 178e196.

Kleinman, A., Yan, Y., Jun, J., Lee, S., & Zhang, E. (2011). *Deep China: The moral life of the person*. Univ of California Press.

Kleinman, A., Yang, L. H., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: adding moral experience to stigma theory. *Social science & medicine*, *64*(7), 1524-1535.

Kumagai, A. K., & Lypson, M. L. (2009). Beyond cultural competence: critical consciousness, social justice, and multicultural education. *Academic medicine*, *84*(6), 782-787.

Lau, S. (1996). Growing up the Chinese way: Chinese child and adolescent development. Chinese University Press.

LeFrançois, B. A., Menzies, R., & Reaume, G. (Eds.). (2013). *Mad matters: A critical reader in Canadian mad studies*. Canadian Scholars' Press.

Lester, R. J. (2009). Brokering Authenticity: Borderline Personality Disorder and the Ethics of Care in an American Eating Disorder Clinic. *Current anthropology*, *50*(3), 281-302.

Liu, M. (2009). Addressing the mental health problems of Chinese international college students in the United States. *Advances in Social Work*, *10*(1), 69-86.

Mandel, A. (1998, February 19). Murder-suicide victim's family files suit against college. The Harvard Crimson

McCarthy, T. (2014). Great aspirations: the postwar American college counseling center. *History of psychology*, *17*(1), 1.

Menzies, R., LeFrançois, B. A., & Reaume, G. (2013). Introducing mad studies. *Mad matters: A critical reader in Canadian Mad Studies. Toronto: CSPI.*

Metzl, J. M. (2010). The protest psychosis: How schizophrenia became a black disease. Beacon Press.

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, *103*, 126-133.

Mignolo, W. D. (2009). Epistemic disobedience, independent thought and decolonial freedom. *Theory, Culture & Society*, *26*(7-8), 159-181.

Miller, J. G. (2002). Bringing culture to basic psychological theory--beyond individualism and collectivism: comment on Oyserman et al.(2002).

Mitchell, D. T., & Snyder, S. L. (2000). *Narrative prosthesis: Disability and the dependencies of discourse*. University of Michigan Press.

Mori, S. C. (2000). Addressing the mental health concerns of international students. *Journal of Counseling & Development*, *78*(2), 137-144.

Morrison, L. J. (2013). Talking back to psychiatry: The psychiatric consumer/survivor/ex-patient movement. Routledge.

Mowbray, C. T., Megivern, D., Mandiberg, J. M., Strauss, S., Stein, C. H., Collins, K. & Lett, R. (2006). Campus mental health services: recommendations for change. *American Journal of Orthopsychiatry*, *76*(2), 226.

Much, K., Wagener, A. M., & Hellenbrand, M. (2009). Practicing in the 21st century college counseling center. *Journal of College Student Psychotherapy*, *24*(1), 32-38.

Nicki, A. (2001). The abused mind: Feminist theory, psychiatric disability, and trauma. *Hypatia*, *16*(4), 80-104.

Nishida, A. (2015). 10 Neoliberal Academia and. Occupying Disability: Critical Approaches to Community, Justice, and Decolonizing Disability, 145.

Parcover, J., Mays, S., & McCarthy, A. (2015). Implementing a Public Health Approach to Addressing Mental Health Needs in a University Setting: Lessons and Challenges. *Journal of College Student Psychotherapy*, *29*(3), 197-210.

Parsons, T. (1951). Illness and the role of the physician: A sociological perspective. *American Journal of orthopsychiatry*, *21*(3), 452-460.

Perry, B. L. (2011). The labeling paradox stigma, the sick role, and social networks in mental illness. *Journal of Health and Social Behavior*, *52*(4), 460-477.

Prendergast, C. (2001). On the rhetorics of mental disability. *Embodied rhetorics: Disability in language and culture*, 45-60.

Rose, N. (2003). Neurochemical selves. *Society*, *41*(1), 46-59.

Rosenbaum, P. J., & Liebert, H. (2015). Reframing the conversation on college student mental health. *Journal of College Student Psychotherapy*, *29*(3), 179-196.

Russo, J. (2016). In dialogue with conventional narrative research in psychiatry and mental health. *Philosophy, Psychiatry, & Psychology*, *23*(3), 215-228.

Russo, J., & Beresford, P. (2015). Between exclusion and colonisation: Seeking a place for mad people's knowledge in academia. *Disability & Society*, *30*(1), 153-157.

Scheyett, A. (2006). Silence and surveillance: Mental illness, evidence-based practice, and a Foucaultian lens. *Journal of Progessive Human Services*, *17*(1), 71-92.

Shuchman, M. (2007). Falling through the cracks—Virginia Tech and the restructuring of college mental health services. *New England journal of medicine*, *357*(2), 105-110.

Singh, N. N., Lancioni, G. E., Wahler, R. G., Winton, A. S., & Singh, J. (2008). Mindfulness approaches in cognitive behavior therapy. *Behavioural and Cognitive Psychotherapy*, *36*(06), 659-666.

Small, C. (2011). Musicking: The meanings of performing and listening. Wesleyan University Press.

Sue, D. W. (1994). Asian-American mental health and help-seeking behavior: Comment on Solberg et al.(1994), Tata and Leong (1994), and Lin (1994).

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development*, *70*(4), 477-486.

Sue, D. W., & Sue, D. (1990). Counseling the culturally different: Theory and practice.

Sugarman, J., & Sulmasy, D. P. (2010). Methods in medical ethics. Georgetown University Press.

Szasz, T. (1961). *Myth of mental illness* (Vol. 15). New York.

Terkelsen, T. B. (2009). Transforming subjectivities in psychiatric care. *Subjectivity*, *27*(1), 195-216.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of health care for the poor and underserved*, *9*(2), 117-125.

Ussher, J. M. (2010). Are we medicalizing women's misery? A critical review of women's higher rates of reported depression. *Feminism & Psychology*, *20*(1), 9-35.

Wolframe, P. M. (2012). The madwoman in the academy, or, revealing the invisible straightjacket: Theorizing and teaching saneism and sane privilege. *Disability Studies Quarterly*, *33*(1).

Yan, Y. (2008). Introduction: understanding the rise of the individual in China. *European Journal of East Asian Studies*, *7*(1), 1-9.

------. (2010). The Chinese path to individualization. *The British journal of sociology*, *61*(3), 489-512.

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: adding moral experience to stigma theory. *Social science & medicine*, *64*(7), 1524-1535.